

# UK Birth Centres Ltd

## Quality Report

The Heath Business and Technical Park  
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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

## Ratings

### Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

## Overall summary

UK Birth Centres Ltd is operated by UK Birth Centre's Limited. It is also known as Private Midwives and provides maternity services in the UK, Ireland and the Channel Islands.

UK Birth Centres Ltd offers packages of care that include antenatal care, birth plans, postnatal care, homemaker and baby support. They also support women with home births, hospital births, private caesarean section and cord blood banking. They do not provide services to women under 18 years old.

The service provides services in Ireland and the Channel Islands which we do not regulate. We inspected all aspects of the maternity service provided in England only.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the service on 28 and 29 November 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

# Summary of findings

are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

The main service provided by this provider was maternity.

## Services we rate

We have not previously rated this service. We rated it as **Good** overall.

We found good practice in relation to maternity care:

- The service had enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and provide the right care and treatment. Mandatory training compliance was high and managers appraised staff performance annually.
- Incidents were managed safely with a clear reporting process understood by staff. There had been one serious incident between January 2016 and November 2018.
- Staff provided care and treatment based on national guidance to achieve positive outcomes for women.

Managers monitored the effectiveness of care and treatment through regular audits. The service invited external specialists to audit care outcomes for women.

- Staff cared for women and their families with compassion and often went the extra mile to support women during home and hospital births. Women we spoke with confirmed that staff were kind, caring and professional and they provided person-centred care.
- The service took account of women's individual needs. We saw that women were offered bespoke care packages that were individualised and took a holistic account of all their circumstances including social and cultural needs.
- Leaders were visible and approachable and promoted a positive culture that supported and valued staff. Governance arrangements were clearly set out through the quality and safety board and included external oversight from expert clinicians in maternity care.

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

## Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
Maternity	Good 	Maternity was the only activity of the provider. We rated this service as good because it was safe, effective, caring, responsive and well-led.



# Summary of findings

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Good 

# UK Birth Centres Ltd

**Services we looked at**

Maternity

# Summary of this inspection

## Background to UK Birth Centres Ltd

UK Birth Centres Ltd is operated by UK Birth Centres Limited. The service opened as a stand-alone birth centre in Cheshire but since 2014 has been a private community midwifery service. The head office is in Runcorn, Cheshire with a second office in Dublin to support midwives based in Ireland. It provides private maternity services to women and their families across the UK, Ireland and the

Channel Islands. This includes antenatal care, birth care and support, postnatal care and home maker support. It also provides midwifery care to women from abroad who come to the UK to access private maternity care.

The provider has had a registered manager in post since October 2016.

We have not previously inspected this provider.

## Our inspection team

The team that inspected the service comprised two CQC inspectors and a specialist advisor with expertise in midwifery, including community midwifery. The inspection team was overseen by Nick Smith, Head of Hospital Inspection.

## Information about UK Birth Centres Ltd

The provider is registered to provide the following regulated activities:

- Maternity and midwifery

During the inspection, we visited the head office and observed a home visit. We spoke with eight staff including midwives, support workers, office staff and senior managers. We spoke with four women. During our inspection, we reviewed eight sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC in 2016.

Activity (April 2017 to March 2018)

- In the reporting period April 2017 to March 2018 there were 458 episodes of care recorded by the provider. The provider told us approximately 10% of activity was outside England and 8% of care was to international women. All care was privately funded.

- The service provided 63 packages of antenatal or postnatal care where the woman did not receive support from a UK Birth Centres Ltd midwife at the birth. It provided 55 single appointments.
- The service supported 120 births in hospital where the NHS trust retained clinical responsibility for care during birth.
- The service had a total of 220 births, of which 184 were planned home births, 17 planned hospital births and 19 were planned vaginal births after caesarean section.

The service employed seven staff, this included midwives, senior managers and office staff. It also had access to 27 midwives and two consultant obstetricians as part of a bank system who worked a variety of hours on a caseload basis. This equalled an average of 14 whole time equivalent midwives between June and August 2018. Midwives were home-based and their caseload varied based on the demand for the service in a particular area of the UK, the amount of work each midwife wished to accept, the specific skills of the midwife and the needs and preferences of women.

# Summary of this inspection

## Track record on safety

- The service has had no never events.
- There has been one clinical incident in 2016.
- There have been no serious injuries.
- There have been no incidences of perineal infections or sepsis.
- There have been three complaints between January and November 2018, one of which was in England.

There were no services accredited by a national body.

The service provided birth support in eight NHS trusts under collaborative working agreements. These were:

- Wirral University Teaching Hospital NHS Foundation Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust
- Southport and Ormskirk Hospital NHS Trust

- Bolton NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Taunton and Somerset NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- The Lister Hospital, London

## **Services provided at the location under service level agreement:**

- Cord blood banking
- Harmony prenatal test
- Interpretation services
- Blood tests

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

We have not previously rated safe. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect women and babies from abuse and the service worked well with other agencies to do so. Midwives received level three safeguarding children training and knew how to recognise and report abuse.
- The service controlled infection risk well. Staff kept themselves and equipment clean and used control measures to prevent the spread of infection. The service provided personal protective equipment in birth packs sent to midwives.
- The service had suitable equipment and looked after it well. Staff monitored equipment which needed maintenance and ensured midwives returned equipment which required maintenance.
- Staff completed and updated risk assessments for women. They kept clear records and asked for support when necessary. Staff could access a senior midwife on call for advice and support 24 hours a day, seven days a week.
- The service had enough midwifery staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The service required midwives to have a minimum of three years post-qualification experience before employing them.
- Staff kept detailed records of women's care and treatment. Records were paper-based, clear and up-to-date. The service kept records in a secure cabinet in the office following discharge and women kept their own records during care and treatment.
- The service followed best practice when prescribing, giving, recording and storing medicines. Medicines were stored securely and appropriately at the head office.
- The service managed women and baby safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents using root cause analysis and shared lessons learnt with the whole team.
- The service used safety monitoring results well. Staff collected safety information and displayed it on the noticeboard in the head office and shared it with midwives by communication mail outs.

Good





# Summary of this inspection

## Are services effective?

Good



We did not previously rate effective. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance through regular audit of clinical notes and observed visits.
- Staff used specialist feeding and hydration techniques when necessary. Staff offered breast-feeding support to women and support to prepare and cook meals.
- Staff assessed and monitored women regularly to see if they were in pain. Staff ensured pain relief medicines and gases were ordered and delivered to women prior to birth.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. Managers updated the clinical dashboard monthly and shared the results with staff to highlight areas for improvement.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance annually and all eligible staff had received their annual appraisal.
- Staff worked with local NHS maternity providers to ensure care and treatment was delivered to women in a coordinated, person-centred way. They ensured all relevant services were informed when a woman was discharged from the service.
- Staff understood how and when to assess whether a woman had the capacity to make decisions about her care. They followed the service policy and procedures when a woman could not give consent.

However,

- Midwives did not have access to supervision from trained professional midwifery advocates. However, they did receive supervision from senior staff and managers had recognised this issue and identified two training places.

## Are services caring?

Good



We did not previously rate caring. We rated it as **Good** because:

- Staff cared for women with compassion. Women valued their relationships with their midwife and there were several examples where staff had gone the extra mile to support women during home and hospital births.
- Feedback from women and their families was universally positive about the way staff treated them. In the monthly satisfaction survey from January to September 2018, 100% of women said they would recommend the service to friend or family member.

