# Bidston and St James Children's Centre

## Quality Report

St James Centre
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Birkenhead
Merseyside
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Tel:07729360214
Website:

Date of inspection visit: 30 November 2015
Date of publication: 27/06/2016

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

This report describes our findings for the quality of care provided within this core service by One to One (North West Limited) Limited Bidston and St James. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by One to One (North West) Limited and these are brought together to inform our overall judgement of One to One (North West) Limited.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

## Overall summary

One to One (North West) Limited is a private community based maternity service that provides antenatal, intrapartum and postnatal care to expectant mothers. The service is based in the Bidston and St James Children's centre. The service was set up in 2011. The company aims to provide a single midwife to support expectant mothers aged 14 years and older through antenatal care, birth and postnatal care. Midwives working for the company were allowed to go into NHS hospitals to act as advocates or support if the woman chose a hospital birth. One to one midwives were not allowed to deliver babies in NHS hospitals but they could stay with women on their case load if the woman made this request. The midwives employed by the trust were responsible for all maternity care once a woman was admitted to hospital.

This service was previously inspected on 13 April 2015 as part of an unannounced focused inspection and we found that there were concerns related to medicines management, the use of Cardiotocography (CTGs) in a community setting and the management of risk and governance. At that inspection we were not given the assurance that risk was being managed effectively across the organisation to provide a safe environment for high risk pregnancies. At that inspection we also found no evidence of joint pathways in place with local providers and agreed processes for flagging up or considering additional needs of the mother were not in place. We asked the provider to make improvements in these areas.

We carried out a further comprehensive inspection on the 30 November and 1 December 2015. We have not published a rating for this service. CQC does not currently have a legal duty to award ratings for those services that provide solely or mainly community maternity services.

We found that incidents were not being reported to CQC under the statutory notifications' regulation. The incidents the staff were required to report to CQC was limited to "serious incidents which has potential to threaten registration status". The clinical incident policy did not require staff to report clinical incidents to CQC. Regulation 18 of the CQC (Registration) Regulations 2009 requires providers to notify CQC of certain defined incidents. This would include incidents of patients experiencing prolonged pain or prolonged psychological harm or certain types of injury to a service user.

The North West service reported 788 births during this period and reported one intrauterine death, one intrapartum death and one neonatal death which involved joint care with an NHS trust. Two serious incidents were reported to the Care Quality Commission between April 2015 and December 2015. Our records indicated that the CCG informed the Care Quality Commission about two of these occurrences. We had to seek additional information from the One to One services. This meant the service was fulfilling their obligation to provide CQC with notifications of incidents required under the Act.

# Summary of findings

Staff we spoke to was confident in the use of the incident reporting systems; however, they were unclear about the breadth of events that should be reported. Staff said they were given feedback from their manager about the incidents they reported.

Managers responsible for running the service undertook the root cause analysis (RCA) of incidents and feedback from incidents was provided. Staff directly involved in incidents received individual feedback and any lessons learned were disseminated throughout the organisation in order to improve the care delivered to women and babies.

Action had been taken to provide the appropriate skill mix of midwifery staff for low risk pregnancies throughout pregnancy. This included changing the notice period for permanent midwives who wanted to leave the service. This was to ensure a handover period during which new recruits could become confident in carrying out their roles.

The provider did not present evidence of specific training about underlying conditions which made a pregnancy high risk. As midwives did not encounter these conditions very often they accessed best practice guidance available at the time the information was needed.

Birth records indicated that midwives took the correct actions during labour and used their skills to deal with complications during childbirth such as shoulder dystocia. This is when women need extra help to allow the shoulders of the baby to be born.

Concerns remained about how well high risk pregnancies were monitored during pregnancy because staff stated they had not received specialist training to support women with underlying conditions such as epilepsy and diabetes. Concerns were also raised about action taken for women who may develop unforeseen complications who then refused to seek medical intervention and/or hospital support when midwives identified that this was needed.

Schedule 2 Controlled Drugs were no longer used by the service and women were well informed about the pain relief the service could provide.

Processes were established to ensure medication was appropriately stored and accounted for.

There were plentiful stocks of personal protective equipment, such as disposable gloves and aprons.

Midwives carried hand gel for use when hand washing facilities were not available.

Midwives held a maximum caseload of 32 women.

Risks within the organisation were identified and included safeguarding training rates for midwives, potential gaps in the handover process between midwives when the lead midwife was unavailable and; women who chose to deviate from NICE guidance who also had complex needs with a risk of overall poor outcomes. A gap in integrated working with other providers was also identified as a risk.

The service continued to work with partner agencies to develop single care pathways for women who would opt for joint care with One to One North West Ltd and the acute trust obstetrician-led service.

The service needed to develop clear pathways for women with high risk pregnancies who refused to accept care based on best practice guidance.

We visited the One to One North West office and clinic at the Bidston and St James children centre and the Warrington Pregnancy Advice Centre in the Golden Square shopping centre.

We carried out 10 telephone interviews with midwives chosen at random and a number midwives attended a focus group. We interviewed two locality co-ordinators and met three midwives working at the pregnancy advice centre. Three women who used the service were interviewed face to face and seven were interviewed over the telephone.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Maternity** | | We found that incidents were not being reported to CQC under the statutory notifications' regulation.The incidents the staff were required to report to CQC were limited to "Serious Incidents which has potential to threaten registration status". The clinical incident policy did not require staff to report any other clinical incidents to CQC. Regulation 18 of the CQC (Registration) Regulations 2009 requires providers to notify CQC of certain defined incidents. This would include those incidents of patients experiencing prolonged pain or prolonged psychological harm and some types of injury to a service user.<br>Two serious incidents were reported to the Care Quality Commission between April 2015 and December 2015. This involved one intrauterine death, one intrapartum death. Oneneonatal death which involved joint care with an NHS trust was also reported.<br>Our records indicated that the CCG informed the Care Quality Commission about two of these occurrences. We had to seek additional information from the One to One services about all incidents. This meant the service was not fulfilling their obligation to provide CQC with notifications of incidents required under the Act.<br>Staff we spoke to was confident in the use of the incident reporting systems; however, they were unclear about the breadth of events that should be reported. Staff said they were given feedback from their manager about the incidents they reported. Managers responsible for running the service undertook the root cause analysis (RCA) of incidents and feedback from incidents was provided. Staff directly involved in incidents received individual feedback and any lessons learned were disseminated throughout the organisation in order to improve the care delivered to women and babies.<br>Action had been taken to provide the appropriate skill mix of midwifery staff for low risk pregnancies throughout pregnancy. This included changing the |

