Abbey Field Medical Centre

Quality Report

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

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 at the Abbey field Medical Centre location. Where relevant we provide detail of each location or area of service visited.

Our judgement was 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.

Our key findings were as follows:

- Services provided to expectant mothers were not always safe because some policies provided information that did not always provide clear guidance for staff.
- Incidents were not being reported to CQC under the statutory notifications' regulation.
- Mandatory training did not include training in the management of high risk situations, for example managing patients who had previously had caesarean sections and opted for home birth.
- Care had not been adequately risk assessed or documented in the patients' notes. We could not be assured that women assessed as requiring medical intervention or assessment were seen by a medical practitioner.
- Training of staff in safeguarding children at level three at 71%, was not sufficient, and we found evidence that required safeguarding referrals had not been made.
- However we also found that the ethos of One to One (North West) Limited to be good for supporting women who have a low risk pregnancy.
- Policies for low risk births followed national guidance. However, policies did not always follow national guidance in respect of high risk births.
- Pain relief for women at home was limited, and stronger pain relief would require hospital admission. We were not assured that women were advised of this prior to booking with the service.
- The service was effective at encouraging women to breast feed their babies, achieving higher than the national average breast feeding rates.
- Outcomes were generally positive for women but the service did not collect data consistently to improve services and identify trends.
- Multidisciplinary working was variable. The provider and the clinical commissioning groups were working to resolve contracting issues. However communication with local hospitals was not sufficient.
- Hand held records were not always contemporaneous or as detailed as required.
- Consent was not always fully recorded in line with national guidance.
- Mental health issues were not always addressed in accordance with national guidance.
- A governance system was in place but that this did not always provide consistent information for the senior team.
- Women were generally satisfied with the service and would recommend it to their family and friends.

  We saw several areas of poor practice where the provider needs to make improvements.

Summary of findings

Importantly, the provider must:

- Ensure that serious untoward incidents are captured, documented, robustly investigated and where required reported to the CQC under the statutory notification regulations.
- Review the risk management practices and supporting documentation to ensure these accurately reflect evidence based practice and provide unambiguous guidance to staff.
- Ensure that women in their care are robustly risk assessed at booking also at each contact and an accurate record is made of risk assessments to determine if One to One (North West) Limited can meet or continue to their needs.
- For women who require referrals to specialist obstetric and or hospital led care, One to One (North West) Limited must ensure that timely referrals are made and accurately documented to ensure that women are protected from the risks of inappropriate care.
- Ensure that women in their care have access to obstetric referral within the locality they intend to give birth.
- Ensure that staff employed by One to One (North West) Limited follows evidenced based practice including best practice guidance contained within their own policies and supporting documentation.
- Ensure that staff make accurate records of information given and or discussed with women about risks and benefits associated with a chosen birth option to ensure they have sufficiently detailed information about the risks to enable them to make informed choices and or consent to treatment.
- Ensure that there are contracts and service level agreements in place between One to One Midwives (Northwest) Limited and all commissioners, community and acute providers in Essex to ensure that women receive appropriate care.
- Ensure that all acute hospitals are notified about women in their locality who are booked with One to One Midwives (Northwest) Limited.

In addition the provider should:

- Consider review of risk management documentation to provide streamlined, clear and up to date guidance for staff on how One to One (North West) Limited expects staff to manage risks.
- Review the audit processes for the service to ensure that all outcomes to demonstrate safe maternity care are provided.
- Look at the staff contracts, job descriptions and working hours to ensure these comply with the European Working Time Directive.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Maternity		At this inspection we found that the provider had policies and procedures in place including for when incidents happen. However, the policies sometimes provided ambiguous information and did not always provide clear guidance for staff on how risks or incidents should be escalated. We found that incidents were not being reported to CQC under the statutory notifications' regulation. We saw that staff were mostly up to date (71%) with mandatory training and had appraisals. However, we did not see records that staff had been trained in the management of high risk situations, for example managing patients who had previously had caesarean sections and opted for a home birth. We found the ethos of One to One (North West) Limited to be good for supporting women who have a low risk pregnancy. However, we also found that the provider was not always providing pregnant women classed as high risk in Essex with evidenced based care. We found that women were not always provided with care that met their needs and protected them from avoidable harm. We found that the provider had guidance including policies and procedures in place to manage risk. However, we found that these were not always followed in contradiction of evidenced based practice. Care had not been adequately risk assessed or documented in the patients' notes. We could not be assured that high risk women were being informed of the risks to them and their unborn baby. We saw that 71% of staff had been trained in safeguarding to level 3. However, we reviewed records for the previous ten months and found that no referrals were made to the local authority safeguarding team. This was despite some women presenting with risk factors indicating a local safeguarding referral should have been made to protect a woman or her children. We reviewed seven sets of records and found that women whose risks during pregnancy indicated that a medical referral was required were not being referred for obstetric care. In these records we found no record