# Summary of this inspection

- Women told us that the care they received had exceeded their expectations. We saw many testimonials from women and their families that praised the exceptional care offered.
- Staff provided emotional support to women and their families. They provided memory boxes for women who had experienced early miscarriage or the death of a baby.
- We saw staff provided emotional support above and beyond the package of care a woman had booked. Women we spoke with told us their midwife was always available when needed on the telephone to offer emotional support.
- There was a strong, visibly person-centred culture, women told us that relationships between staff, themselves and families were respectful and supportive.
- Staff involved women and those close to them in decisions about their care and treatment. Staff provided truly individualised care that always reflected the needs and preferences of women.
- Staff used creative ways to involve siblings in the woman's pregnancy through play and belly painting.
- Staff were fully committed to working in partnership with women. Staff providing home making and baby support services worked in partnership with women to provide appropriate support to the whole family.
- Staff showed determination and creativity to overcome obstacles to delivering care. For example, staff had slept on couches in women's homes during bad weather and liaised with insurance companies on behalf of women.

## Are services responsive?

We did not previously rate responsive. We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of women across England. It had worked with a local hospital to pilot a private caesarean section service in response to the high number of requests from women.
- The service took account of women's individual needs. Staff provided flexible packages of care and support based on women's individual circumstances.
- The service employed a specialist perinatal mental health nurse consultant to give staff advice and guidance on how to support women with phobias and mental health issues.
- People could access the service when they needed it. Staff responded quickly to initial enquiries and offered free of charge initial consultations to help women decide if the service was right for them.

**Good**



# Summary of this inspection

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. We saw evidence that action was taken following complaints to change practice.

## Are services well-led?

We did not previously rate well-led. We rated it as **Good** because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. The Director of Midwifery worked closely with the Chief Executive Officer and both were highly visible and approachable.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values of quality and person-centre care. Staff told us they were proud to work for the company.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish. Service quality was monitored through a clinical dashboard and scrutinised by the quality and safety board which included external experts in maternity care.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected. Senior managers reviewed and updated the risk register monthly.
- The service collected, analysed, managed and used information well to support all its activities. Clinical outcome data and women's personal details were recorded on secure electronic systems with security safeguards.
- The service engaged well with women, staff and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. The service had separate collaborative agreements with nine NHS trusts to provide private midwife care within their hospitals.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation. Staff contacted all women after discharge to get feedback about her care and treatment.

However,

- The service did not have a well-developed leadership strategy, though senior managers were supported to develop leadership skills through mentoring and shadowing.

**Good**








# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

# Maternity

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

## Are maternity services safe?

Good 

We did not previously rate safe. We rated it as **good**.

### Mandatory training

- The service provided mandatory training in key skills to all staff including staff employed on the bank and accessing their insurance scheme. The service made sure everyone completed it. The service outlined the mandatory training required by all midwives in their risk management and quality assurance framework.
- The service set a compliance target of 100% for mandatory training. At the time of our inspection all eligible staff had completed mandatory training. One member of staff had not completed mandatory training as they had started in October 2018 but the service planned to deliver training in March 2019 which they would attend.
- The service provided mandatory training in clinical skills and drills, fetal monitoring, risk management and quality, health and safety and safeguarding. Staff updated clinical skills through annual face to face training and drills. The annual skills training included cord prolapse, shoulder dystocia, vaginal breech, antenatal and postnatal haemorrhage, eclampsia, significant maternal compromise and neonatal resuscitation and new-born life support.
- Fetal monitoring training included Gestation Related Optimal Weight (GROW) and intermittent monitoring of

the fetal heart. GROW is a system to monitor foetal growth during pregnancy. Midwives monitored the growth of the baby and provided women with an individualised growth chart.

- The service provided mandatory skills and drills training in partnership with Chester University. Staff had attended sessions at the university and the training room had been equipped like a home environment to ensure staff received relevant skills training.
- Staff received risk management and quality training which included clinical policies, record keeping, sepsis, perinatal mental health, maternal antenatal screening, risk management and quality, infant feeding, perineal and genital tract trauma. Health and safety training included the staff handbook and manual handling.
- All staff had completed new-born life support training which was accredited by the Resuscitation Council (UK).
- Managers told us they planned to repeat the mandatory training in March 2019. They planned to use a professional film maker to video the sessions so that staff could use them for reflection and to update knowledge. Staff could access the slides and videos from mandatory training online.
- Office staff monitored the compliance with mandatory training monthly and sent email reminders to staff who needed to update their training.

### Safeguarding

- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

# Maternity

- The service provided safeguarding training which included safeguarding adults and level three safeguarding children. All eligible staff had completed the training apart from one midwife who had been in post less than one month.
- Staff also received training in Prevent, the UK's counter terrorism strategy to safeguard people and communities from the threat of terrorism.
- The Director of Midwifery and Deputy Director of Midwifery were trained to level four in safeguarding children. They provided safeguarding supervision to midwives. The Director of Midwifery received safeguarding supervision from the Head of Midwifery at a local specialist NHS trust.
- Safeguarding training included awareness of female genital mutilation. Staff we spoke with confirmed they had received this training but there had been no cases of female genital mutilation within the service.
- The service had a safeguarding adults and children policy which contained clear guidance for staff and the safeguarding concern referral form. The safeguarding referral form included a prompt to notify CQC. The policy referenced relevant legislation and professional guidelines. Managers updated the policy during our inspection to reference the 201 Department of Health guidelines on working together to safeguard children.
- Managers updated the safeguarding policy in November 2018 to reflect when and how they could cancel care if there were safeguarding concerns and how to report this to relevant local authorities.
- Staff we spoke with told us the main safeguarding concern they saw was domestic violence. They told us they would carry out an unannounced visit if they were struggling to see a woman on her own. Staff could give examples of safeguarding cases they had appropriately referred to the local authority. They gave examples of liaising with hospital safeguarding teams and attending case conferences led by the hospital and local authority. Staff also explained how they would follow up cases with the local authority and gave examples of doing this.
- The service had good links with hospital safeguarding teams in the areas they worked. They received local police safeguarding alerts which were circulated to

midwifery staff. Managers told us they had requested general safeguarding alerts from the Department of Health and Social Care but this request was refused as they are a private company.

## Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept themselves and equipment clean. They used control measures to prevent the spread of infection. We saw that staff washed their hands during a home antenatal appointment using the World Health Organisation five moments for hand hygiene. We observed staff followed 'bare below the elbows' guidance and wore a plastic disposal apron. Women we spoke with confirmed that staff washed their hands at the beginning and end of each visit and before providing care and treatment.
- The service provided information that showed they had no incidents of perineal wound infections or sepsis between April 2017 and November 2018.
- Staff collected clinical waste during home visits in designated yellow clinical waste bags and took these to the local hospital for disposal.
- Managers carried out spot check visits with midwives to check compliance with infection control procedures. The service had infection control guidelines which were reviewed every three years and were issued in July 2016. We reviewed the guidelines and saw that they were based on NHS Professionals standard infection control precautions. They clearly outlined staff responsibilities for maintaining infection control measures and the measures and equipment to be used in different situations. We saw that following the hand hygiene audit for April 2016 to March 2018 staff had been sent a reminder about ensuring they were 'bare below the elbows' when providing care.
- The service provided personal protective equipment to staff which included sterile and non-sterile gloves, aprons, cleaning wipes and alcohol wipes.

## Environment and equipment

- The service provided suitable equipment to staff and ensured staff looked after equipment well. Staff told us they could quickly and easily get equipment they needed by requesting it by telephone from the head office.