# Summary of findings

notice period for permanent midwives who wanted to leave the service. This was to ensure a handover period during which new recruits could become confident in carrying out their roles.
The provider did not provide specific training about underling conditions which made a pregnancy high risk. Midwives stated that they didn't encounter these conditions very often and they felt it was best to revise best practice guidance at the time the information was needed.
Birth records indicated that midwives took the correct actions during labour and used their skills to deal with complications during childbirth such as shoulder dystocia. This is when women need extra help to allow the shoulders of the baby to be born.
Concerns remained about how well high risk pregnancies were monitored during pregnancy because staff stated they had not received specialist training to support women with underlying conditions such as epilepsy and diabetes. Concerns were also raised about action taken for women who may develop unforeseen complications who then refused to seek medical intervention and/or hospital support when midwives identified that this was needed.
Schedule 2 Controlled Drugs were no longer used by the service and women were well informed about the pain relief the service could provide.
Processes were established to ensure medication was appropriately stored and accounted for.
There were plentiful stocks of personal protective equipment, such as disposable gloves and aprons. Midwives carried hand gel for use when hand washing facilities were not available.
Midwives held a maximum caseload of 36 women and said this number was small enough to allow them to provide individualised care.
Risks within the organisation were identified and included safeguarding training rates for midwives, potential gaps in the handover process between midwives when the lead midwife was unavailable and; women who chose to deviate from NICE guidance who also had complex needs with a risk of overall poor outcomes. A gap in integrated working with other providers was also identified as a risk.

# Summary of findings

The service continued to work with partner agencies to develop single care pathways for women who would opt for joint care with One to One North West Ltd and the local trust authority obstetrician-led service.
The service needed to develop clear pathways for women with high risk pregnancies who refused to accept care based on best practice guidance.

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**Services we looked at**
Maternity

# Summary of this inspection

## Background to Bidston and St James Children's Centre

One to One (North West) Limited is a private community based maternity service that provides antenatal, intrapartum and postnatal care to expectant mothers. The service is based in the Bidston and St James Children's centre. The service was set up in 2011. The company aims to provide a single midwife to support expectant mothers aged 14 years and older through antenatal care, birth and postnatal care. Midwives working for the company were allowed to go into NHS hospitals to act as advocates or support if the woman chose a hospital birth. One to one midwives were not allowed to deliver babies in NHS hospitals but they could stay with women on their case load if the woman made this request. The midwives employed by the trust were responsible for all maternity care once a woman was admitted to hospital.

We carried a comprehensive inspection on the 30 November and 1 December 2015. We have not published a rating for this service. CQC does not currently have a legal duty to award ratings for those services that provide solely or mainly community maternity services.

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# Summary of this inspection

for women who may develop unforeseen complications who then refused to seek medical intervention and/or hospital support when midwives identified that this was needed.

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The service needed to develop clear pathways for women with high risk pregnancies who refused to accept care based on best practice guidance.

## Our inspection team

Our inspection team was led by:

**Chair: Ann Ford Head of Inspection, Care Quality Commission.**

**Inspection Lead: Wendy Dixon,** Care Quality Commission, Inspection Manager.

The team included CQC hospital and pharmacy inspectors and inspection managers. A consultant midwife, the head of an NHS Trust maternity service, an obstetrician and an expert by experience provided specialist input for the inspection team.

## Why we carried out this inspection

We carried out this follow-up comprehensive inspection on the 30 November and 1 December 2015 to review the changes the service had made in relation to use of cardiotocography, medication management and risk management.

We have not published a rating for this service. CQC does not currently have a legal duty to award ratings for those services that provide solely or mainly community maternity services.

## How we carried out this inspection

1. Before visiting the provider we reviewed a range of information we held about One to One (North West) Limited Bidston and St James location.
2. The announced inspection took place on 30 November and 1 December 2015.
3. During the inspection we talked with 10 women, 17 midwives, one sonographer, five senior staff and three maternity and mother assistants (MaMas).
4. We reviewed 12 complete sets of care records and treatment plans and also three sets of hand held records held by women we interviewed. We also reviewed other relevant records and documents held by the provider such as governance framework meeting notes, incidents reports and policies and procedures.
5. We spoke with six midwives face to face and 10 on the telephone.

# Summary of this inspection

6. We spoke with seven women on the telephone and three face to face.
7. We spoke with the Clinical Governance Lead and the Risk Manager face to face.
8. We visited and inspected the pregnancy advice centres for the North West service situated in Warrington Town centre and the St James Children's centre in Birkenhead

## Information about Bidston and St James Children's Centre

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## What people who use the service say

We interviewed ten women who were receiving antenatal and postnatal care from One to One North West Limited. All said they felt safe using the service. Women told us they were provided with enough information to make an informed choice about their care.

All ten women said they had received care from a small team of midwives and knew how to contact the midwife allocated to them. Women who had given birth confirmed that they had been attended to by their allocated midwife or their buddy at the time of birth.

Women said they were able to contact their midwife in between planned appointments.

Women told us that appointments were arranged at a time and place to meet their needs.

# 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?

The service did not always measure safety issues against quality targets and so could not be sure the processes were protecting women and babies from abuse and avoidable harm were as effective as possible. Care pathway risk assessments for antenatal care and protocols for dealing with emergencies were unclear and did not provide a firm basis on which to support home births for high risk pregnancies. Protocols were needed to ensure girls aged 18 and under were protected if they contacted the service.

The service had processes to ensure there were sufficient numbers of midwives and monitored this against the number of referrals into the service.

Women who were identified as high risk in pregnancy, who required care under a consultant obstetrician were seen by local NHS Providers if the women agreed to receive the service.

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Staff were clear about how to complete incident reports, however guidelines and policies for reporting and reviewing incidents lacked rigour and the implementation of change was not timely.

The service had just moved to an electronic reporting incident system in order to manage incidents more effectively.

### Are services effective?

Care and treatment for low risk women was based on best practice evidence. Pain control was well managed by the service. The service was effective at supporting women to breast feed their babies. Service provision was flexible and available 24 hours a day, seven days a week.

An audit programme was in place, however it was difficult to measure comparative success for this service as national data was not always comparable with a community based midwifery led service providing care for low and high risk pregnancies.

The service had developed operational procedures for joint working with their partner agencies, in particular the maternity services at district general hospitals. Pathways into partner trusts were not consistent.