Summary of findings

of intervention by an obstetrician or an indication that they had received a hospital appointment placing them at risk of avoidable harm in five of the seven sets of records we looked at.
We found that referrals to NHS partners and/or other agencies were not always made in line with the provider's risk management documentation or evidenced based guidance. One to One (North West) Limited did not have clear pathways between their own service and local trusts for when women had to be escalated to hospital care. One to One Midwives staff were seeking to establish and improve pathways for women across services.
The provider described a good governance process for managing the service which included managing risks, incident reporting and collection of information for a key performance dashboard locally and organisation wide.

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Background to Abbey Field Medical Centre

The Abbey field Medical Centre is the primary base for the One to One Midwives (North West) Limited group. One to One (North West) Limited work predominantly out of the north west of England but have also based themselves to provide services to women across Essex. The location became registered with CQC for One to One Midwives (North West) Limited in 2015. This is their first inspection of this location.

Our inspection team

The team included two CQC inspectors, one who was a registered midwife. Specialist advice was remotely sought from a specialist risk midwife and our National Professional Advisor for Maternity and Gynaecology.

Why we carried out this inspection

We carried out this inspection on 29 February 2016 following concerns raised with CQC by NHS England in Essex and the local area team of the Clinical Commissioning Groups (CCG) in north and mid Essex. Significant concerns were raised about high numbers of serious incidents, lack of risk assessment and onward referral to the most appropriate service based on identified risks, failures to provide sufficiently detailed information to facilitate women giving informed consent, poor record keeping and lack of formalised emergency care pathways.

Information about Abbey Field Medical Centre

One to One (North West) Limited is a private, community based, maternity service that provides antenatal, intrapartum and postnatal care to expectant mothers aged over 14 years of age. The company ethos is to promote choice in women's birth experience by providing a single midwife to see women through antenatal care, birth and postnatal care.

The company is based in the north west of England and where it has one registered location in Birkenhead. The service was set up in 2011 and the service in Essex was first registered in March 2015 as Abbey Field Medical Centre. The registered manager resigned in July 2015 and the service does not currently have a registered manager in place in Essex. However, the registered manager from Birkenhead was overseeing this location at the time of the inspection. The service is provided to women in north, east, west and mid Essex areas. A service level agreement with west Cheshire CCG forms the basis of the contracting agreement for services provided to women in Essex. At the time of the inspection there was only one service level agreement in place with one of the CCGs and acute providers in Essex.

We visited the service at the registered location of Abbey Field Medical Centre in Colchester and an address in in Cromar Way, Chelmsford from where the service in Essex is also provided. We spoke with two members of staff who worked locally and the Quality Governance Lead who facilitated the inspection. We looked at seven sets of patient records on site and obtained a further six sets of patient records following this inspection. We looked at the provider's risk management policies and procedures and we spoke with the clinical lead about how the service operates in Essex. Due to the unannounced nature of the inspection we were unable to speak with patients using the service.

Maternity

Safe	
Effective	
Well-led	

Information about the service

One to One (North West) Limited is a private, community based, maternity service that provides antenatal, intrapartum and postnatal care to expectant mothers aged over 14 years of age. The company ethos is to promote choice in women's birth experience by providing a single midwife to see women through antenatal care, birth and postnatal care.

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Summary of findings

We undertook this inspection due to receiving a number of concerns from stakeholders. This was a focused inspection and only reviewed the key lines of enquiry for the safe, effective and well led domains. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

We found that there were a number of issues which required addressing by the provider in order to ensure that women and children aged 14 and over received a service that protected them from abuse and avoidable harm and was in line with national guidance. Following the inspection we sent the provider a letter requesting further information and met with the senior team to discuss our concerns. Following this meeting the provider reviewed and changed their policies and processes to address some of our concerns.

At this inspection we found that the provider had policies and procedures in place including for when incidents happen. However, the policies sometimes provided ambiguous information and did not always provide clear guidance for staff on how risks or incidents should be escalated. We found that incidents were not being reported to CQC under the statutory notifications' regulation.

We saw that staff were mostly up to date (71%) with mandatory training and had appraisals. However, we did not see records that staff had been trained in the management of high risk situations, for example managing patients who had previously had caesarean sections and opted for a home birth. We found the ethos of One to One (North West) Limited to be good for supporting women who have a low risk pregnancy. However, we also found that the provider was not always providing pregnant women classed as high risk in Essex with evidenced based care.