# Maternity

- Managers told us that staff brought equipment that required portable appliance testing, calibration or maintenance to the annual training. It was taken by an external company and returned the same day. We saw that office staff monitored which staff had brought in equipment and the calibration, maintenance and test date for equipment. Office staff checked the equipment log monthly and sent emails to staff to remind them to get outstanding equipment checks carried out. At the time of our inspection three pieces of equipment required maintenance and office staff had sent emails to the relevant staff.
- Where staff made their own arrangements to get equipment checked they sent a copy of the calibration, maintenance or test certificate by email to the head office. This meant the service was assured that staff were using equipment that had been properly maintained and was safe for use.
- We examined the stores cupboard which contained sharps boxes, blood bottles and personal protective equipment. The service stored all this equipment in a locked cabinet. The equipment was all in date, clearly labelled and stored neatly.
- We reviewed the home birth kit the service sent to midwives close to a woman's delivery date. The kit contained everything needed to support a home birth including a delivery pack, x-ray swabs, suture pack, catheter, syringes, needles, mouthpieces, plasters, blood bottles, sharps bin, placenta bag, personal protective equipment, maternity pads a torch and mirror. We saw that all items were in date and presented neatly within the box sent to midwives.
- The service provided emergency kits to staff which included neonatal bag and masks, maternal bag and masks, catheter and bag, dressing pack, airways, sodium chloride, an intravenous fluid giving set, mucus remover, cannula, needles and alcohol wipes.
- For water births, the service provided a single use birthing pool and sterile liner that women kept after giving birth. Staff carried out risk assessments of the woman's home to ensure it was safe to use a birthing pool. Staff told us they checked the water temperature every hour in line with the policy and the service provided thermometers.

- The service provided all staff with a uniform. Staff wore the uniform at the first appointment with woman and every time they attended a hospital. The service issued photographic identification to all staff which they wore during all visits.

## Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Staff used pregnancy notes that were supplied by the perinatal institute for maternal and child health to record risk assessments. We reviewed the notes booklet and saw it contained risk assessments for medical factors, obstetric factors, venous thromboembolism, mental health, social factors, smoking, drug or alcohol use and weight.
- We reviewed eight women's records and saw the antenatal risk assessments and screening had been completed in all eight records. We saw the VTE assessment was completed in all eight records. VTE stands for venous thromboembolism and is a condition where a blood clot forms in a vein.
- During our inspection we observed an antenatal visit in a woman's home. We saw the midwife carried out a comprehensive assessment which included discussion of signs and symptoms, blood pressure check, check of abdomen and position of the baby, dietary advice and check of urine output and bowel movements.
- Staff escalated any concerns or incidents to a senior manager who was also a midwife who was on call 24-hours a day, seven days a week. Midwives completed quality monitoring forms which gave clear guidelines on the type of incident which required immediate escalation to the on-call manager and the telephone number.
- Midwives called the local NHS provider when a woman giving birth at home went into labour. They told us they always called an ambulance if a woman required escalation during a home birth. Midwives told us that they would do this so women were jointly assessed by themselves and another health professional and a best interest decision to take a woman to hospital could be made with the ambulance crew if appropriate and necessary. Staff gave us an example of when this happened and a joint best interest decision was made with the ambulance crew, local NHS trust and midwife

# Maternity

to keep the woman safe. Midwives told us they received good support from senior managers when this situation had arisen and got an immediate response from the manager on call.

- Midwives completed modified early obstetric warning scores only for patients that had been assessed as high risk. Early warning scores are used to monitor women and recognise any deterioration in their condition. Midwives told us that if they noted any concerns during a routine examination they would monitor the woman using a modified early obstetric warning scores chart and inform the local hospital. We reviewed one set of records for a high-risk woman and saw that the modified early obstetric warning scores chart had been completed appropriately.
- We saw that postnatal notes contained a first risk assessment chart that included a prompt to use maternity early obstetric warning scores if there were concerns with temperature, pulse, breathing or blood pressure. Staff completed the risk assessment before leaving a home birth or on admission to a postnatal ward.
- Midwives received simulation training on responding to maternal compromise in their annual face to face skills and drills training.
- Some women gave birth in hospitals where the service had a collaborative agreement. In these hospitals the service's midwives were clinically responsible and carried out all observations of women and babies. In these cases, they followed the hospital policy and procedure for escalating deteriorating women.
- Some midwives were trained to carry out the new born and infant physical examination (NIPE). This is the NHS screening programme for new born babies and the first examination should happen within 72 hours. If the midwife at a home birth was not trained to carry out this examination they advised women to go to the GP within 72 hours. This is important as it ensures the baby receives an examination to detect any abnormalities and screening reduces morbidity and mortality. Managers told us if the GP could not carry out the NIPE the midwife would make alternative arrangements. This might include another private midwife who was trained in NIPE travelling out of area to complete the assessment.

- Staff carried out additional visits for women where they had concerns. For example, staff told us they had reviewed one woman daily who was overdue and had refused to go to hospital.
- The service provided care to women who were having a vaginal birth after a previous caesarean section. The case notes and medical history for such women was reviewed by a consultant obstetrician before care was offered. The consultant obstetrician wrote the care plan for these women.
- Senior managers told us they refused to provide care to women who requested a free birth or who refused to allow any fetal monitoring during labour. A free birth is where there is no midwife present at the birth but the midwife is nearby so they can be called in if the woman identifies an issue. The service told us this was because of the risk to women and their babies in these situations.

## Nurse staffing

- The service had enough midwifery staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Midwives worked with a caseload of women and usually cared for no more than two women each month who were due to give birth. Midwives provided one to one care in labour.
- The service employed some midwives on a contract but most were employed through their own internal bank or were self-employed and using the Professional Risk and Indemnity Scheme for Midwives (PRISM) system. PRISM midwives were self-employed and set their own fees. They paid a monthly fee to the service to access the appropriate insurance. PRISM midwives followed the policies, procedures and guidelines of UK Birth Centres Ltd and had an annual review. The service reviewed PRISM midwife notes to ensure they complied with UK Birth Centres Ltd policies and procedures.
- The service required midwives providing home birth support to have a minimum of three years post-qualification experience. They did employ some midwives with less experience and students in their third year of training, where they could offer appropriate mentorship.



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- The service did not always provide complete care packages as some women booked only postnatal care, antenatal care or birth support only and some women were supported during birth in an NHS hospital which took responsibility for the birth. Therefore, the service was not able to give an accurate midwife to birth ratio however they told us that the busiest midwives cared for two births each month if a woman took a complete care package. Some midwives held higher caseloads of three women each month if they did not provide complete antenatal, birth and postnatal support.
- Senior managers told us they placed an emphasis on safe practice and this was confirmed by staff we spoke with. Staff told us managers allocated caseloads based on the number of cases a midwife could see safely.
- Midwives worked under a 'buddy' system. Every woman had a named midwife and was introduced to a back-up midwife by the main midwife. The back-up midwife could take over care if the named midwife was not available and act as a second midwife at birth if required.
- We saw that the service had an ongoing social media campaign to recruit midwives.

## Medical staffing

- The service employed two consultant obstetricians through their internal bank. These were employed in the NHS and operated under practising privileges. Practising privileges are where a medical practitioner is granted permission to work in an independent hospital or clinic. Consultant obstetricians did not see women but acted in an advisory role. They reviewed case notes and advised on the care plan for more complex care such as vaginal birth after caesarean section.