# Summary of this inspection

## Are services caring?

The service provided compassionate care to expectant mothers which was individualised to fit their individual preferences. The management systems and philosophy of the service encouraged midwives to work flexibly and collaboratively with women and their families.

The service had completed a comprehensive customer satisfaction survey 2014/2015 which provided positive feedback which indicated the service operated in a caring, compassionate and person-centred manner. The service also participated in the friends and family test which also provided information which indicated the service was caring.

Women had access to antenatal and post-natal groups run by One to One midwives.

## Are services responsive?

The service actively sought to work in partnership with commissioners and GPs to promote the service to all women who fit the referral criteria. This was sometimes challenging, due to different contracts in place with different commissioners.

The service was planned and provided services to meet the needs of current and potential women who wanted to use the service in a timely way, for example, the parents' advice centre in a busy shopping precinct was innovative and enabled and encouraged women to seek advice and access antenatal care as frequently as they wanted.

The service accepted women with low and high risk needs, however specialist midwives for epilepsy, diabetes, mental health or substance misuse were not employed and women were not automatically referred to NHS trust specialist services

Concerns were listened to and acted on however all concerns were not recorded for the purpose of audit.

## Are services well-led?

Policies and procedures included a statement about auditing the quality of the service and clinical outcomes; however no target dates for audits were included and the service did not include updating policies and procedures to support good practice in their audit plan.

Monthly quality assurance and board meeting records did not provide detailed and comprehensive information about what plans were been made in response to information received.

The service had a clear philosophy of care and a clear management structure. Leaders were visible and accessible to staff, and staff were clear on the values and philosophy of the service.

# Summary of this inspection

The culture was open and staff and people who used the service had a voice, and were able to contribute to service developments.

Quality and performance monitoring was in place and there was evidence of some improvements since the last inspection and the risk register was reviewed monthly at the quality assurance group, which was evidenced through the standard agenda item and minutes.

# Detailed findings from this inspection

**Notes**

We have not published a rating for this service. CQC does not currently have a legal duty to award ratings for those services that provide solely or mainly community maternity services.

# Maternity

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

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The service needed to develop clear pathways for women with high risk pregnancies who refused to accept care based on best practice guidance.

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## Are maternity services safe?

### Incident reporting, learning and improvement

- All the midwives spoken with were clear about filing an incident report and told us there was a good reporting culture. Many gave examples of incidents they had reported and indicated they received feedback following a report and were well supported. We found, however, a number of midwives were unclear about the breadth of incidents including near misses that needed to be reported.
- An electronic system was in place for reporting incidents. The new automated system automatically flagged incidents to senior managers and staff.
- Incident reporting policies and procedures included a timeline by which key people had to be informed, but did not include the name or contact details which may cause a delay in escalating a concern.
- Two serious incidents had been reported to the Care Quality Commission (CQC) between April 2015 and December 2015 and evidence provided by the service indicated three had occurred. This meant the service was not performing all statutory duties.
- We observed that incident reporting policies were unclear about reporting to the CQC. Discussion with the senior manager indicated delays had been caused because arrangements in place lacked clarity about who was accountable for reporting and checking that the CQC received serious incident reports in a timely way.
- Managers reviewed incidents and discussed and monitored actions at monthly governance meetings. Information was cascaded to different levels of staff through weekly co-ordinators meetings, round table discussions and daily handovers between consultant midwives, locality co-ordinators and their teams. Lessons learnt were also shared through the One to One 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 adverse event.
- One RCA investigation had been completed since the previous inspection in April 2015 and one was being investigated at the time of our visit. As a result of the completed investigation the service had taken steps to

introduce the GROW fetal growth measurement package. This is a specialised method of measuring and recording how well babies are growing while in the womb so that the correct birth plan can be agreed before birth. We found however that the service was slow to implement changes because although this investigation was concluded in April 2015 training for staff was not scheduled to commence until January 2016. This was due to computer program compatibility problems.

- Duty of candour responsibilities were 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.
- The One to One (North West) quality performance report indicated that the service reviewed all incidents monthly including injury (morbidity) to women or babies and still births (mortality). Reviews included confirming the level of harm sustained and detailed the action taken by the service in relation to updating staff and investigating the incident. The reviews did not provide, however, a description of the event and why the actions prescribed would prevent a recurrence. The provider's records should demonstrate that morbidity and mortality issues are discussed and reviewed includes the full care pathway and are completed by suitably qualified and senior staff.

**Safeguarding**

- The service had a named lead safeguarding midwife whose duties were outlined in the One to One adult safeguarding policy; however dealing with potential child protection issues were not addressed. Information provided did not provide assurance that the service dealt with child protection issues appropriately. For example the One to One referral pathway identified that only young women aged 14 years and over were eligible for the service, but staff were not prompted to involve the criminal justice system if a 13 year old became known to them. Neither were staff prompted to make vulnerable young people enquiries for those aged between 14 and 18 years old. The service planned to increase the number of safeguarding supervisors with training by the NSPCC by April 2016
- The One to One safeguarding adult's policy (version 2) 2014 was not specifically relevant to the community based services; however, the policy prompted midwives to refer to and follow the relevant local authority safeguarding policy.
- The safeguarding policy did not reference actions midwives should take if they were aware the female genital mutilation had occurred.
- We were informed there was a longstanding relationship both with the safeguarding team at the Local Acute Trusts, the CCG on the Wirral and neighbouring CCG areas. Safeguarding referrals were monitored through reporting arrangements with each CCG using dashboards.
- It was reported that the named midwife for safeguarding had regular meetings with the designated nurse for safeguarding at Wirral/West Cheshire/Warrington CCG to ensure all legal and contractual requirements were met. This was monitored through contractual obligations with lead CCGs.
- The 'Safeguarding Level 3 training Action Plan' provided at the time of the inspection indicated 80% of staff had completed safeguarding level three training. This was worse than the service's target of 95%. The action plan stated the target for achieving 95% compliance was April 2016. Further training had been planned to reach the compliance target.

**Medicines**

- Medication held at the main office and the clinic in Warrington was stored safely in locked cabinets and cupboards. Charts and records confirmed medication fridges were checked and maintained within the required temperature ranges.
- Portable medication gas cylinders were stored in secure cabinets correctly labelled so that emergency services would be alerted in the event of a fire. These were packaged correctly when transported by midwives in keeping with best practice guidance.
- Midwives carried medication to treat the most common maternity emergencies as advised in the Kings Fund safer birth initiative 2010.
- Midwives did not carry controlled drugs.
- Midwives explained the use of the medication they carried and indicated they knew the purpose of medication and would respond correctly in an emergency.

