One to One (North West) Limited

Bidston and St James Children's Centre

Quality Report

Bidston and St James Children's Centre
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This report describes our judgement of the quality of care at this hospital. 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

One to One (North West) Limited is a private community based maternity service that provides antenatal, intrapartum and postnatal care to women. The service is based in the Bidston and St James Children's centre.

The service was set up in 2011.The company provides a single midwife to see women through antenatal care, birth and postnatal care. Midwives working for the company are allowed to go into NHS hospitals to act as advocates or support if the woman chooses a hospital birth.

We carried out an unannounced focussed inspection on 13 April 2015.This was due to a number of concerns raised about the care of women at the service and to follow up the compliance actions issued at our previous inspection in September 2014.

The main areas of concern found were the way medicines were managed and operating outside of the widest accepted view of normal midwifery scope of practice re Cardiotography (CTGs). Cardiotography is a method of monitoring and recording fetal heart rate and uterine contractions during pregnancy and labour, allowing for assessment of fetal response and well-being. It is usually used in hospital where medical staff are available to review the recording. CTG is not recommended for low risk labour (NICE Intrapartum Guidelines, 2014).

Overall the provider showed some improvement in governance since our last inspection. However there was a continued issue re the management of governance in the organisation. We were not given the assurance that risk was being managed effectively across the organisation to provide a safe environment for mothers and unborn babies.

Our key findings were as follows:

Incidents

- There had been six maternity incidents reported through the local NHS Commissioning reporting system for 2013/ 2014 averaging over 1500 births.
- Staff were confident in the use of the incident reporting systems for the reporting of adverse clinical incidents, but told us they were less likely to report non- clinical incidents such as access to staff. Staff were reporting incidents and feedback.
- Managers responsible for the running of the service undertook the root cause analysis (RCA) of incidents.
- Feedback from incidents was found to be good. 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. The Local Supervising Authority (LSA) expressed concerns that the number of junior staff grades would require a lot of support to carry out their job role particularly as they all worked predominantly in isolation. This was of particular concern for women who may develop unforeseen complications who then refuse when advised by the midwife to seek medical intervention and/or hospital support.

Medicines

- Schedule 2 Controlled Drugs were being supplied to midwives from Bidston and St James's Children's Centre without the appropriate Home Office licence. We brought this to the attention of the provider following our inspection and this practice has now ceased.
- Midwives stored some medicines, including medical gases, in their homes when not on duty. With the exception of Controlled Drugs, the standard operating procedures for the management of medicines did not contain any information on how any risks associated with the storage of these medicines were to be managed.
- The standard operating procedures for the management of medicines did not contain satisfactory information regarding how the risks associated with the transport of medicines by midwives, including Controlled Drugs, were to be managed.

Summary of findings

Cleanliness, infection control and hygiene

- 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.

Midwifery staffing

- There were approximately 50 midwives employed at One to One at the time of our inspection. Due to nature of the way the service was provided there was a lack of comparable data with which to determine whether the midwifery establishment was sufficient for the numbers of women booked under their care.
- Midwives without additional duties held a maximum caseload of 40 women. None of the midwives we spoke with held the maximum number of women on their caseloads at the time of our inspection.
- We found examples of staff reporting that they did not always have a second midwife. One example given was that they would not always contact their buddy in the middle of the night. This did not assure us that access to support for women was available in a timely manner.

Governance, risk management and quality measurement

- A quality dashboard had been developed and was being used to monitor performance and quality against a range of targets. We were not assured by the data, monitoring and review of the dashboard to maintain an effective monitoring process. For example when looking at the minutes of the monthly quality monitoring meeting we saw no reference that the quality dashboard had been referred to.
- Risks within the organisation were not always identified and those which had been identified were not always managed effectively. This included risks where actions had been completed which should have been closed on the risk register. This had not always been done. We were not assured that the provider was managing risk appropriately and safely in line with their statement of purpose.
- Although we saw comprehensive handover sheets we did not see any evidence of joint pathways in place with local trusts in order to manage the risks associated with the women's journey. The provider told us they had made representations to other trusts to have pathways in place however this had not been actioned.
- We found that the provider may be operating outside of the widest accepted view of normal midwifery scope of practice re Cardiotography (CTGs).Cardiotography is a method of monitoring and recording fetal heart rate and uterine contractions during pregnancy and labour, allowing for assessment of fetal response and well-being. It is usually used in hospital where medical staff are available to review the recording. CTG monitoring is not recommended for women experiencing low risk labour (NICE Intrapartum Guidelines, 2014).