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We found that women were not always provided with care that met their needs and protected them from avoidable harm. We found that the provider had guidance including policies and procedures in place to manage risk. However, we found that these were not always followed in contradiction of evidenced based practice. Care had not been adequately risk assessed or documented in the patients' notes. We could not be assured that high risk women were being informed of the risks to them and their unborn baby.

We saw that 71% of staff had been trained in safeguarding to level 3. However, we reviewed records for the previous ten months and found that no referrals were made to the local authority safeguarding team. This was despite some women presenting with risk factors indicating a local safeguarding referral should have been made to protect a woman or her children.

We reviewed seven sets of records and found that women whose risks during pregnancy indicated that a medical referral was required were not being referred for obstetric care. In these records we found no record of intervention by an obstetrician or an indication that they had received a hospital appointment placing them at risk of avoidable harm in five of the seven sets of records we looked at.

We found that referrals to NHS partners and/or other agencies were not always made in line with the provider's risk management documentation or evidenced based guidance. One to One (North West) Limited did not have clear pathways between their own service and local trusts for when women had to be escalated to hospital care. One to One Midwives were seeking to establish and improve pathways for women across services.

The provider described a good governance process for managing the service which included managing risks, incident reporting and collection of information for a key performance dashboard locally and organisation wide.

Are maternity services safe?

We found that:

- There were policies and procedures in place including for when incidents happen. However, the policies sometimes provided ambiguous information and did not always provide clear guidance for staff on how risks or incidents should be escalated.
- We found that incidents were not being reported to CQC under the statutory notifications' regulation.
- We saw training records which included mandatory training, but this did not include training in the management of high risk situations, for example managing patients who had previously had caesarean sections and opted for home birth.
- We found the ethos of One to One (North West) Limited to be good for supporting women who have a low risk pregnancy.
- Care had not been adequately risk assessed or documented in the patients' notes. We could not be assured that women assessed as requiring medical intervention or assessment were seen by a medical practitioner.
- We saw that 71% of One to One (North West) Limited staff in Essex had been trained in safeguarding to level 3. However, we reviewed records for the previous ten months and found that no referrals were made to the local authority safeguarding team. This was despite some women presenting with risk factors indicating a local safeguarding referral should have been made to protect a woman or her children.

Incidents

- The provider had a serious incident and a separate clinical incident policy.
- Between April 2015 and December 2015 we looked at the three quarterly reports available which showed nationally there were 36 clinical incidents; including 4 intrauterine deaths (IUD) (occurring during the antenatal period) and 2 intrapartum stillbirths.
- The serious incident (SI) policy requires staff to report incidents to agencies including the Nursing and Midwifery Council (NMC) and the CQC.

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- The incidents the staff were required to report to CQC was limited to "SI which has potential to threaten registration status".The clinical incident policy does 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 or certain types of injury to a service user. The local trusts highlighted to us that they had reported 74 incidents of patients using this service. We were not assured that the provider was reporting in line with Regulation 18. For example, reporting of baby deaths.
- The provider had notified the CQC of the resignation of the registered manager in July 2015.
- The provider recognised that it should be learning from incidents and this was part of the standing agenda item for the team minutes. However we reviewed six sets of minutes and found that all but one had documented statement "lessons learnt shared and discussed with group on documentation during labour." There was no detail of specifically had been discussed.We were unable to corroborate this with midwives as none were present during our inspection.

Cleanliness, infection control and hygiene

- The premises inspected in Colchester and Chelmsford were visibly clean and the provider had an infection control policy which met the requirements of the Hygiene code.However, there was no cleaning schedule in place for the freezer used to store placentas.
- Placentas were stored in the freezers whilst awaiting monthly collections by a clinical waste disposal service at Colchester or Chelmsford. We asked if a log of placentas was kept in relation to monitoring storage and disposal and we were informed that this information was not recorded and could not be provided as evidence.
- The freezer in Colchester was not clean and had notable blood smears on the inside of the unit.We drew this to the attention of the clinical lead for their immediate attention, who assured us this would be addressed.
- The clinical waste process policy dated September 2015 described the process for storage and disposal of placentas.We checked the infection control policy and the clinical waste process policy.However, the policies did not state how often or by whom the fridges or freezers should be cleaned.Therefore we were not assured that appropriate infection control practices were taking place, nor were we assured that placentas were being appropriately stored and disposed of at the earliest opportunity.