# Maternity

**Environment and equipment**

- The service operated from a suite of offices and clinic rooms at Bidston and St James children's centre and a drop-in clinic in Warrington's main shopping precinct. Both areas were accessible.
- Midwives were supplied with a home birth tool kit and we checked three kits. Each kit was complete and in good repair. They contained the equipment advised in the Kings Fund Safer births guidance.
- Adult and neonatal sized emergency breathing equipment was included.
- All items looked clean and were intact.
- Equipment included a sonic aid fetal listening devices and cardiotocography (CTG) machines which were used to monitor a baby's heart rate. These were visibly clean and in good condition.
- Midwives knew the purpose of each piece of equipment and told us they checked their equipment daily; this was recorded through the electronic reporting system. However compliance with completing check this was not audited by the service.
- We saw that locality co-ordinators completed the locality checklists weekly.

**Quality of records**

- The One to One North West service was commissioned to provide a midwifery led service to expectant mothers throughout their pregnancy, birth and during the post-natal period. The contract made no distinction between low and high risk pregnancies. One to One (North West) Limited supported women with low and high risk pregnancies to have home births.
- Records did not indicate that both high and low risk women had been supported to make an informed choice about their antenatal, intrapartum (care during labour) and postnatal care.
- Electronic and hand written records were used and we reviewed 12 sets of records in full and three sets of hand held records.
- Hand held records were a summary of care only and it was not always clear from these whether midwives had discussed best practice guidance with expectant mothers. The electronic health records indicated that best practice guidance was discussed and documented in the care plans and risk assessments.
- Information in the electronic records for identified high risk pregnancies indicated that midwives repeated information about risk and best practice to these women, checking for understanding at each stage for high risk pregnancies; however, we were not clear about what the discussions included because best practice guidance was quoted but not described. Neither was it clear that discussions about best practice had taken place with low risk women.
- Although electronic records were clear, hand held records did not provide enough information to help determine whether the service considered a pregnancy as low or high risk. Neither was it always possible to confirm in the hand held records, if all the risks had been fully explored when women with a high risk pregnancy opted for a home birth.
- The 12 records reviewed which included records of care during the birth indicated midwives recorded clear and detailed information of each birth which included the condition of the mother and baby.
- Hand held and electronic post-natal records about post-natal care were completed in sufficient detail to provide comprehensive information about the care of mother and baby for up to six weeks after labour.
- The hand written records were kept by the women and returned to One to One (North West) Limited 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 patient records been accessed by those without the correct authority.

**Cleanliness, infection control and hygiene**

- The service used robust infection control and monitoring systems and had completed a comprehensive review of compliance with the infection control hygiene code of practice in April 2015.
- No reports of Methicillin resistant staphylococcal aureus (MRSA), Clostridium difficile (C. Diff) or puerperal infections were made between January 2015 and October 2015.
- Key policies and service level agreements to promote compliance with the code of practice such as hand hygiene, use of protective clothing and disposal of clinical waste were in place.

- Midwives were provided with cleansing wipes, hand gels, waste disposal bags and other infection control items and additional supplies were readily available from stores at Bidston and St James children's centre and the Warrington parent advisory centre.
- There was always a good stock of infection control equipment including vaginal pads and paper tissues.
- Women said staff used hand rubs during home visits and were observed washing their hands between contacts when at the office or Parents Advisory Centre (PAC).
- We saw handwashing and drying equipment in each centre and clinic room.
- Placentas were transported to the PAC by midwives, and these were securely stored and packaged. A service level agreement was in place for the disposal of placentas which were stored in a special freezer kept in a locked room.
- Systems were in place to ensure HIV and hepatitis B screening was provided.
- The services 2014/15 screening data showed 91% of women received HIV screening; this was better than the 90% target and none of the women seen had met the hepatitis B referral criteria.

**Mandatory training**

- Data from the service indicated 100% of staff had completed mandatory training in October 2015.
- Midwives told us the training included skills and drills in dealing with medical emergencies, advanced life support training and neonatal advanced life support.
- The skills and drills sessions were aimed at managing an emergency in the home setting.
- We were informed that a new training manager had redesigned the training programme, in January 2016.
- Staff informed us the drills and skills and training did not involve their partner agencies such as the ambulance service or local acute trust maternity services, which they felt would be beneficial.

**Assessing and responding to patient risk**

- Women were not accepted or refused on the basis of clinical risk or complexity. Initial acceptance was based on location, age and the availability of midwives to provide individual support throughout the pregnancy.
- The service aimed to support all women to have their babies at home including those in a high risk category. This meant midwives had to deal with complications in the community which were usually managed on a consultant led maternity unit at a local acute trust hospital.
- One to One (North West) Limited's 'Management of women with complex needs' policy v2 October 2015' placed a lot of emphasis on the responsibility of the midwife to support high risk women through their pregnancy. No minimum standards were set with regards to risk assessing complex cases and so the application of best practice guidance was open to interpretation. Midwives we spoke to did not raise this as a concern.
- The service carried out a quality audit of records between November 2014 and November 2015. The report identified that midwives did not routinely complete additional risk assessments for women who identified themselves as uncomplicated. However the service reported that the booking assessment was a 'risk assessment' assessing medical, social, psychological, obstetric and family history and 100% of women had undergone this process.
- Policies did not always promote the safest response to the results of risk assessments. For example the One to One 'Discharge of care practice point 2011' stated 'Antenatal transfer of care should only be initiated by the woman. One to One will provide midwifery care for all women regardless of risk.' The policy did not provide additional guidance for staff if a woman would not transfer when the level of risk included a high likelihood of injury or mortality.
- The service policy instructed midwives to complete specific variance sheets, 'practice point' forms and care pathways depending on whether the pregnancy was assessed as low, intermediate or high risk. Records were completed using the electronic recording system and similar information was replicated in a hand held file.
- The 12 care plans reviewed by the CQC maternity and obstetric specialist advisors had been completed with reference to NICE guidance but the guidance was quoted, the records did not always specify individual aspects of the guidance. Those who with high risk pathways were reviewed by a consultant midwife but not an obstetrician. Copies of the care plans were sent to the GP and supervisor of midwives, stored in a paper file and the women were also given a copy.
- The electronic records indicated that risks had been discussed with women at each antenatal clinic. It was

not always clear that midwives completed the variance sheets when women chose care which deviated from best practice guidance because these were not seen on hand held records or in the electronic patient record systems reviewed by the specialist advisors.