## Records

- Midwives kept detailed records of women's care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Midwives completed paper based pregnancy notes, birth notes, postnatal notes for mother and postnatal notes for baby based on templates provided by the perinatal institute for maternal and child health.
- Records returned to the head office following discharge were securely stored in a locked cabinet in a locked office. Women kept their own records throughout their

episode of care and the midwife returned these to the office following discharge. If the woman transferred to hospital or attended a hospital appointment she took her paper records with her. This meant that records were treated confidentially and readily available for every appointment.

- We reviewed eight sets of patient records. We saw they were comprehensive, easy to follow, signed and dated. Midwives kept contemporaneous notes and all records we looked at contained individualised care plans for pregnancy and labour. The name of the named midwife was recorded in all records we looked at and risk assessments were completed. All eight records contained an assessment of the new born baby and a record of initial breast feeding and skin to skin contact.
- We saw the clinical information booklet given to all staff contained a section with hints and tips for effective record keeping. Staff recorded telephone conversations with women on a specific template which included a confirmation of action taken and was kept in the notes.
- Managers audited the quality of records returned to the office. Each record was returned with a quality monitoring form that showed all sections were completed and managers checked the completion of all these forms. The service gave midwives returning notes a checklist with the prepaid envelope used to return notes. The checklist prompted midwives to say that postnatal risk assessments, grow chart, birth weight percentile, quality monitoring form, birth registration, telephone and text conversations, signatures and dates were complete and included in the notes.

## Medicines

- The service followed best practice when giving, recording and storing medicines. Staff checked the temperature of the room and fridge where medicines were stored daily. We reviewed records for January to November 2018 and saw temperature checks had been completed for the room and fridge every day and temperatures were within range.
- The service stored medicines in a locked cupboard or fridge. We examined all medicines in the store cupboard and fridge. We saw they were all stored correctly in line with manufacturers guidance, in boxes with no loose sheets of medicines and all were in date.

# Maternity

- Staff completed a log book completed for all medicines and we saw that all stock was accounted and signed for. Midwives did not prescribe medicines for women.
- Medical gases such as Entonox were delivered directly to women from the manufacturer and collected by the manufacturer after use. Midwives carried the mouthpiece and tubing required to use medical gases so they could not be used without the midwife present.
- The service supplied medicines in sealed packs to midwives when the woman reached 34 weeks of pregnancy. They sent out information leaflets with all medicines. Midwives we spoke with told us they stored medicines in the sealed packs in their fridge in a separate compartment from any food.
- We reviewed the medicines policy and saw it reflected relevant UK guidelines. It was dated November 2018 with evidence of policy review and well referenced throughout. The service monitored staff compliance with the policy in line with National Institute of Health and Care Excellence and Nursing and Midwifery Council guidelines and Medicines and Healthcare products Regulatory Agency regulations. We saw that the medicines audit for 2018 showed 100% compliance with the medicines policy.
- Staff completed annual training on the risk management and quality assurance framework as part of their mandatory training. Senior managers had completed NHS root cause analysis incident review training.
- Midwives completed a quality monitoring form which they returned with patients notes following discharge. Senior managers reviewed these forms and patient notes to ensure that all incidents had been identified and reported. During our inspection, the service introduced a new quality monitoring and incident form to be completed for every woman and returned with the notes. This simplified the reporting system and clearly identified the ratings for specific incidents and actions to take to report them. The record of incident reviewed contained a brief summary, an initial review of findings, a record if the family had been informed of findings and an action plan with review date and final date actions were completed.

## Incidents

- The service managed safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learnt with the wider service. When things went wrong, staff apologised and gave women honest information and suitable support.
- Staff reported incidents by telephone to the on-call manager. Managers completed a paper incident form and recorded all incidents on a spread sheet. Senior managers reviewed all incidents and rated them red, amber or green in line with the seriousness of the incident. The service had a risk management and quality assurance framework which outlined the assessment criteria for rating incidents which was based on the NHS Serious Incident Framework 2015. It also contained examples of incidents and the likely rating, a guide to managing serious clinical incidents and the rating matrix.
- Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff had we spoke with were aware of the term and the principle behind the regulation and could give examples of when the duty of candour would be applied.
- Though there had been no serious incidents in the UK since 2016, senior managers could describe the process for investigating serious incidents and were able to describe how changes following an investigation would be communicated to staff.
- We reviewed the online incident log for November 2017 to November 2018. We saw staff had reported three incidents rated as green, seven rated as amber and no serious or significant incidents rated red. The incident log contained a record of initial findings and action taken. It showed that appropriate action had been taken including communication with women and families and reflection and learning offered by staff. It also showed that disciplinary action was taken where appropriate.
- We reviewed the records of one serious incident which took place in 2016. We saw that managers had followed the root cause analysis methodology recommended by

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the National Patient Safety Agency. Clinical experts from the quality and safety board took part in the investigation. There was evidence of joint review and investigation with the head of midwifery in the relevant NHS trust. The root cause analysis report included safeguarding, history, incident detail, time line and issue identified, conclusion and recommendations. We saw evidence that duty of candour had been applied.

- The quality monitoring form contained a statement that explained the importance of identifying incidents so learning could be shared and improvements made. Staff we spoke with told us that any incidents that had been escalated were discussed at regional team meetings. Staff could give examples of changes to practice as a result of learning from incidents. For example, the service now required all women to provide photographic identification after a woman gave a false name to access the service. The service communicated learning from incidents through the staff social media page and monthly communication envelopes. Managers recorded changes to practice or policy on the electronic staff record system which was accessed by all staff.

## Safety Thermometer (or equivalent)

- The service used safety monitoring results well. Staff collected safety information and shared it with staff and stakeholders. Managers used this to improve the service.
- The clinical dashboard was displayed on a noticeboard in the head office. This showed indicators of maternal and neonatal quality of care and outcomes. The dashboard set thresholds for tears, normal vaginal delivery, significant shoulder dystocia, unplanned admissions to hospital, postpartum haemorrhage and breast-feeding initiation rates.
- We reviewed the clinical dashboard for January to September 2018 and saw that all elements were rated green and were within the threshold identified by the service. The average normal vaginal delivery rate for January to September 2018 was 86% and emergency caesarean section rate for July to September 2018 was 6.82%.
- Between January and September 2018 there had been no incidents of significant shoulder dystocia or postpartum haemorrhage. There had been one case of a 3rd/4th degree tear. There had been one case of a baby admitted to hospital within 28 days of birth.

- The service monitored AGPAR scores for all new born babies. AGPAR stands for appearance, pulse, grimace, activity and respiration and is a quick test performed on babies at one and five minutes after birth to tell the midwife if the baby requires medical assistance. The AGPAR score given is between one and 10, the higher the score the better the baby is doing. Between January and September 2018 there were no babies with a score of less than eight.
- The clinical dashboard was monitored monthly by the Director of Midwifery and quarterly by the quality and safety board. The service shared performance information from the clinical dashboard with staff in the monthly communication envelopes sent to all midwives.

## Are maternity services effective?

Good 

We did not previously rate effective. We rated it as **good**.

## Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff used care bundles for managing sepsis in babies, sepsis in women, new born life support, postpartum haemorrhage in the community and shoulder dystocia. A care bundle is a set of interventions that, when used together, significantly improve patient outcomes.
- The service had developed guidelines for vaginal birth following a caesarean section which followed guidance from the National Institute of Care and Health Excellence and Royal College of Obstetricians and Gynaecologists Top Guidelines No 45, 2015.
- The service had implemented recommendations from NHS England's 'Better Births' initiative including the use of Gestational Related Optimal Weight (GROW) charts. Managers audited the use of GROW and identified low compliance with chart completion. We saw this had been raised in clinical audits results sent to staff in monthly communication envelopes and included in the annual mandatory training requirements. Managers told

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us they had an ongoing action plan to address this which included awareness raising via social media pages and communication envelopes and a peer audit to identify low areas of compliance and offer additional support and training. Managers told us they planned to audit compliance in February 2019 to see if the action plan had led to improvement.