Medicines

- The provider had a medicines management policy dated October 2015.We found that this policy provided contradictory information regarding safe storage, for example of medical gases.
- The policy stated that gas cylinders should be stored securely and not subject to extremes of temperature and should be laid horizontally in the boot of the midwives' car. The policy was contradictory and stated "Entonox must NOT be stored in a midwife's garage or home." The policy then stated that "The cylinders should not be subjected to extremes of heat or cold. One to One Midwives storing cylinders in the car should take extra care overnight during freezing weather. Cylinders should be stored under cover, preferably inside and kept dry and clean."
- There was no further information in this policy about ensuring medical gas cylinders are stored in for purpose made containers for transportation which would protect the cylinders form sudden rapid release of gas or explosion and would be safe.CQC were not assured that the medicines management policy provided clear guidance in line with Health & Safety legislation for storage and transportation of medical gases.
- The Home Office requires providers to have a licence to store schedule two controlled drugs for example morphine, pethidine or diamorphine.One to One (North West) Limited does not have a Home Office licence permitting use of schedule two drugs for example pethidine which may be used in home birth settings.
- The policy stated "One to One Midwives do not carry controlled drugs for pain relief in labour, they are therefore not discussed within this policy. Women who request opiate analgesia for use at a home birth will be

advised that they will need to transfer into their local trust."There was no evidence that this information had been provided to women at the time of booking and planning their home birth.

- Drugs were checked and observed to be in date and stored in a locked cupboard.
- The medicines management policy stated that daily checks of the drugs' fridge should be made.However, there was a drugs' fridge at the location in Colchester and the daily temperature checks, which were required for medicines requiring chilled storage, were not routinely undertaken.
- In December 2015, 4 days were checked, in January 2016, 9 days were checked and in February 2016 15 days were checked.The provider did not follow their own policy by carrying out daily checks and this had the potential to compromise the efficacy of medication requiring temperature control.Further, the provider was not protecting people from avoidable harm through safe storage of medicines requiring chilled storage.

Records

- The One to One (North West) Limited service was commissioned to provide midwifery led service to all women 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, which included access to a choice of having a home birth.
- 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 seven sets of records.
- In six of the seven records inspected risk assessments were not detailed and it was not always clear that midwives had discussed best practice guidance with women.
- Hand held records did not provide enough information to help determine whether a pregnancy was 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 high risk women opted for a home birth.
- 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.

Safeguarding

- One to One (North West) Limited had a safeguarding adults policy dated October 2014.The policy was dated October 2013, updated October 2014 and due to be reviewed in October 2017.
- The adult safeguarding policy was generic and did not refer to women in Essex and does not provide clear guidance for staff in Essex raising a safeguarding concern for adults. The safeguarding policy did not reference actions midwives should take if they were aware the female genital mutilation had occurred.
- A flow chart for making safeguarding referrals was observed pinned to the wall in the Chelmsford office; however this was not referenced within the provider's safeguarding adults policy.
- The provider whilst having an adult safeguarding policy in place did not have a specific policy relating to the safeguarding of children under 18 years old. These are currently managed by two different local authority safeguarding boards and required different interventions by midwives.
- All clinical staff were required to undertake safeguarding Level 3 training.From the records we looked at four of the eleven midwives (36%) and one of three maternity and mother support assistants (33%) in Essex had not completed this training.Three of the midwives who had not completed safeguarding Level 3 training were new starters.
- Mandatory training including safeguarding training was scheduled to take place bi-monthly.

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- The provider had a safeguarding lead for the service. The safeguarding lead was based in the North West. We were told that midwives have supervision every three months, via telephone.

Mandatory training

- One to One (North West) Limited provided 10 days' annual training for clinical staff. The mandatory training included; 'record keeping, risk management & incident reporting, recognition of the unwell neonate and referral, care of the perineum &suturing workshop, Skills Drills & Unique Home Birth Scenarios including NLS/ALS Physiological Birth Support – Care at Home, Hypnobirthing, Mental Health, Parent Education Update andIT & Electronic Health Record Refresher.'
- The provider told us that 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 asked the clinical lead about training for maternity emergencies and she told us they were looking at providing in-house training without "certain obstetric emergencies".We were not assured that staff were sufficiently skilled to identify and effectively manage women for whom pregnancy became increasingly high risk or for whom a low risk pregnancy suddenly changed so as to require obstetric intervention.
- We saw information that of the 11 midwives employed in Essex, 81(%) were up to date with mandatory training. Two qualified staff had not completed skills and drills including resuscitation training.Mandatory training was scheduled to take place bi-monthly and there were dates in place for March through to November 2016.There were three new midwives who had not completed all the training.