Culture within the service

- Midwives expressed concern that although they were satisfied with the current model of working, this may not be sustainable in the longer term. Although they had at least one guaranteed day off per week, they told us that the requirement for them to be responsive to the needs of women on their caseload 24 hours per day had an impact on their family lives.

There were some areas of poor practice where the provider needs to make improvements.

Importantly the provider must:

- The provider must ensure that Schedule 2 Controlled Drugs being supplied to midwives from Bidston and St James's Children's Centre with the appropriate Home Office licence.
- The provider must have processes and policies are in place to ensure the proper and safe use of medicines in the service.
- The provider must review its practices to ensure that it is working within the widest accepted view of normal midwifery scope of practice such as the use of Cardiotography (CTGs).
- The provider must take steps to ensure a robust system is in place for good governance.

Summary of findings

- The provider must ensure that is clearly identifies risks and they are managed effectively and safely.

In addition the provider should:

- The provider should review the access to a second midwife to ensure that support for women is available in a timely manner.
- The provider should work closely with partners such as the LSA Midwifery Officer with regard to the number of practice reviews and supervisory investigations and practice reviews that are being triggered.
- The provider should ensure they follow best practice in regards to independent review of serious incidents.
- Ensure all newly qualified midwives receive support and supervision as per their perceptorship guidance, taking into account the lone working and model of care at one to one.
- The provider should continue to ensure the interface between risk, governance and supervision remains robust and that Managers take the lead on feeding back 'lessons learned' to midwives and staff.
- The provider should review its processes for providing appropriate medical support when women choose to remain at home when advised by the midwife to the contrary.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We were not assured that the service provide by One to One (North West) limited was safe.

Schedule 2 Controlled Drugs were being supplied to midwives from Bidston and St James's Children's Centre without the appropriate Home Office licence. We brought this to the attention of the provider following our inspection and this practice has now ceased. We also found that the service had gaps in both processes and polices to ensure the safe management, storage and use of medicines.

Although we found that risk assessments were carried out on expectant mothers we found evidence that this was not always carried out in a timely manner. Information we had received prior to the inspection had raised concerns that on one identified occasion there was a delay in transferring a women in labour in a timely manner. Due to nature of the way the service was provided there was a lack of comparable data with which to determine whether the midwifery establishment was sufficient for the numbers of women booked under their care.

All women should receive one to one care during their labour and delivery. Midwives informed us that all women received one to one care in the first stage of labour and an additional midwife usually provided two to one care in the second and third stage of labour, unless the labour progressed so quickly that the second midwife did not have time to attend. Women we spoke with confirmed this. We found examples of staff reporting that they did not always have a second midwife. One example given was that they would not always contact their buddy in the middle of the night. This did not assure us that access to support for women was available in a timely manner.

Are services well-led?

The provider had a very clear strategy and vision for the service.Risks within the organisation were not always identified and those which had been identified were not always managed effectively. This included risks where actions had been completed which should have been closed on the risk register and had not been done. We were not assured that the provider was managing risk appropriately and safely in line with their statement of purpose.

Although we saw comprehensive handover sheets we did not see any evidence of joint pathways in place with local trusts in order to

Summary of findings

manage the risks associated with the women's journey. The provider told us they had made representations to other trusts to have pathways in place however we did not see evidence of pathways in place.

All the midwives spoke enthusiastically about their work, particularly the opportunity to provide wholly patient centred one to one care for women. Midwives expressed concern that although they were satisfied with the current model of working, this may not be sustainable in the longer term.

We found that the provider may be operating outside of the widest accepted view of normal midwifery scope of practice re Cardiotography (CTGs). Cardiotography is a method of monitoring and recording fetal heart rate and uterine contractions during pregnancy and labour, allowing for assessment of fetal response and well-being. It is usually used in hospital where medical staff are available to review the recording. CTG is not recommended for women experiencing low risk labour (NICE Intrapartum Guidelines, 2014).