- The service employed a specialist nurse consultant for perinatal mental health who provided midwives with expert advice if they were concerned about a woman's mental well-being or needed to carry out a postnatal depression assessment.
- The service had an audit plan for 2016 to 2019 to monitor staff compliance with national and local guidelines and policies. We reviewed the audits conducted between April 2016 and November 2018. We saw that there was excellent compliance with guidance on antenatal screening, managing anaemia, medicines management and care of women who were rhesus negative.
- The service audited incidents of gestational diabetes in January 2017 and found that practice was safe and midwives risk assessed gestational diabetes, identified issues and acted appropriately to provide care and support to women at risk of gestational diabetes.
- We saw that summaries of annual audit results were sent to staff in the communication envelopes. These were displayed in an easy to understand format that highlighted areas of good practice and areas for improvement.

## Nutrition and hydration

- Staff discussed the importance of nutrition and hydration for maternal and baby health with women at antenatal visits. We saw that appropriate advice was given by a midwife during an antenatal visit to a woman with iron deficiency. The midwife discussed the impact of low iron levels on the woman's health and delivery. They provided advice on iron rich foods and how to take iron tablets.
- Midwives could access advice and support on gestational diabetes from a specialist midwife on gestational diabetes. They provided women with special diet plans when required.

- Staff provided breast-feeding support to women. We saw that between July and September 2018 the breast-feeding initiation rate was 99%. The percentage of babies receiving breast milk for their first feed in NHS maternity services in 2017 to 2018 was 74%. For women receiving postnatal care, the breast-feeding rate at discharge for July to September 2018 was 100%.
- The service offered women an intensive breast-feeding package that included homemaker support. The service provided breast pumps to women who were breast-feeding. Staff could access advice and support from two breast-feeding and lactation specialist maternity support workers. Homemaker support also included support to women to cook nutritious meals for them and their family.

## Pain relief

- Midwives assessed and monitored women regularly during labour to see if they were in pain. Midwives used a formal pain score for high risk women and recorded this in the modified early obstetric warning score.
- Midwives ensured pain relief medicines and gases were ordered and delivered to women prior to birth. Midwives received a medicines pack when a woman was 34 weeks pregnant that contained pain relief medicines to be used in labour. Pain relief used was recorded in the woman's birth notes.

## Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The normal birth rate for women who started labour under the care of the service between April 2017 and March 2018 was 87.44%. During our inspection the service provided updated information that showed in April to June 2018 the normal birth rate was 84.44% and in July to September 2018 80.43%.
- Between April 2017 and March 2018, the service planned 184 home births. They achieved 148 home births and 36 women were transferred to hospital, 19 at antenatal stage and 17 intrapartum (the period between onset of labour and the delivery of the placenta). Between April and September 2018 there were 87 home births planned. The service transferred 16 women to hospital, four at antenatal stage and 12 intrapartum.

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- Between April and September 2018 there were five emergency caesarean sections carried out for women transferred during home birth. The emergency caesarean section rate between July and September 2018b was 6.82%
- Between April 2017 and March 2018, the vaginal birth after caesarean section rate was 64.71%.
- Between April 2017 and March 2018, the service planned 17 births in hospitals in collaborative arrangements where a midwife from the service was clinically responsible for the birth. The service achieved 15 births and two women were transferred to the care of the hospital whilst in labour.
- Managers audited women's outcomes and acted to address areas of concern. There was evidence this led to improvement. For example, we saw that the hypertension audit in April 2016 identified an issue with completing urine analysis. Managers told staff about this and audited compliance in January 2017 and saw that postnatal compliance with urine analysis was still low. Managers acted and audited in January 2018 and that audit showed improved compliance with urine analysis.
- Managers monitored incidents of perineal tears and audit results for January to November 2018 showed that staff documented perineal trauma, consent and care given. The service had one 3rd to 4th degree tear in the period.
- Managers told us they submitted the data collected in GROW charts to the national database of the perinatal institute of maternal, and child health.
- Managers told us in 2017 a senior midwife from a local NHS trust had been employed to conduct audits of women's outcomes to ensure external scrutiny.

## Competent staff

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and all eligible staff received an annual appraisal and we saw evidence of annual appraisal completion in eight staff personnel records we examined. The annual appraisal included peer review and feedback from clients.
- The service provided all staff with a clinical information booklet. This was easy to read and well presented in user friendly format. The booklet contained key messages to staff in different size boxes and showed a good emphasis on staff development and updating of skills. Staff we spoke with told us the service supported them to access external training and development opportunities and gave examples of being given funding to undertake additional role specific training.
- The service provided additional specialist training to midwives such as suturing training. They invited their own staff and midwives from hospitals with which they had a collaborative arrangement. We saw that evidence of training provided was recorded in the staff personnel files.
- The service had a robust recruitment procedure. We saw that personnel files contained application forms, evidence of eligibility to work in the UK, two references and a registration check. We saw staff used a comprehensive recruitment checklist to ensure all necessary checks were complete before a midwife started work. The service ensured it received two references before employing staff.
- Staff were given a comprehensive employee handbook which included information on policy and procedures and the standards expected of employees.
- The service completed an enhanced Disclosure and Barring Service check (DBS) for all staff at the start of their employment. A DBS check allows employers to check if people applying for voluntary or paid roles working with vulnerable people have a criminal record.
- The service completed a nursing and midwifery council registration check when a midwife was employed and again at annual appraisal. We saw that initial registrations checks had taken place when a midwife was employed. However, at the time of our inspection we did not see evidence of ongoing nursing and midwifery council registration checks. During our inspection, the service contacted the provider of the electronic staff record system to set up a reminder and record of registration checks on this system to improve record keeping. We saw that there were two midwives with cases pending at the Nursing and Midwifery Council, that related to care provided outside of their employment with UK Birth Centres Ltd. Managers told us that these midwives would not be offered any work until their cases were resolved.

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- The service required midwives to have at least three years post registration experience in a hospital and one year's experience on a delivery suite or labour ward. This was to ensure they had sufficient skills and experience in suturing and cannulation. Many midwives continued to also work in the NHS to keep their skills up to date. The deputy director of midwifery told us they carried out ad hoc visits and meetings to supervise and support staff.
- The service had not replaced the supervisor of midwives' role since statutory changes in April 2017. However, we saw evidence the new model of supporting midwives had been discussed at quality and safety board. The service had identified that two midwives needed to be trained to ensure they provided supervision that was equal to or exceeded national best practice. We saw places had been secured at a local university for two midwives to start the required training in February 2019. In the interim, senior midwives gave clinical supervision to staff and all staff received one to one supervision. We saw evidence that reflective discussion had taken place between managers and midwives that had led to changes in personal practice.
- Managers told us that they matched the midwife's skills to the needs of women and the care package purchased.
- Staff shared information and skills via a closed social media page. We reviewed the page and saw that staff shared articles and examples of good practice. The information shared was anonymised to ensure women's confidentiality was maintained. They also asked for support from peers on difficult or rare cases. Staff we spoke with told us they found the peer support from the group page helpful.