Assessing and responding to patient risk

- The Essex dashboard showed that seven women were identified as having substance abuse problems and 79 women were identified as having mental health problems.The Essex dashboard showed that no safeguarding referrals had been made between April 2015 and January 2016.
- Some women with complex social histories, including safeguarding issues, require a multi-agency needs assessment, usually in partnership with the local authority, midwife and obstetrician. This is so that a coordinating care plan can be developed to ensure the women and her baby have all the support necessary for optimum health and wellbeing.
- We were concerned that of the seven women identified as having substance abuse problems and 79 women with mental health problems safeguarding issues were not appropriately identified and escalated for those who may require extra support through a safeguarding referral to the local authority.
- Of the seven sets of records looked at on-site, the assessment of risks at booking identified risk factors that required referral to obstetrician, partner agency or NHS services for six of these records. The summary sheet was missing for four of them making risks difficult to easily identify quickly and despite risk factors indicating that a different pathway should have been followed. There was a lack of clear information showing whether women were experiencing low risk or high risk pregnancies.
- We spoke to the clinical lead who had applied to be the registered manager about assessment of risk and she told us "We accept women regardless of risk". One to One (North West) Limited did have policies and procedures for managing risks during pregnancy.However, we found clear evidence that midwives were identifying risk factors but not always escalating these risk factors in line with their Midwives Mitigating Risks guidance.
- There was concern over the availability and access to a consultant for the expectant mothers. The consultant employed by the service worked full time for an NHS service and provided a service to One to One Midwives in both Essex and the North We were not assured by this process and there was no evidence which supported how the obstetric care for these women could be safely provided.

Staffing levels and caseloads

- We spoke to the clinical lead about working hours for One to One staff in Essex.They told us staff worked a seven day week and there was no manager on-call rota for Essex.They also told us that the locality lead was available 24 hours a day, 7 days a week.

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- Midwives managed their own diaries, worked with a buddy and had 48 hours protected study time each month.They also told us that staff had an annual leave entitlement (8 weeks) to compensate for the long working hours.These working hours are not in line with the European Working Time Directive.
- The information on the off duty rota did not clearly state the actual working hours staff were required to work.We were concerned that the long working hours provided insufficient rest time for midwives employed by One to One Midwives and potentially put women at risk by being looked after by midwives that worked excessive hours.
- We looked to the job description and the person specification for the midwife role to identify the full time working weekly hours of work.The job description stated "Full Time – Flexible including evening and weekends plus on-call commitment".Neither the job description nor the person specification for the role mentioned the requirement to opt out of the maximum weekly working hours.
- Each midwife had a caseload of less than 1:28, which was well within the expected limits. Caseloads for midwives was monitored by the service.
- It was noted that there had been periods of vacancies within the service over the previous year, and we were told that the service was recruiting more midwives to meet the demand.

Are maternity services effective?

We found that:

- Policies for low risk births followed national guidance. However, policies did not always follow national guidance in respect of high risk births.
- Pain relief for women at home was limited and stronger pain relief would require hospital admission. We were not assured that women were advised of this fact prior to booking with the service.
- The service was effective at encouraging women to breast feed their babies, achieving higher than the national average breast feeding rates.
- Outcomes were generally positive for women but the service did not collect data consistently to improve services and identify trends.
- Staff received training in order that they had the skills and knowledge to provide care for women.
- Multidisciplinary working was variable. The provider and the clinical commissioning groups were working to resolve contracting issues. However communication with local hospitals was not sufficient.
- Hand held records were not always contemporaneous as electronic records had to be updated and printed records produced.
- Consent was not always fully recorded in line with national guidance.
- Mental health issues were not always addressed in accordance with national guidance.

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.
- National Institute for health and care excellence (NICE) recommends low risk pregnancy care is provided by midwives and women 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 record 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.

- 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. NICE clinical guidance 62.
- Emergency procedures for example shoulder dystocia; post-partum haemorrhage and antepartum haemorrhage were not based on UK national best practice guidance. The provider's policy states that the midwife should consider transfer of a woman if she loses 1000mls of blood. The World Health Organization definition of primary post-partum haemorrhage encompasses all blood losses over 500ml. A major post-partum haemorrhage is defined as 1000mls.For antepartum haemorrhage the provider's policy definitions differed to national best practice guidance. It did not include risk factors and the transfer to the local trust policy was vague and lacking in specific scenarios of when an ambulance should be summoned. This could delay transfer and result in a serious risk to the woman's health or to her unborn child.
- We saw six instances where best practice was not followed by the midwives at One to One (North West) Limited in Essex. In both the electronic and paper record for one woman we identified that there was no summary sheet to identify the level of risk for a woman with a history of asthma. The notes for this woman lacked information about whether or not a referral had been made to the hospital or for obstetric led care and the information sharing section had not been completed or signed.
- In records for a second woman there was no summary sheet identifying the level of risk. This woman's baby required treatment at Great Ormond St Hospital and there was no evidence that a referral had been made. There was no name or signature of the treating midwife on any of the notes.
- In records for a third woman there was no summary sheet to identify the risk for a woman with a history of, and taking medication for, hypothyroidism.This woman was not referred to the hospital or for obstetric led care.This woman had multiple symptoms of a urinary tract infection and was not referred to her general practitioner for treatment. This woman had an emergency caesarean section under general anaesthetic.