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Maternity		The main areas of concern found were the way medicines were managed, and operating outside of the widest accepted view of normal midwifery scope of practice re Cardiotography (CTGs). Cardiotography is a method of monitoring and recording fetal heart rate and uterine contractions during pregnancy and labour, allowing for assessment of fetal response and well-being. It is usually used in hospital where medical staff are available to review the recording. CTG is not recommended for low risk labour (NICE Intrapartum Guidelines, 2014). Overall the provider showed some improvement in governance since our last inspection. However there was a continued issue re the management of governance in the organisation. We were not given the assurance that risk was being managed effectively across the organisation to provide a safe environment for mothers and unborn babies.

Bidston and St James Children's Centre

Detailed findings

Services we looked at Maternity

Detailed findings

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Background to Bidston and St James Children's Centre

One to One (North West) Limited provide a community case loading model of care based on the concept that birth is a normal life event within the context of a social model of health and wellness. Guided by humanistic principles, One to One midwives work in partnership with mothers to deliver safe, evidence-based care that empowers women to be active participants in their birth. The midwife's role encompasses lead professional status guiding women through pregnancy, birth and motherhood as normal physiological processes.

The One to One model requires community-based midwives to carry a caseload of 40 women providing care 24 hours a day, 7 days a week, for 52 weeks of the year. 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, facilitate women's choice of birth whether it is hospital or home and to be present at the birth for women who choose to birth at home.

The company signed a contract to provide midwifery services with NHS Wirral in November 2011. The company provides a single midwife to see women through antenatal care, birth and postnatal care. Midwives working for the company are allowed to go into NHS hospitals to act as advocates of support if the woman chooses a hospital birth. One to One Midwives have a 33% home birth rate, compared to the National average of 2%.

Our inspection team

Our inspection team as led by Sue Fawcett Inspector and Mandy Forrester Specialist advisor.

How we carried out this inspection

To get to the heart of patients experiences of care, we asked the service provider.Is the service safe and is the service well led?

Before visiting the provider we reviewed a range of information we held about One to One (North West) limited.The unannounced inspection took place on 13 April 2015. During the inspection we talked with patients and staff.We reviewed relevant patient records and treatment and reviewed other relevant records held by the provider such as governance framework, incidents and relevant policies.

Detailed findings

We would like to thank all staff and patients for sharing their views and experiences of the quality of care and treatment provided by One to One (North West) Limited.

We spoke with 3 midwives face to face and 5 on the telephone. We spoke with one patient face to face and 6 on the telephone. We spoke with the Clinical Governance Lead and the Risk Manager face to face. We looked at the community based services for maternity care.

Facts and data about Bidston and St James Children's Centre

One to One has grown in capacity since its initial contract and for the period 2013/14 they had 859 births.

At the time of our inspection the service employed approximately 50 midwives

There had been six maternity incidents reported through the local NHS Commissioning reporting system.

Are services safe?

Our findings

Incidents

- There was a system in place for reviewing mortality and morbidity. Reviews were undertaken on a case by case basis due to the size of the service, which did not warrant regular mortality and morbidity meetings. There had been six maternity incidents reported through the local NHS Commissioning reporting system.
- There were clear systems in place for reporting incidents and 'near misses'. Staff were confident in the use of the incident reporting systems for the reporting of adverse clinical incidents, but told us they were less likely to report non- clinical incidents such as access to staff. Staff were reporting clinical incidents and feedback.
- Managers responsible for the running of the service undertook the root cause analysis of incidents.
- Feedback from incidents was found to be good. 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. The local LSA expressed concerns that the number of junior staff grades would require a lot of support to carry out their job role particularly as they all worked predominantly in isolation.

Cleanliness, infection control and hygiene

- 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.
- There were suitable arrangements in place for the disposal of clinical waste, including the disposal of birth waste products. Sharps such as needles and syringes were disposed of in approved receptacles.
- Birthing pools were loaned to women who chose to give birth at home. Appropriate infection control advice had been given to them about the storage and use of the birthing pools. Women we spoke with confirmed this.

Environment and equipment

- The single use disposable equipment provided to midwives was plentiful, readily available and well within the use by date.
- Midwives informed us the systems in place to repair and/or replace any electronic equipment they carried worked well.