## Multidisciplinary working

- Staff worked with local NHS maternity providers to ensure care and treatment was delivered to women in a coordinated, person-centred way. The service had collaborative arrangements with nine NHS trusts and one private hospital to provide birth support in hospital for women who requested this.
- Staff told they worked in partnership with local providers throughout a woman's pregnancy to provide appropriate antenatal and postnatal care. They gave examples of joint care provided by the service and the

NHS. For example, where a woman had requested a home birth but was at high risk, staff met with the woman and the consultant obstetrician at the local hospital. They designed a joint care plan for the woman that included giving birth in the hospital midwifery led unit with private midwife support.

- Midwives told us they worked with hospitals and health visitors to ensure babies got their red book. The red book is a personal child health record given to all babies shortly after birth. Midwives booked hospital appointments for babies to attend the postnatal hearing test.
- Midwives took blood tests and worked with colleagues in the NHS to gain and deliver results to women. They ensured women who required anti-d injections because they were Rhesus negative had an appointment booked with the local hospital. Staff told us they encouraged women to ensure they booked with a local NHS trust as well as receiving care from themselves.
- The service employed a midwife who was lead for screening. They worked closely with hospital screening teams, attending regular team meetings and sharing information with the service.
- Staff told us when a woman was discharged from their care they would continue to receive care from their GP, local NHS trust or local health visiting service.

## Seven-day services

- The service operated 24 hours a day, seven days a week, 365 days a year. Women were offered flexible appointments that were mutually agreed between the woman and her midwife.
- Midwives had a work mobile telephone and they gave the number to women on their caseload. Women could contact their named midwife in case of emergency or starting labour 24 hours a day, seven days a week.

## Health promotion

- Staff supported women to lead healthier lifestyles. At first appointment midwives asked lifestyle related questions on smoking, drug and alcohol use. They recorded this in the woman's pregnancy notes and offered referral to appropriate support services where appropriate.

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- Staff offered advice on a healthy diet during pregnancy and provided diet plans and support to women to eat healthily.
- All women were given information about the influenza and pertussis vaccinations. Staff recorded this in perinatal notes. Staff advised women to book their influenza vaccination at and NHS hospital, their GP or a pharmacy. The service had arrangements with private GP practices for women who were from abroad and not entitled to free NHS care. The service did not stock or administer the vaccines itself as it could not maintain the vaccines at the required temperature.
- Women we spoke with told us they were given numerous information leaflets in health-related subjects such as diet, diabetes and alcohol consumption.
- Midwives did not conduct a carbon monoxide test in line with 2010 National Institute of Health and Care Excellence guidelines for smoking: stopping in pregnancy and after birth, as all women were registered with the NHS who offered the test. Managers told us the smoking rate for women was less than 1%.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They followed the service policy and procedures when a woman could not give consent. Staff received training on the Mental Capacity Act annually as part of the mandatory training requirement for safeguarding adults.
- We saw that managers audited compliance with the informed consent procedure. We reviewed the audit conducted in March 2017 and saw it showed 100% compliance with the informed consent procedure.
- Women we spoke with told us midwives gained consent before carrying out any care. One woman told us her mother was often present at antenatal appointments and the midwife talked to her in private before sharing information in front of her mother.

## Are maternity services caring?

We did not previously rate caring. We rated it as **good**.

### Compassionate care

- Feedback from women and their families was continually positive about the way staff treated people. Women we spoke with told us staff went the extra mile to support them and care exceeded their expectations, for example by staying overnight in hospital with them following the birth of their child.
- One woman told us she was very happy with the care she received describing it as ‘everything I wanted and more’. We saw many testimonials from women and their families that praised the exceptional care offered. We saw comments such as ‘exceeded our expectations’, ‘I’ll never forget the hours my midwife spent with me’, ‘it made such a difference to have a midwife who had the time to explain everything and reassure me in every way’ and ‘she always went above and beyond to put my mind at rest throughout my pregnancy’.
- All the women we spoke with told us they were very happy with the care offered by their midwife using words such as perfect and amazing to describe the staff’s attitude. Women told us they were given time and opportunities to ask questions. They told us midwives delivered care in a calm, friendly and compassionate manner.
- Relationships between women, their families and midwives were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. We saw evidence of strong positive relationships with the whole family in stories midwives told us, photographs and the many personal thank you gifts and cards received.
- One woman had requested the same midwife for her third pregnancy after the midwife had supported the home birth of her second child. During antenatal visits for the previous pregnancy the midwife formed a close relationship with the woman’s three-year-old daughter through play. The midwife continued this strong relationship with the siblings through play throughout the antenatal visits for the third pregnancy.

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- There were many examples of staff providing 'little extras' that ensured women felt really cared for and that they mattered. Midwives knitted soft toys for new babies, baked cakes for women, made worry bead garlands from beads donated by other women and designed mood boards with women and their families. Midwives used pool thermometers that were also rubber ducks that women could keep following a water birth.
- Maternity support workers stayed overnight in hospital with women who had a private caesarean section. They provided non-clinical support such as help to care for the baby and support with breast feeding.
- Staff provided person-centred care. One midwife told us about intensive breast-feeding support she had given following a home birth. They stayed overnight for the first night with a woman having difficulties breast-feeding. They returned after the next day's appointments and stayed overnight a second night to offer support.
- Staff provided 'home maker' support to women. Staff offered diverse, person-centred support that included looking after the baby, housework, cooking, emotional support and practical support with breast-feeding. They told us this was usually asked for by women who did not have a wider family network to support them.
- The service sent congratulation cards to parents following the birth of their baby. They provided post-delivery hampers to women who had a private caesarean section. The hampers contained gifts for mother and baby including a soft toy, sock flowers, sock cupcake, ice cream bibs, alcohol free prosecco, lip rescue and baby cream and a snuggle wrap.
- Managers told us the service offered free of charge postnatal care to women after upsetting and difficult births, such as when the woman had experienced a still birth.
- We saw staff provided emotional support above and beyond the package of care a woman had booked. For example, one midwife offered weekly appointments to a highly anxious woman, though only fortnightly antenatal appointments were offered as part of the care package. The midwife spent time with the woman to alleviate her anxieties, taking an hour to reassure her sufficiently to wear a blood pressure cuff and three appointments to take her blood pressure. Another midwife immediately attended a woman's home when the woman called distressed and with blood loss. She went with her to hospital and stayed with her for emotional support until her husband arrived. She maintained contact with the woman, who had suffered recent family bereavements, for several months after she had cancelled care to provide emotional support.
- Midwives signposted women to additional peer support from external agencies with specialist knowledge of home births and being a parent with a disability.
- The service provided memory boxes to women who had lost a baby by miscarriage or still birth. The service also signposted bereaved families to a charity for ongoing emotional support. The boxes were suitable for parents of all faiths or no faith. They contained keepsakes such as soft toys, one of which would go with the baby and the other with parent.
- Women we spoke with told us staff provided emotional support that recognised their specific needs. One woman told us 'sometimes I find it difficult to take things in but I was so comfortable, could ask questions and my midwife was really clear'.
- Staff offered home maker support which included support to minimise emotional distress. Staff described this as 'mothering the mum'. As well as practical support staff offered a cuddle, a listening ear and time for women to have a cry.
- We saw evidence following a serious incident staff spoke to the family about accessing counselling and ensured they accessed this through their faith community.
- The service employed a specialist perinatal mental health nurse through its own bank. This meant staff could access expert guidance and advice on supporting women with mental health issues and phobias. We saw that women were asked about their mental wellbeing during antenatal appointments.