- Plans of care were individualised and confirmed the wishes of women. However the reasons why care pathways did not involve an obstetrician or consultant led maternity service were not always clearly documented. The policy stated that consultant midwives reviewed the care needs of high risk women at weekly meetings to identify additional support needed to prepare midwives and the home environment for a high risk birth. Mitigation included additional training to midwives and staff rostering to ensure the correct skill mix and number of midwives are available during the expected period of delivery and liaison with the appropriate NHS maternity service if agreed by the woman and accepted by the trust. Documents were not available to confirmed specialist bespoke training had been provided.
- Policies did not fully support joint decision making because although consultant midwives had to be involved in the review and ongoing care of high risk women the final responsibility in managing the birth was deferred to the allocated case holder midwife and their buddy. The plan of care had a check box for obstetric and multidisciplinary team referral. It also included a section for obstetric input to the plan. The plans of care included a reference number for NWAS for prior planned emergency transfer arrangements. This was also documented in the risk assessment in the electronic health records.
- If the women declined ongoing obstetric care this was documented in the care plan. It was not evident whether the suggested preparation such as ongoing obstetric care or emergency transfer arrangements had been accepted and put in place.
- The service supported women to choose where to give birth until they decided to transfer or agreed to a request for additional help. This level of flexibility did not support robust and consistent systems for managing the timely transfer of a deteriorating mother or baby. The service was introducing a 'Midwives Mitigating Risk" (MMR) assessment process. We reviewed the draft November 2015 document. This comprehensive assessment record, which included detailed risk assessment prompts and mitigating guidance, was going to be used with practice points. Deadlines for piloting and introducing this assessment were not included in the plan.
- The specialist advisors (SpA's) reviewed the birth records for twelve women and specifically looked at records of women who had been transferred to hospital either during or post labour. Four of the transfers had been due to post-partum bleeding. The SpA's saw that midwives completed vital sign observations and responded to deterioration in condition. The specialist advisors also noted that the service did not use the modified early warning score (MEWs). The MEWs matrix aggregate the results of the observations and indicates when additional medical assistance may be required before a collapse occurs. The use of this matrix early warning observation system is been introduced on the basis of guidance from the Royal college of anaesthetists because it promotes earlier intervention from the midwife.

**Staffing levels and caseload**

- The service had taken steps to ensure adequate numbers of qualified midwives were employed. One midwife carried a case load of 32 women; each attended approximately five births and led on two each month. This situation was closely monitored.
- The staffing policy considered the National Institute of Clinical Excellence (NICE), Safe Staffing for Maternity Setting Guideline 2015. This service had reviewed the recommendations and though not specifically related to their model of care, used the headings to report on their staffing plans.
- Staffing numbers and deployment had been reviewed in June 2015 and the action plan included an increase in the number of midwives and mother and midwife assistants (MAMAs).
- Reports indicated staffing was under continual review through taking historical data into account and in response to feedback from stakeholders.
- The service was organised in locality teams, each headed by a locality co-ordinator who was an experienced midwife.
- Each midwife worked closely with two other midwives within the team, and women were introduced to three midwives in total. This meant two additional midwives were aware of the antenatal care and birth plan.

# Maternity

- During labour women were supported by the lead midwife and a buddy.
- The service also employed three consultant midwives nationally with responsibility for reviewing the care of high risk women.
- Midwives were allocated caseloads within a 30 minute radius of where they lived, which meant they could attend women quickly.
- All midwives said staffing was sufficient to provide the required support to women. Staff indicated they received good support from colleagues, the locality co-ordinator and consultant midwives.
- Midwives stated there was continual informal communication with peers and locality co-ordinators.
- Staff also said there were weekly locality meetings to discuss cases, clinics, new developments, training opportunities however these were not recorded.
- The service had taken steps including extending the notice period from four to 12 weeks to ensure there were always sufficient experienced staff to work alongside newly qualified or recently employed midwives.
- This service did not use agency staff.

**Managing anticipated risks**

- One to One (North West) Limited employed a consultant obstetrician for non urgent obstetric advice to give advice to women using the service and midwives providing care. Contractual arrangements stated that the obstetrician may complete medical examinations, order investigations and review the care of individual women. The obstetrician was contracted for 12 hours a week between all locations.
- Staff told us that they accessed an obstetrician mostly for non urgent telephone advice. The service level agreement lacked detail and clarity about what actions the responsibility the consultant had for individual management of their obstetric care. Discussion with senior staff and midwives indicated there was no ongoing responsibility on the part of the obstetrician for managing the care of high risk women throughout the pregnancy, and in particular in preparation for a potential home birth.
- Women with high risk pregnancies, who agreed to multidisciplinary care, attended an NHS trust maternity service to access obstetric care.
- High risk women who declined NHS input had access the same consultant who would provide non urgent advice on an individual basis. The obstetrician also made referrals to NHS providers, but only if the woman was in agreement. Women with high risk pregnancies, who remained exclusively under the care of One to One (North West) services, did not have access to an obstetrician for medical clinical assessments and monitoring, as would be expect for high risk conditions in pregnancy.

**Major incident awareness and training (only include at service level if variation or specific concerns)**

- The service had developed a robust business continuity plan which provided staff with detailed information about how to respond to specific scenarios such as loss of IT, loss of medical supplies or loss of key staff.
- Each written scenario also included full contact details of the emergency response team member responsible for each event.
- Staff stated major incident training was been planned by the newly recruited training midwife.

## Are maternity services effective?

**Evidence based care and treatment**

- 'Low risk' refers to a pregnancy that is anticipated to be problem free. A 'high risk' pregnancy refers to a pregnancy which is thought from the outset to be more at risk of complications before, at or after the delivery. This assessment of risk is based on a woman's past medical gynaecological/obstetric history, pre-existing conditions and any other relevant issues as the pregnancy continues.
- Royal colleges and other best practice guidance recommends that for the pregnancy and birth for high risk conditions, a system of clear referral paths should be established so that pregnant women who require additional care are managed and treated by the appropriate specialist teams when problems are identified. This is set out in NICE clinical guidance 62.
- National Institute for health and care excellence (NICE) recommends low risk pregnancy care is provided by midwives and that women are supported to have their baby at home or on a midwifery led unit. Records

should indicate that both high and low risk women have been supported to make an informed choice about their antenatal, intrapartum (care during birth) and postnatal care.