Medicines

- Schedule 2 Controlled Drugs were being supplied to midwives from Bidston and St James's Children's Centre without the appropriate Home Office licence. We brought this to the attention of the provider following our inspection and this practice has now ceased.
- Midwives stored some medicines, including medical gases, in their homes when not on duty. With the exception of Controlled Drugs, the standard operating procedures for the management of medicines did not contain any information on how any risks associated with the storage of these medicines were to be managed.
- Some medicines routinely carried by midwives were sensitive to light and temperature. There were no processes in place to monitor the storage of such drugs in line with the requirements. This meant it was not possible to establish when these medicines should be discarded as no longer fit for use.
- The standard operating procedures for the management of medicines did not contain satisfactory information regarding how the risks associated with the transport of medicines by midwives, including Controlled Drugs, were to be managed.

Records

- Handheld records were used effectively. Women we spoke with understood the purpose of their own records and their baby's health and development review record, commonly known as the 'red book'.
- Midwives kept a summary of the woman's care in the form of an electronic care record. We were assured that the level of security for these devices was robust to ensure that patient records were held securely.
- Midwifery records for women transferred in an emergency to a maternity unit were transferred using a detailed SBAR (Situation, Background, Assessment, and Recommendation) form, which was completed to accompany their admission. An SBAR form is a communication form which promotes safety and sharing of information between health care professionals involved in caring for a patient

Safeguarding

Are services safe?

- There was an effective system in place for raising safeguarding concerns. Staff were aware of the process and demonstrated a good understanding of their role in safeguarding vulnerable adults and children. This process was supported by staff training.
- Safeguarding training formed part of the mandatory training programme. Training records showed that over 95% of staff had received safeguarding training in the last year.
- Staff had a supervisory review of any safeguarding issues on their caseload each month, which was reduced to quarterly if they did not have any active safeguarding on their caseload. This is in line with Department of Health requirement (Working Together to Safeguard Children, 2010).

Mandatory training

- There was a comprehensive programme of mandatory training in place which staff were required to attend annually. All staff we spoke with were up to date with their mandatory training. Training records we requested confirmed this.

Assessing and responding to patient risk

- Midwives undertook comprehensive risk assessments for all women on booking. The risks were reviewed at each subsequent contact with the woman.
- We saw evidence that when the risks to a woman increased, midwives took appropriate action. This was usually to refer or transfer them to a consultant led maternity unit.
- We viewed the organisation's transfer policy, which gave clear information regarding the transfer of women and babies in an emergency and how information regarding their care and treatment should be communicated. Information we had received prior to the inspection had raised concerns that on one identified occasion there was a delay in transferring a women in labour in a timely manner.

Midwifery staffing

- There were approximately 50 midwives employed at One to One at the time of our inspection. Due to nature of the way the service was provided there was a lack of comparable data with which to determine whether the midwifery establishment was sufficient for the numbers of women booked under their care.
- Midwives without additional duties held a maximum caseload of 40 women. None of the midwives we spoke with held the maximum number of women on their caseloads at the time of our inspection.
- All women should receive one to one care during their labour and delivery. Midwives informed us that all women received one to one care in the first stage of labour and an additional midwife usually provided two to one care in the second and third stage of labour, unless the labour progressed so quickly that the second midwife did not have time to attend. Women we spoke with confirmed this. We found examples of staff reporting that they did not always have a second midwife. One example given was that they would not always contact their buddy in the middle of the night. This did not assure us that access to support for women was available in a timely manner.

Medical staffing

- One to one is a midwife led service and there were no medical staff directly employed by the organisation to provide care and/or treatment at the time of our inspection.
- Consultant obstetric opinion and support was provided by the local maternity units, when necessary. In addition the provider told us they had access to a consultant obstetrician on an ad hoc basis.

Are services well-led?

Our findings

Vision and strategy for this service

- The there was a vision and strategy in place for the organisation with clear aims and objectives. The vision, values and objectives had been cascaded across all staff who had a clear understanding of what these involved in relation to their individual roles within the organisation.

Governance, risk management and quality measurement

- The system in place to communicate safety alerts to midwifery staff had improved since our last inspection. At the time of our inspection there was an effective system in place for the dissemination of safety alerts to midwives. All midwives we spoke with confirmed this.
- We saw that a quality dashboard had been developed and was being used to monitor performance and quality against a range of targets. A quality assurance committee met monthly.
- Risks within the organisation were not always identified and those which had been identified were not always managed effectively. This included risks where actions had been completed which should have been closed on the risk register this had not been done. We were not assured that the provider was managing risk appropriately and safely in line with their statement of purpose.