Pain relief

- Entonox and birthing baths were offered to women who required pain relief in labour.
- If opioid medication was required this would necessitate transfer to a local hospital. Nice guidelines state: "Ensure that pethidine, diamorphine or other opioids are available in all birth settings" (NICE, Intrapartum Care for Healthy Women and Babies, CG190, 18.2.12). However this was not available to women using the service.
- Local anaesthetic was used to alleviate pain when peritoneal tears were repaired after birth.

Nutrition and hydration

- The service was effective at enabling women to breast feed their babies. The mother and midwife 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 2015 to January 2016 provided national information and indicated that nationally 81% of women using the service started breastfeeding immediately following birth. This was better than the service target of 70%.
- The percentage of women breastfeeding after 10 – 14 days was 72% according to the national dashboard held by the service.

Patient outcomes

- The national One to One maternity quality results for April 2015 to January 2016 counted 1388 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.

Maternity

- The percentage of planned home births was 30.5%, which was better than the 2.4% England national target.
- The percentage of normal vaginal delivery rate was 74%, which was better than the 70% England target.
- The average percentage of instrumental births was 8.4%, which was better than the England target.
- One to One (North West) Limited monitored post-partum haemorrhages (PPH) of over 3000mls or 2 litres and reported 0 between April 2015 – January 2016. It was noted that national monitoring arrangements for this outcome is set at 1500mls or greater.
- The percentage of overall caesarean section rate was 17.4% (emergency 10.4% and planned 6.7%), which was better than the national average of 24.8% and the national target of 21%.
- Nationally there were 17 babies admitted to hospital post-delivery.
- The dashboard did not include the reasons for unplanned hospital admissions such as retained placenta, additional pain control, or maternal collapse. The service should consider collecting and auditing this data.

Competent staff

- We looked at the off duty rota for the clinical lead and her buddy the locality coordinator for January, February and March 2016.We saw that in January, February and March 2016 the clinical lead was scheduled off duty for 48 hours protected study time each month.
- The locality coordinator had 96 hours protected time each month and five annual leave days in January, February, and March.
- The locality coordinator was provided with buddy support from two midwives working in the north Essex team.
- The provider did not offer CTG monitoring at this location.
- The national maternity dashboard demonstrated that 95% of staff had completed mandatory training.
- We saw records that demonstrated that midwives had received appraisal.
- There were clear training protocols. The provider told us that there was a nine month preceptorship program for newly qualified (less than one year post qualification) and newly employed midwives. However locally we were told that preceptorship was not in place “due to our working arrangements”.
- The clinical lead told us the service uses a sub-contracted Supervisor of Midwives who provided supervisions for all midwives annually. This was confirmed by the service provider.
- Around 50% of staff were newly qualified midwives. Newly qualified midwives undertake an induction and a three month period where they have a reduced caseload of around 16 women.

Multidisciplinary working and coordinated care pathways

- Service level agreements to provide shared care for high risk pregnancies were not in place with all commissioners of services, acute or community care providers. We saw and heard from local Clinical Commissioning Groups that there were ongoing discussions between senior managers and the commissioning agencies about how to facilitate shared care and increase acceptance of joint working with GPs and local acute trusts.
- Relationships with the local Clinical Commissioning Groups and the local trusts were not good in all cases. The provider had good relationships with one Clinical Commissioning group and one local trust but in other areas of Essex the relationships were more difficult. It was noted that some CCGs and acute providers had concerns with the way in which care was provided to the women in their catchment area.
- Lack of a sufficient process meant that a two way flow of information between the trusts and the provider did not always occur. For example the provider informed us that they notified the trusts of all women booked on their system, however all three acute trusts asked confirmed that they were not aware of all women on the One to One Midwives caseload. This meant that women arrived at the acute services for care or treatment, and the hospitals had no information about their maternal history.

- To mitigate the risks midwives offered to accompany women to their hospital appointments. However, should women not chose this option the information received about further treatment and care was limited. We saw evidence of this in two women's notes where a known medical condition existed but no information was sent to the hospital consultant obstetrician by the One to One Midwives consultant obstetrician.