- Women with low risk pregnancies were receiving care in line with NICE guidelines. We saw assessments, care plans and referrals for low risk women included internet links to the relevant online best practice guidance. Midwives referenced best practice guidance in the summary following their contact with women.
- We saw evidence that antenatal care and advice for low risk women was based on NICE/Royal College guidelines. Best practice links included: Antenatal care for uncomplicated pregnancies NICE CG2; Intrapartum care for healthy women and babies NICE QS 190; Antenatal care NICE QS 22, and Postnatal care NICE QS 37 guidance.
- We saw that high risk women received information available about their circumstances and choices, including the statistics and likelihood of an untoward incident during their delivery. However the 12 records reviewed did not stipulate the risks associated with home birth for high risk pregnancies compared with birth in an obstetric led unit, in keeping with best practice guidance. This was important because women with high risk pregnancies were able to opt for a home birth.
- The service's risk register identified that training, supervision, clinical decision making and the paper record keeping system did not fully protect high risk women who deviated from NICE guidance. The service had recorded six actions points they would take to mitigate this risk. However these were not due to be completed until 27/06/2016.

**Pain relief**

- Records confirmed pain relief was discussed with women during antenatal care, during labour and postnatally.
- The service made women aware of the options available for home births. Entonox and birthing baths were always offered. Women were encouraged to attend pain management hypnotherapy classes provided by One to One midwives in preparation for their labour.
- Local anaesthetic was used to alleviate pain when perineal tears were repaired after birth.
- We observed information which indicated midwives appropriately supported women to transfer to local maternity units when additional pain control was requested during the first stage of labour.

**Nutrition and hydration**

- The service was effective at enabling women to breast feed their babies. The midwife and mother assistants (MAMAs) received training in how to support new mothers with feeding their babies. Breast feeding was promoted in keeping with best practice "Baby Friendly" guidance.
- The overall One to One maternity dashboard for April to October 2015 provided national information and indicated that nationally 82% of women using the service started breastfeeding immediately following birth. This was better than the service target of 70%.

**Patient outcomes**

- The One to One North West service recorded for April 15 to October 2015 counted 788 births and indicated good outcomes for women in most areas of care.
- 100% of women were offered a booking appointment within two weeks of referral.
- The percentage of planned home births was 29%.
- The percentage of normal vaginal delivery rate was 78%.
- The average percentage of instrumental births was 6%.
- There were no reports of eclampsia (excessively high blood pressure) and no cases of maternal sepsis were reported.
- One to One record PPH of 2 litres or above on the main maternity dashboard and reported nil between April 2015 and October 2015. It was noted that national monitoring arrangements for this outcome is set at 1000 mls or greater.
- There were two reported incidents of third and fourth degree perineal tears; one was in the North West. We saw that the reasons for these had been discussed by senior staff and one case was still under review.

# Maternity

- The percentage of unplanned caesarean section rate was 16%, which was better than the national target of 21%.
- There were 14 babies admitted to hospital post-delivery for both all One to One locations.
- The safety information indicated that fetal monitoring was completed for all expectant mothers booked within 12 weeks of pregnancy. Ultrasound sessions were run at different locations to enable women to take up screening.
- The service reported five still births for all locations between April 2015 and October 2015.
- The service had not set quality targets and did not benchmark locations against each other in order to assist with assessing the quality of outcomes for women who used different parts of the service.
- With regards to the incidents of still births at the time of inspection we were unable to identify if these women had previously been identified as high risk in this pregnancy.
- The service participated in the Uk National Screening Committee: antenatal and new-born screening education audit and was submitting data for the 2014/2015 audit. Results indicated some audits had improved, for example, monitoring for Downs syndrome had improved from 4% in June 2014 to 90% by December 2015. The national target for this test was 97% and an improvement plan aimed at achieving the 97% target was in place.
- We observed data was incomplete because information regarding completion of the new-born initial physical examination (NIPE) was not submitted for two periods.
- Nationally the service had managed 1013 home births and fourteen babies had been transferred to hospital, this figure was not desegregated into locations.
- Care records did not provide a detailed description of additional care and support provided during high risk pregnancies and the service had only recently introduced the GROW fetal measurement system to enable a closer watch on women at risk of small for dates babies. An audit on GROW and training of this is being carried out.The aim was to reduce the number of low birth babies born at term.

**Competent staff**

- In response to the previous CQC inspection, the service had introduced monitoring arrangements for CTG monitoring and staff competency. Details of all CTGs performed during 1 November 2014 to April 2015 were reviewed to assess the following: appropriate reason for CTG; appropriate management plan in place following CTG and appropriate onward referral for abnormal CTGs. In particular One to One (North West) Limited wanted to ensure that no CTGs were being performed on women in labour. The finding was that One to One had performed 36 CTGs and all were appropriate and dealt with correctly. None had been completed on women in labour.
- Discussion with staff indicated they were knowledgeable about the care pathways for low risk women and had practical experience of low risk births. However, when we spoke to midwives about the care pathway for a specific risk (epilepsy) they said they would refer to best practice guidance. However, none had practical experience in caring for a pregnant woman with this condition.
- Data for the service showed that 100% of midwives and midwife and mother assistants (MAMA's) had received an appraisal in 2013/14. 60% had received appraisals in June 2015, which indicated the service was on target to achieve 100% 2015/2016.
- There were clear training protocols, including a nine month preceptorship program for newly qualified (less than one year post qualification) and newly employed midwives.
- Preceptorship and induction included shadowing established staff, practice observations, completing e-learning sessions and classroom training sessions provided by consultant midwives. Newly qualified midwives had two to three of their records reviewed each month.
- The service promoted continual professional development, and included in the contract of employment that staff were entitlement to 10 days paid study leave each year.
- Staff said they had opportunities to complete specialist courses such as hypno-birthing therapy training.

- Staff described a rolling programme of training which included mental health training.
- The service had employed a training development lead who was in the process of completing a training needs analysis in order to ensure the training program met the needs of the service.
- The supervisor of midwives (SOM) ratio met the recommendation of one supervisor to 15 midwives and midwives indicated that at least one SOM was on duty at all times.
- In their 2015 report, the Local Supervising Authority (SLA) identified that all the Supervisors of Midwives had completed their mandatory training and continual professional development requirements.
- All staff had training consolidation passports which provided information about available support, how to access a supervisor of midwives, the frequency of meetings and opportunities to reflect on practice.

**Multi-disciplinary working and coordinated care pathways**

- Service level agreements to provide shared care for high risk pregnancies were not in place with commissioners of services. The midwives we talked with indicated arranging multidisciplinary working with local acute trust maternity services could be problematic.