Leadership of service

- Midwives told us they attended regular staff meetings within their locality teams, which they found valuable and that their immediate line managers were accessible and approachable.

Culture within the service

- All the midwives spoke enthusiastically about their work, particularly the opportunity to provide wholly patient centred one to one care for women.
- Midwives expressed concern that although they were satisfied with the current model of working, this may not be sustainable in the longer term. Although they had at least one guaranteed day off per week, they told us that the requirement for them to be responsive to the needs of women on their caseload 24 hours per day had an impact on their family lives.

Public and staff engagement

- The staff survey undertaken in December 2014 found that 89% of staff felt they were able to make suggestions to improve the work of their team/department, while 76% felt they involved in deciding on changes introduced that affected the work of their teams.
- We saw evidence of several initiatives introduced to engage patients and members of the public, which included coffee mornings and the location of administration offices within the local community centre.

Innovation, improvement and sustainability

- The service was dependent on one contract which had expired, but had been extended at the time of our inspection while contract negotiations took place.

Maternity

Safe	
Well-led	
Overall	

Information about the service

One to One (North West) Limited provide a community case loading model of care based on the concept that birth is a normal life event within the context of a social model of health and wellness. The midwife's role encompasses lead professional status guiding women through pregnancy and birth.

Summary of findings

We were not assured that the service provide by One to One (North West) limited was safe. We found that the provider had reported a number of maternity incidents which we was disproportionate to that expected of the number of births in the service. We were not assured that incidents were reviewed independently and not in line with expected good practice.

Schedule 2 Controlled Drugs were being supplied to midwives from Bidston and St James's Children's Centre without the appropriate Home Office licence. We brought this to the attention of the provider following our inspection and this practice has now ceased. We also found that the service had gaps in both processes and polices to ensure the safe management, storage and use of medicines.

Although we found that risk assessments were carried out on expectant mothers we found evidence that this was not always carried out in a timely manner. Information we had received prior to the inspection had raised concerns that on one identified occasion there was a delay in transferring a women in labour in a timely manner. Due to nature of the way the service was provided there was a lack of comparable data with which to determine whether the midwifery establishment was sufficient for the numbers of women booked under their care.

All women should receive one to one care during their labour and delivery. Midwives informed us that all women received one to one care in the first stage of labour and an additional midwife usually provided two to one care in the second and third stage of labour, unless the labour progressed so quickly that the second midwife did not have time to attend. Women we spoke with confirmed this. We found examples of staff reporting that they did not always have a second

midwife. One example given was that they would not always contact their buddy in the middle of the night. This did not assure us that access to support for women was available in a timely manner.

The provider had a very clear strategy and vision for the service.Risks within the organisation were not always identified and those which had been identified were not always managed effectively. This included risks where actions had been completed which should have been closed on the risk register and had not been done. We were not assured that the provider was managing risk appropriately and safely in line with their statement of purpose.

Although we saw comprehensive handover sheets we did not see any evidence of joint pathways in place with local providers. The provider told us they had made representations to other trusts to have pathways in place however this had been actioned. This presents a risk that timescales and thresholds for intervention are not defined and agreed and may lead to confusion trusts in order to manage the risks associated with the women's journey.

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Are maternity services safe?

Incidents

- There was a system in place for reviewing mortality and morbidity. Reviews were undertaken on a case by case basis due to the size of the service, which did not warrant regular mortality and morbidity meetings. There had been six maternity incidents reported through the local NHS Commissioning reporting system.
- There were clear systems in place for reporting incidents and 'near misses'. Staff were confident in the use of the incident reporting systems for the reporting of adverse clinical incidents, but told us they were less likely to report non- clinical incidents such as access to staff. Staff were reporting incidents and feedback.
- Managers responsible for the running of the service undertook the root cause analysis of incidents. If staff from local maternity units had been involved in an incident they were routinely invited to take part in the incident review process, but did not always participate.
- Feedback from incidents was found to be good. 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. The local LSA expressed concerns that the number of junior staff grades would require a lot of support to carry out their job role particularly as they all worked predominantly in isolation.