Access to information

- The provider told us and confirmed through documentation that the booking form was faxed to the local hospital, the GP and the intended health visitor. It was not possible to e-mail these into the NHS services due to IT restrictions. It was unclear what the local NHS services did with this information. The provider told us that when a woman was transferred to hospital care, a telephone handover was given by the attending midwife and records of care were taken by the woman into hospital with her.
- 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.
- Some hand held records were not contemporaneous as the electronic records were updated on return to the base unit. The process for updating hand held records was that the electronic record would be printed out and inserted into the hand held records at the next visit.
- 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.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Of the seven records we examined we identified that three did not contain evidence of recorded informed consent where this would be required.
- In six of the seven records we reviewed, there was a lack of clearly documented discussion about risk factors. This related to women who had one or more risk factors indicating that a home birth was a less safe option than in an obstetric led unit as defined by NICE guidelines CG192.
- In a record for one woman who previously had an elective caesarean section we saw a lack of detailed information regarding the risks and benefits of choosing a hospital pool birth. There was a lack of detailed recorded evidence in her records to demonstrate that informed consent had been given.
- We were concerned that women who had mental health issues were not being appropriately risk assessed and treatment was not offered in line with national guidance.
- In records for one woman there was no summary sheet identifying risks for a woman with a history of mental ill health and in receipt of treatment by mental health practitioners.We identified that contrary to the provider's midwives mitigating risk (MMR) policy, a referral was not made to hospital or obstetric led care, or that had the cooperation of the mental health practitioners been sought. Further, there was no evidence that a referral had been made to the local authority safeguarding team or postnatally to a health visitor.
- In the records for the same woman with a history of mental health issues there was no evidence of assessment of this woman's mental health needs post-delivery or a referral to mental health practitioners as indicated by NICE best practice guideline CG192 for Antenatal and postnatal mental health. This meant that the care provided was not in accordance with best practice.

Are maternity services well-led?

We found that:

- There was a strong vision and strategy for the service.
- A governance system was in place but that this did not always provide consistent information for the senior team.
- Policies and procedures were in place but that staff did not always follow these. They were not always based on current national guidance.
- There was a clear structure of responsibility and accountability for the service.

Maternity

- Women were generally satisfied with the service and would recommend it to their family and friends.

Vision and strategy for this this core service

- The senior managers had a clear vision for the service. This was to increase commissioning to provide a service in all geographical areas.
- The Vision was also to ensure that all women have access to choice of model of care and of the provider who provides this care.
- 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.
- The strategy also included 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. However at the time of the inspection the service had only established this strategy with one of three acute trusts in the area where the service was operating.
- The service's philosophy of providing individualised care throughout pregnancy was clearly outlined in all policies, procedures and communication with commissioners.

Governance, risk management and quality measurement for this core service

- 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 assuranceand board meetings occurred and notes indicated that the clinical director attended as appropriate, however minutes from these meetings did not provide detailed and comprehensive information about what plans were been made in response to information received.
- The service in Essex was first registered in March 2015 with Abbey Field Medical Centre being added as a location from which regulated activities were to be provided. The registered manager resigned in July 2015. The registered manager from the North was providing support and cover for midwives whilst the provider recruited and registered the clinical lead at the Essex branch.
- The registered location of Abbey Field Medical Centre was used for storage, but not used as a base from which to manage the registered regulated activities.In discussion with the providers they assured us that the Chelmsford base was a storage facility. However they had plans to relocate as the current base did not offer sufficient space for the service.
- Policies and procedures did not always provide clear unambiguous guidance for staff. They did not always reflect the national guidance they referenced. Staff did not always follow the given guidance, deviating from best practice and, in some cases, the midwives scope of practice. For example in five of the seven sets of records we looked at the staff were not adhering to the provider's own Midwives Mitigating Risk (MMR) document and five women who should have had referrals to hospital for obstetric input were not referred.
- Key performance indicators recorded inconsistent information nationally from within Essex.We found that the organisation dashboard information included some morbidity data such as 'Number of hypoxic encephalopathy', but excluded the number of 'Stillbirths'.

Leadership / culture of service

- The organisation chart identified the roles and responsibilities of the executive team. The chart indicated each management team member had responsibility for a 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.
- The provider had a strong culture of providing choice for women and this was shared by staff.

Maternity

- Improvements were needed to ensure the culture of the service enabled the teams to work well with other stakeholders and commissioners.