## Emotional support

- Staff saw women's emotional and social needs as being as important as their physical needs and provided emotional support to minimise women's distress. Women we spoke with told us their midwife was always available when needed on the telephone to offer emotional support.



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

- Women and their families were active partners in their care. Staff were fully committed to working in partnership with women and families. Women we spoke to told us they felt empowered by the way staff offered choice and supported them to come to informed decisions. One woman told us her 'care was 100% what I wanted, the midwife discussed everything with me and made things clear and discussed risk, my choice was supported'.
- Staff used creative methods to involve siblings in the woman's pregnancy through creative play and belly painting. Staff used mini medical kits to involve younger siblings in antenatal appointments. We saw photographs of midwives demonstrating how to use blood pressure cuffs and stethoscopes to siblings to explain what they were doing to their mum. We observed the midwife engaging with and involving a younger sibling throughout a home antenatal appointment. Women we spoke with told us staff had involved siblings, partners and their wider families throughout their pregnancy.
- Staff showed determination to overcome obstacles to delivering care. Staff told us they made extra efforts to attend home births during adverse weather conditions, sleeping on sofas to ensure they were present for the birth. Staff worked with other services and companies to ensure women received the care and treatment they had chosen. For example, one woman told us that her insurance company had been reluctant to support her decision to have a home birth and had delayed care. Staff had shown determination in liaising with the company to advocate on her behalf and ensure she got the care of her choice.
- The service supplied midwives of specific faiths where requested. Staff gave us an example of arranging for a female obstetrician to see a woman who refused to have a male doctor present at birth due to her religious beliefs. Staff offered beginning of the week appointments to women of Jewish and Islamic faith to take account of holy days.

## Are maternity services responsive?

We did not previously rate responsive. We rated it as **good**.

## Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of women. The service had developed a private caesarean section service following feedback and many enquiries from women, even though it posed a financial risk. They introduced a pilot in collaboration with a local NHS trust in 2018 and managers told us they would evaluate the pilot before extending it to other parts of the country.
- Managers from the service had worked with an NHS trust to support them to develop their home birth service.
- Staff we spoke to told us they valued the fact the service spoke with women about the package of care they could afford and how they could finance this. They stated this helped them to concentrate on how they delivered care to women.
- Managers contributed to the Cheshire and Merseyside sustainability and transformation plan. They attended meetings of the women's and children's workstream. They also attended Cheshire and Merseyside Women's and Children's Services Partnership local maternity systems meeting.
- Managers worked with one north west NHS trust as part of the improving choice for women work developing shared pathways and sharing outcome data.
- The service supported women who were not entitled to NHS care due to nationality or residency. They offered women a choice of home birth or hospital birth in a hospital they had a collaborative arrangement with. The service charged a flat fee to women and paid all NHS fees from this.

## Meeting people's individual needs

- The service took account of women's individual needs. Care packages were flexible and tailored to women's individual needs, circumstances and preferences. Care packages were easy to follow and understand. The service gave women information on care packages in

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easy to read and clear booklets. The service gave all women a free of charge introductory consultation after which women could decline care. Midwives we spoke to told us they valued the fact the service spoke with women about the package of care they could afford and how they could finance this. They stated this helped them to concentrate on how they delivered care to women.

- Staff matched the care package and midwife to the needs and preferences of women. Staff told us when a woman first contacted them they asked what was important to her so they could advise her on the best care and match her with the most suitable midwife for her. They considered where the woman lived, their history and midwives' skills and specialities to match the woman to the most appropriate midwife. Women we spoke with confirmed they were given enough information by office staff and offered bespoke care packages.
- The service provided care to women from a diverse range of backgrounds including international clients and those accessing private midwifery services due to anxiety or previous traumatic experiences. One woman told us other private midwife services had refused to work with her as she was not a UK citizen and lived on a military base. She had contacted the service based on feedback from other women and been offered a bespoke care package.
- Staff worked with surrogate families to provide parenthood education and preparation. The service had provided support to same sex couples which included antenatal, birth support and postnatal support and parenthood education.
- The service supplied midwives of specific faiths where requested. Staff gave us an example of arranging for a female obstetrician to see a woman who refused to have a male doctor present at birth due to her religious beliefs. Staff offered beginning of the week appointments to women of Jewish and Islamic faith to take account of holy days.
- Staff could access language line for translation and staff we spoke with gave examples of using this. Staff told us they did not use families for translation to maintain the woman's confidentiality and ensure information was

relayed correctly. The service could order information leaflets in other languages if they needed them for women. However, the website was in English only and did not have a translate button or facility.

- Staff had access to specialist equipment to support women's individual needs such as large blood pressure cuffs for bariatric women.
- Staff provided information leaflets to disabled parents and signposted them to support from a charity which offered advice, assessments and information about life as a parent with a disability or additional needs.
- Staff had access to midwives with specialist skills to support women's individual needs and preferences. For example, the service employed midwives with specialist interests in gestational diabetes, hypnotherapy, aromatherapy and lotus birth. Staff shared their experience and skills through the social media page. If a woman requested a specialist in these areas she was matched to a midwife with those skills.

## Access and flow

- Women could access the service when they needed it. Arrangements to treat and discharge women were in line with good practice.
- Staff provided antenatal appointments every two weeks and agreed the date, day and time of the next appointment at the end of each visit. We saw that staff offered appointments which were flexible, mutually agreed and considered the needs of the whole family.
- Staff responded quickly to women making enquiries. The head office was open Monday to Friday, 9am to 5pm. Out of hours women could contact their midwife directly by mobile telephone. Staff contacted women within a week of the initial enquiry to offer an initial free of charge consultation.
- Staff told us they could offer women short notice appointments and respond quickly when required. Managers described an example of receiving a phone call from a hospital for a woman who needed intensive postnatal support and was being discharged that day. They responded immediately and met with the woman and the hospital that day to arrange a shared package of postnatal support that started immediately.

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- Staff informed the GP and local health visiting service following the birth of a baby. They sent a letter to both the GP and health visitor using a standard template when a woman was discharged.

## Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with staff. All women were given written information on how to raise a concern or complaint at the time they made a booking. The service displayed comprehensive information on the complaints process on its website. Women we spoke with confirmed they felt confident to raise a concern if one occurred. Staff described to us how they would support women to raise concerns.
- The service collated results of feedback from women including complaints annually. We saw that between July 2017 and June 2018 the service had received eleven formal complaints. This was 2.7% of women who had completed care in that period.
- Managers reviewed the complaints and identified that nine of the complaints were in a three-month period and related to inconsistencies between the care package agreed, the care expected and the care offered by the midwife. The service introduced two handbooks, one for midwives and one for women. Managers communicated the change to staff through communication envelope mail out, social media page and team meetings. After introducing the handbooks, the number of complaints fell with only two in six months.
- We reviewed the complaints policy and booklet and saw it was updated in October 2018. The complaints policy clearly outlined the stages of a complaint would go through with the timeline for response.
- We reviewed the files for two complaints which had been comprehensively investigated. We saw the service responded within the timescales set out in their policy. They offered a written apology for elements of the complaint which had been upheld. However, only one file contained evidence of learning from the complaint shared with staff.

We did not previously rate well-led. We rated it as **good**.