Cleanliness, infection control and hygiene

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Environment and equipment

Maternity

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- Safeguarding training formed part of the mandatory training programme. Training records showed that over 95% of staff had received safeguarding training in the last year.
- Staff had a supervisory review of any safeguarding issues on their caseload each month, which was reduced to quarterly if they did not have any active safeguarding on their caseload. This is in line with Department of Health requirement (Working Together to Safeguard Children, 2010).

Mandatory training

- There was a comprehensive programme of mandatory training in place which staff were required to attend annually. All staff we spoke with were up to date with their mandatory training. Training records we requested confirmed this.

Assessing and responding to patient risk

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Midwifery staffing

Maternity

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Are maternity services well-led?

Vision and strategy for this service

- The there was a vision and strategy in place for the organisation with clear aims and objectives. The vision, values and objectives had been cascaded across all staff who had a clear understanding of what these involved in relation to their individual roles within the organisation.

Governance, risk management and quality measurement

- The system in place to communicate safety alerts to midwifery staff had improved since our last inspection. At the time of our inspection there was an effective system in place for the dissemination of safety alerts to midwives. All midwives we spoke with confirmed this.
- A quality dashboard had been developed and was being used to monitor performance and quality against a range of targets. We were not assured by the, monitoring and review of the dashboard to maintain an effective monitoring process.
- A quality assurance committee met monthly. We reviewed the minutes of three meetings from December 2014 to February 2015 and found no evidence that the quality dashboard had been discussed. Monitoring of quality data by appropriately skilled and experienced people who can provide assurance to the board, provide challenge where appropriate and suggest improvements, is fundamental to the good governance of an organisation.
- Risks within the organisation were not always identified and those which had been identified were not always managed effectively. This included risks where actions had been completed which should have been closed on the risk register this had not been done. We were not assured that the provider was managing risk appropriately and safely in line with their statement of purpose.
- Although we saw comprehensive handover sheets we did not see any evidence of joint pathways in place with local providers. This presents a risk that timescales and thresholds for intervention are not defined and agreed and may lead to confusion

Leadership of service

- Midwives told us they attended regular staff meetings within their locality teams, which they found valuable and that their immediate line managers were accessible and approachable.

Culture within the service

- All the midwives spoke enthusiastically about their work, particularly the opportunity to provide wholly patient centred one to one care for women.
- Midwives expressed concern that although they were satisfied with the current model of working, this may not be sustainable in the longer term. Although they had at

least one guaranteed day off per week, they told us that the requirement for them to be responsive to the needs of women on their caseload 24 hours per day had an impact on their family lives.

Public and staff engagement

- The staff survey undertaken in December 2014 found that 89% of staff felt they were able to make suggestions to improve the work of their team/department, while 76% felt they involved in deciding on changes introduced that affected the work of their teams.
- We saw evidence of several initiatives introduced to engage patients and members of the public, which included coffee mornings and the location of administration offices within the local community centre.

Innovation, improvement and sustainability

The service was dependent on one contract which had expired, but had been extended at the time of our inspection while contract negotiations took place.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that Schedule 2 Controlled Drugs being supplied to midwives from Bidston and St James's Children's Centre with the appropriate Home Office licence.
- The provider must have processes and policies are in place to ensure the proper and safe use of medicines in the service.
- The provider must review its practices to ensure that it is working within the widest accepted view of normal midwifery scope of practice such as the use of Cardiotography (CTGs).
- The provider must take steps to ensure a robust system is in place for good governance.
- The provider must ensure that is clearly identifies risks and they are managed effectively and safely.

Action the provider SHOULD take to improve

- The provider must review the access to a second midwife to ensure that support for women is available in a timely manner.
- The provider should work closely with partners such as the LSA Midwifery Officer with regard to the number of supervision investigations and practice reviews that are being triggered.
- The provider must continue to ensure the interface between risk, governance and supervision remains robust and that managers take the lead on feeding back 'lessons learned' to midwives and staff.

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
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The management of medicines did not always protect patients from risks associated with the unsafe use of management of medicines. Regulation 12**

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.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good Governance regulation 17 (2) (a) (b) (f) Risks within the organisation were not always identified and those which had been identified were not always managed effectively. This included risks where actions had been completed which should have been closed on the risk register. We were not assured that the provider was managing risk appropriately and safely in line with their statement of purpose.