**Referral, transfer, discharge and transition**

- We were informed that although communication was more effective with some trusts each maternity unit had to be approached in a different way to secure joint working for high risk pregnancies who wanted to birth at home. Issues described included problems securing specialist support which included joint care pathways following referral for obstetric care and delays in developing a pre-planned transfer pathway from home to hospital during labour.
- We found examples of effective multidisciplinary work for women who wanted to have their babies on a maternity unit. For example joint working protocols enabled the midwives to work as part of a multiagency team so that a woman with learning disabilities received their preferred care and treatment. Although not responsible for delivering the baby One to One midwives could stay with women on their case load during hospital births.
- We saw there were ongoing discussions between senior managers and the commissioning agencies about how to facilitate shared care and increase acceptance of joint working with GP's and local acute trusts.
- Records and audits indicated there was appropriate communication between the service, GP and health visitors during the antenatal and postnatal period.
- Information technology and procedures meant effective working between staff was promoted at all times.
- The service provided a seven day, 24 hour midwifery service.
- There was a consultant midwife, supervisor of midwives and team of case loading midwives on duty at all times.
- Midwives could access all equipment seven days a week.
- There was a service level agreement with an independent screening service for routine antenatal screening. For out of hours emergency services women would be supported to access local gynaecology or maternity services.

**Access to information**

- Staff had ready access to electronically held maternity records. Women were provided with hand held paper records which they were expected to carry with them for all appointments.
- The samples reviewed by the SpAs and those of the three women we interviewed at the clinic indicated all contact was recorded in hand held records and these were to be updated by all agencies accessed by women.
- There were systems to ensure screening reports were uploaded into electronic records and recorded in handheld records.
- The service had completed an audit of electronic records but not hand held records. The service should consider completing audits of all records to ensure required information is readily accessible in both formats.

- Staff accessed policies, guidelines and other information through the services intranet and all staff had access to computers.

**Consent, Mental Capacity act and Deprivation of Liberty Safeguards**

- In total we reviewed 15 paper records and 12 electronic records for women over 18 years of age and consent was indicated in the paper records and confirmed in the electronic records reviewed.
- All women we talked with confirmed that midwives spent time talking through the risks and benefits when deciding on birth options.
- We reviewed the records of women with high risk pregnancies and assessed that although best practice advice was discussed the consequences if a problem arose were not always fully explained. We were not assured that women were given sufficient information by an appropriately qualified clinician to make a fully informed decision.
- Records confirmed midwives and women discussed the birth plans at each consultation and women were supported to amend their plans of care.

## Are maternity services caring?

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  Women stated they felt listened to and treated with dignity and respect. One woman said their initial booking appointment took over one hour to complete and so she was satisfied that her concerns were fully documented and understood by her named midwife.
- Consultations were completed in clinic rooms with closed doors and so privacy was respected.
- One to One (North West) Limited gave women the option to provide feedback on the service, during specific points in their care using the National maternity Friends and Family Test.
- Between April 2015 and October 2015, 97% of women at 36 weeks said they would recommend the service. Following home birth, 98% of women would recommend the service and 97% of women would recommend community services. This figure related to r all One to One service and had not been aggregated into locations.

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

- All women who had previous experience of maternity services stated the service compared favourably with their previous experiences.
- Women described receiving information about hypnobirthing, diagnostic tests; healthy eating and other information on which they could reflect.
- All women said they felt in control and involved in developing their birthing plans.
- Women said because they always saw the same midwives, it was easy to check all information or discuss concerns.
- Routine antenatal clinic checks were arranged at a time to suit women and could be completed at home. Antenatal classes were organised throughout the day including evenings and weekends. These meant partners could be involved.

**Emotional support**

- The service ran a support group to help women and their families who had suffered Post Traumatic Stress Disorder (PTSD) after childbirth. This was free and open to all women who felt they qualified.
- All women had the option of six weeks postnatal care and this period could be increased if necessary and women with early pregnancy loss had access to a midwife for as long as they require it and were not automatically discharged early
- Midwives felt able to respond to the emotional needs of women because they had time to develop trust during the period of care.
- Women told us support from midwives was readily available and provided through different forums including individual planned visits, referrals to specialist support groups, phone calls and short notice pop-in visits and access to midwives at the advice centre and baby clinics.

# Maternity

## Are maternity services responsive?

### Planning and delivering services which meet people's needs

- The service was working with commissioners in different geographical areas to enable access for all eligible women; however NHS contracts were interpreted differently in each area.
- The parents' advice centre in a busy shopping precinct was innovative and 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.
- Minutes indicated the senior managers had reflected on the service's model in light of the Morecombe Bay investigation report and RCOG 'Better care together'.
- The service promoted continuity of care as the named midwife provided care from the antenatal booking until the transfer to health visitor services six weeks after the birth.

### Meeting the needs of people in vulnerable circumstances

- Midwives were expectedto access or ensure specialist care and advice required to all the women on their caseload, irrespective of specialist physical needs.
- The service accepted low and high risk women for maternity care. Midwives manged the overall care of all women with pre-existing conditions were referred for appropriate obstetric or medical review if the woman agreed.
- Midwives told us they always researched the required best practice guidance for managing the care of women with pre-existing conditions.

  The midwives stated specialist care plans using best practice guidance would be developed in response to individual needs.
- The service completed an equality impact assessment when policies and procedures were reviewed to ensure changes did not adversely affect stakeholders with protected characteristics.
- The service presented 'Patient stories' to commissioners which indicated women with special needs were supported to access the service in full.
- Publicity indicated that hypnobirthing courses were offered to all women who used the service. Hypnobirthing is considered to reduce the need for pain control during birth through self-hypnosis which enables deep relaxation.
- The service provided specialist new-born baby clinics including 'tongue tied' and breast feeding clinics.
- In relation to completing new born infant physical examinations within the required timescale the service was not able to provide data for the September, October, November 2015 (quarter three) submission and stated the service planned to join the national new-born physical examination programme (NIPE) which would help with this. No date for achieving this was provided in the action plan.
- A maternal mental health risk assessment form was completed and the midwives received training to provide initial support. Midwives referred women to perinatal mental health services, which include antenatal and postnatal mental health.
- The One to One national data indicated that 100% of women with mental health needs were offered additional support.

### Access to the right care at the right time

- Women were able to access midwives and maternity care 24 hours a day, seven days a week. The service had clear criteria for accepting or excluding expectant mothers referred to the service. Expectant mothers were excluded if they lived outside the area of a commissioning CCG and if they were under 14 years old.
- The service was marketing a 'choose and book' system with GP services in the Wirral area. The aim was to improve access as women could organise their initial booking appointment. Booking in clinics, screening, antenatal and post-natal classes were negotiated

between the woman and midwife. The service had a service level agreement with an independent screening service to perform 12 and 20 week scans and other scans as required.