Public and staff engagement

- The provider undertook a national friends and family test survey (FFT) at three points in the woman's pregnancy and birth journey. The 36 Week Antenatal Service FFT score for April 2015 to January 2016 showed that 98% of women would recommend the service. However, response rates were poor at 13%. The Home Birth Postnatal Service FFT score for the same period was 98.5%. Response rates improved for this part of the survey to 33%. The Postnatal Community FFT Score was 97% with a response rate of 43%.
- One to One (North West) limited told us that they undertook a staff survey. The draft results showed 69 out of 91 staff responded to the on-line survey. For the question 'I am trusted to do my job' 97% of staff who took part agreed or strongly agreed.
- For the question 'I am able to do my job to a standard I am personally pleased with' 89% agreed or strongly agreed.

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 One to One philosophy was that the woman is at the centre of care, the service will protect her human rights and the right to self-determination underpinned by the organisations five core values of safety, excellence, integrity, professionalism, and being woman-centred.
- Antenatal, intrapartum and postnatal care was free at the point of access to NHS patients. The service was dependant on referrals made from GPs, self-referrals or referrals from the local acute trusts. Women could also self-refer.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure that serious untoward incidents are captured, documented, robustly investigated and where required reported to the CQC under the statutory notification regulations.
- Review the risk management practices and supporting documentation to ensure these accurately reflect evidence based practice and provide unambiguous guidance to staff.
- Ensure that women in their care are robustly risk assessed at booking also at each contact and an accurate record is made of risk assessments to determine if One to One (North West) Limited can meet or continue to their needs.
- For women who require referrals to specialist obstetric and or hospital led care, One to One (North West) Limited must ensure that timely referrals are made and accurately documented to ensure that women are protected from the risks of inappropriate care.
- Ensure that women in their care have access to obstetric referral within the locality they intend to give birth.
- Ensure that staff employed by One to One (North West) Limited follows evidenced based practice including best practice guidance contained within their own policies and supporting documentation.
- Ensure that staff make accurate records of information given and or discussed with women about risks and benefits associated with a chosen birth option to ensure they have sufficiently detailed information about the risks to enable them to make informed choices and or consent to treatment.
- Ensure that there are contracts and service level agreements in place between One to One Midwives (Northwest) Limited and all commissioners, community and acute providers in Essex to ensure that women receive appropriate care.
- Ensure that all acute hospitals are notified about women in their locality who are booked with One to One Midwives (Northwest) Limited.

Action the provider SHOULD take to improve

- Consider review of risk management documentation to provide streamlined, clear and up to date guidance for staff on how One to One (North West) Limited expects staff to manage risks.
- Review the audit processes for the service to ensure that all outcomes to demonstrate safe maternity care are provided.
- Look at the staff contracts, job descriptions and working hours to ensure these comply with the European Working Time Directive.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1), and 12 (2)(a), and 12 (2)(c), and 12 (2)(i) • Some women with complex social histories, including safeguarding issues, requiring a multi-agency needs assessment, usually in partnership with the local authority, midwife and obstetrician had not been appropriately escalated. • Policies did not always follow national guidance in respect of high risk births. • Multidisciplinary working was variable. Communication with local hospitals was not sufficient. • Mental health issues were not always addressed in accordance with national guidance. • Midwives were identifying risk factors but not always escalating these risk factors in line with their Midwives Mitigating Risks guidance. • We were not assured that staff were sufficiently skilled to identify and effectively manage women for whom pregnancy became increasingly high risk or for whom a low risk pregnancy suddenly changed so as to require obstetric intervention.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (1) and 17 (2)(b), and 17 (2)(c), and 17 (2)(f) • Hand held records were not always contemporaneous as electronic records had to be updated and printed

This section is primarily information for the provider

Requirement notices

records produced. In six of the seven records inspected risk assessments were not detailed and it was not always clear that midwives had discussed best practice guidance with women

- The governance system in place did not always provide consistent information for the senior team. Key performance indicators recorded inconsistent information nationally from within Essex
- Policies and procedures did not always provide clear guidance for staff. They did not always reflect the national guidance they referenced. Emergency procedures for example shoulder dystocia; post-partum haemorrhage and antepartum haemorrhage were not based on UK national best practice guidance.
- Staff did not always follow the given guidance, deviating from best practice and, in some cases, the midwives scope of practice.
- Improvements were needed to ensure the culture of the service enabled the teams to work well with other stakeholders and commissioners.
- The dashboard did not include the reasons for unplanned hospital admissions such as retained placenta, additional pain control, or maternal collapse. Some monitoring was not in line with national best practice requirements.
- We found that incidents were not being reported to CQC as statutory notifications' where required.
- Consent was not always fully recorded in line with national guidance.