- Information leaflets and booklets about all aspects of pregnancy including healthy eating, fetal movements and smoking cessation were available at the office and drop in centre.
- The women's expected date of delivery and home address were taken into consideration prior to allocation, so that midwives were given an even workload throughout the year. The service did not monitor the percentage of women seen by a midwife within 30 minutes of being in labour and should consider completing this audit. However women were allocated to midwives who lived within a 30 minute radius.
- The service provided post-natal care to women who had their babies in hospital.

**Learning from complaints and concerns**

- The service recorded 24 formal complaints between March 2014 and April 2015. A trend analysis had not been completed.
- We saw that the complaints policy was accessible to staff through the company intranet and information about how to make a complaint was printed on the handheld notes provided to expectant mothers when booked into the service.
- The service reported complaints and concerns could also be made through the One to One internet pages. We found the complaints policy was not available on the internet and information did not signpost people to where they could raise concerns.
- Midwives stated women were able to raise concerns and comment on the service as issues arose. They said concerns were treated seriously and changes made in response.
- Records indicated complaints and concerns were discussed at locality team meetings and monthly quality meetings.
- The service aimed to address complaints through local resolution; however, if the complainant was unhappy with the response then the complaint was escalated to the Quality and Governance team for review.
- The service did not have full information about complaints because only formal complaints were logged onto the electronic database. Formal complaints were investigated by the risk manager or relevant department lead.
- Evidence indicated lessons were learnt and changes made due to concerns and complaints. For example, following feedback the service had made it clear on their website and at booking that there were male and female students working in the organisation.

## Are maternity services well-led?

**Service vision and strategy**

- The senior managers had a clear vision for the service. This was to increase market share and to provide a high quality safe service to the expectant mothers who accessed the service.
- The service's philosophy of providing individualised care throughout pregnancy was clearly outlined in all policies, procedures and communication with commissioners.
- All staff we spoke with were aware of and agreed with the vision and strategy of the service. The strategy included liaising more closely with general practitioners to promote the service to a wider market.
- Working closely with midwifery networks and developing service level agreements with all local maternity trusts to promote joint care for women who wanted to make that choice.
- The vision was for all women to have autonomy over the birth of their antenatal, intrapartum and post-partum care.
- Staff indicated this was a primary reason for seeking employment with the organisation.

**Governance, risk management and quality measurement**

# Maternity

- The Clinical Governance Strategy described the aspiration of the service in relation to future audits and local involvement.
- The organisational structure indicated the maternity services executive team comprised the national chairman, chief executive officer and clinical director. The clinical director had direct communication and lines of responsibility to consultant midwives, locality coordinator and operational staff. The structure showed the clinical director was the conduit between the board and all departments and staff.
- Monthly quality assurance and board meeting occurred and notes indicated the clinical director attended as appropriate, 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.
- There were nine items on the risk register. These did not include the date risks were entered onto the register, a date to review the risk was not entered and the date provided to remind the managers to check progress on plans was the same as the target for resolution. This meant it was difficult to identify from board meetings or the risk register how long risks had been open and what monitoring had taken place. This was a finding at the previous inspection and an issue, which must be addressed.
- The service produced monthly quality data through their quality standards and maternity dashboards this information was used reviewed monthly by senior lead and clinical lead to inform priorities for improvement and training
- Policies and procedures included a statement about audit however no target dates for audits were included and the service did not include policies and procedures in their audit plan.

**Leadership of this service**

- The organisation chart identified the roles and responsibilities of the executive team. The chart indicated each management team member had responsibility for number of different management streams.
- The structure included consultant midwives responsible for providing clinical advice. Locality coordinators provided day to day management to their team and organised caseloads. Supervisor of midwives provided monthly supervision to midwives as required.
- Midwives stated the management team were accessible and listened to their opinions.

**Culture within this service**

- Midwives we talked with said there was a supportive and enabling culture within the service.
- Staff said they felt listened to and had easy access to the senior management team.

**Public engagement**

- The One to One North West service had not completed a comprehensive survey of all staff. Local area surveys had been completed; however, the results did not include the response rate of staff and so the significance of the result could not be assured. The risk register stated a staff survey would be sent out monthly; however the process for reviewing and collating the response was not identified.
- The service was involved with the maternity service liaison committee (MSLC) in developing local maternity services.The MSLC is a forum for maternity service users, providers and commissioners to come together to design services that meet the needs of local women, parents and families.

**Staff engagement**

- Staff indicated and a report from the service showed staff opinion was taken into account for example; the service reduced the size of caseloads and increased salaries as a result of feedback from staff.

**Innovation, improvement and sustainability**

- The service was innovative in its aim to provide women with a single point of contact and a single lead midwife as soon after conception as possible until the baby is six weeks old. The service aimed to offer the same opportunities for a home birth to both high and low risk women.

# Maternity

- Antenatal, intrapartum and postnatal care was free at the point of access. The service was dependant on referrals made from GPs, self-referrals or referrals from the local acute trusts.
- The sustainability of the service was reviewed regularly by the executive team and innovations to encourage take-up of the service included providing a 'choose and book' system to GP's.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- Develop robust risk registers, policies, procedures and guidelines, which relate directly to working with women with high-risk pregnancies in the North West.
- Ensure records provides evidence that expectant mothers have received detailed information about their care and treatment to enable them to give informed consent.
- Ensure evidence of informed consent is available.
- Ensure all expectant mothers receive care and support from professionals best qualified to provide best practice care and guidance.
- Use an early warning tool to help identify when a woman's condition is deteriorating when in labour. Develop and introduce detailed and clear child protection and safeguarding policies which address the different aspects of teenage pregnancies.
- Develop and introduce policies and guidelines in relation to female genital mutilation.

### Action the provider SHOULD take to improve

- Ensure risk assessments and action plans have review and completion dates.
- Develop a comprehensive outcomes focussed audit and monitoring strategy for the North West.
- Develop benchmarks and implement a range of local and national audits, which will measure performance against set targets and drive improvement.
- Consider completing audits of electronic and paper records to ensure all required information is readily accessible in both formats.
- Consider having multidisciplinary skills and drills training and competency assessment based learning.
- Ensure all concerns and complaints are recorded.
- Consider providing specific information about raising complaints and concerns on the internet.

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.