## Leadership

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. The Chief Executive Officer led the service and focussed on business and finance aspects. They were supported by a Director of Midwifery, Quality and Safety who was the clinical lead for midwives. They were supported by Deputy Director of Midwifery based in the south of England and a coordinator based in Ireland.
- Staff we spoke with told us senior managers from the chief executive officer down were visible and approachable. They stated a senior manager was always available for support.
- We reviewed the personnel files for the Chief Executive Officer and Director of Midwifery. We saw that comprehensive 'fit and proper person' checks were completed. Fit and proper person checks are checks carried out on directors of services to ensure they are fit and proper to carry out the role of director and take responsibility for overall quality and safety of care.
- The service had started to develop leadership succession plans. Leaders had identified key midwifery staff and provided leadership development roles and support to address this. These midwives told us they had received mentorship and support from the director of midwifery to take up their roles. They had been supported to attend head office and take on management duties such as compiling the clinical dashboard.
- Leaders had expanded the membership of the quality and safety board to midwifery leads to help them gain experience and develop management and leadership skills.

## Vision and strategy

## Are maternity services well-led?

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- The service had a vision for what it wanted to achieve and a clear philosophy of care and set of values that were communicated to all staff. We saw the philosophy of care and vision was set out in the clinical information booklet given to all staff.
- Managers had developed the philosophy of care with staff and it had been circulated to all staff for feedback prior to adoption in the clinical information booklet. Staff we spoke to were aware of the vision and philosophy of care.
- We saw leaders placed strong emphasis on quality and person-centred care above financial and business considerations. This evidenced by the development of the private caesarean section service which had started with a small-scale pilot following feedback from women.
- The service had a clearly defined strategy for 2015 to 2018 which was displayed on a noticeboard in the head office. However, at the time of our inspection the service had not yet developed a strategy for after 2018. Leaders told us this was because they wanted to evaluate the outcome of the caesarean section service pilot before developing the new strategy. Following our inspection, the service developed and introduced a midwifery strategy and philosophy for 2019 to 2022 which contained clear priorities for the next three years.

## Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Leaders made clear statements, shared with staff, that emphasised the importance of clinical safety and outcomes over business risk.
- Staff we spoke with were universally positive about the culture. Staff told us they were proud to work for the service and proud of the standards of care they could offer women.
- Staff told us there was excellent team work and staff supported each other 'like a community'. There was an emphasis on staff wellbeing we saw evidenced through advice to staff in the clinical information booklet. Managers regularly contacted staff by telephone and text to check they were well and felt supported. Staff told us managers supported them to maintain a good work life balance. We reviewed the results of the 2018

staff survey and saw that 93.3% of staff said they felt very supported by their line manager, head office and peers. Of the staff who said they had raised an issue in the past 100% said the support received was very good.

- Staff felt safe to raise concerns and knew how to do so. In the 2018 staff survey 97% of staff said they felt confident to raise a concern. Of the 32% of staff who said they had raised concerns in the previous 12 months all of them said they had been listened to.
- We saw managers took a supportive approach to address performance issues. For example, we saw training and development plans had been put in place for midwives involved in incidents of shoulder dystocia.

## Governance

- The service systematically improved the service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish. The service had clear lines of governance and accountability from the quality and safety board to senior managers and through to all staff.
- The quality and safety board met quarterly and consisted of senior managers, consultant obstetricians, independent members, representatives from the local university and non-executive directors. Independent members brought expertise in business and maternity care. The membership offered a good balance of business leadership and medical and midwifery clinical leadership.
- Senior managers told us they had recently reviewed the membership and terms of reference for the quality and safety board and we saw this was discussed in the quality and safety board meeting in October 2018. The membership had been expanded and format of meetings changed to improve engagement and offer development opportunities to senior midwives.
- We reviewed the terms of reference for the quality and safety board and saw they clearly outlined the purpose of the board to provide strategic leadership, monitor clinical outcomes, investigate complaints and incidents and to provide challenge and scrutiny to quality and safety processes. We saw there were standing agenda items which aligned with the board's responsibility and were related to the five key questions monitored and inspected by CQC.

# Maternity

- We reviewed minutes of the quality and safety board for 2018. Four meetings had taken place in March, May, July and October 2018. The service circulated all the papers and reports to be discussed at the board one month before the meeting. We also saw that the clinical dashboard, complaints and any clinical incidents were discussed at every board meeting. The board received an annual quality, safety and performance report which presented staff survey results and learning from any incidents and changes as a result of this.
- Feedback from the quality and safety board meetings was shared with staff at team meetings and in monthly communication envelope mail outs. We reviewed the results of the staff survey completed in summer 2018 and saw that all staff said they got feedback on audits, developments and new services. Staff could feedback directly to the quality and safety board through senior managers and regular team meetings that were attended by senior managers who also were members of the board.
- Staff were clear about their roles and responsibilities as evidence in the staff survey for 2018. Only one member of staff stated in the survey they were not clear because they were new and had not yet provided care to any women.

## Managing risks, issues and performance

- The service had effective systems to identify risks, plan to eliminate or reduce them, and cope with the unexpected. The service maintained a risk register which clearly outlined key risks and control measures to mitigate the risk. The service rated risks red, amber or green based on the probability of the risk happening and the severity of the outcome. We saw the risk register was reviewed and updated at every quality and safety board meeting and the scores agreed. The service kept risks which were resolved, on the register for a monitoring period of one year before closing them.
- The service had a robust business continuity plan that outlined the actions to be taken in the event of a range of emergency situations such as power failure, fire and natural disaster.
- The service had a lone working policy that was shared with all staff in the employee handbook. Staff told us they were encouraged to decline a visit if they had concerns about lone working in a home. Staff texted a

manager when they went in and out of visits that were late or at weekends. Managers told us staff could attend home visits in pairs if they felt there was a risk of attending alone.

## Managing information

- The service collected, analysed, managed and used information well to support all its activities. It used a mix of paper-based records for clinical notes and electronic systems for collecting and storing performance, staffing and client data. It used secure electronic systems with security safeguards.
- The service used an electronic staff record which used cloud storage for security. Cloud storage is when data is remotely maintained, managed and backed up. Information can be accessed from any location via the internet. The system held all staff training and registration and there was an accompanying application to the system which allowed midwives to access it via mobile telephones. This meant all staff had access to their records and key documents whilst working remotely. Staff could also access policies on the social media page, which was only open to staff.
- The service maintained a client database of contact details of women who had received care. This was also cloud based. The database included a tracking tool so the service could monitor what type of care had been purchased and delivered and when key milestones in care had been met.
- The service collected, analysed and stored key performance information electronically. This was secure and could only be accessed by head office staff, leaders and managers. Access to specific information was reviewed and limited by the office manager in agreement with senior leaders and access was limited to that required by specific roles. Office staff maintained a spread sheet that recorded women's outcomes. This was analysed to produce the clinical dashboard.
- We saw there were effective arrangements to ensure notifications were submitted to CQC as required. These guidelines were displayed on a noticeboard in the head office.
- However, some staff highlighted issues accessing relevant electronic record systems in hospitals. For example, midwives completing the examination of new

# Maternity

born babies in hospital could not access the hospital electronic patient record system and had to send the information to the hospital so their staff could enter it onto the system.

## Engagement

- The service engaged well with women, staff and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service collected and shared feedback from women through social media, their website and an online review site. Staff contacted women after discharge to seek feedback on if they would recommend the services to family and friends. We saw that between January and September 2018 100% of women stated they would recommend the service. The response rate to the survey was 100%.
- Managers engaged with the public through attendance at mother and baby events and conventions across the country.
- Every year the service raised funds for a different nominated charity. For 2018, this was a charity that supports families experiencing miscarriage, stillbirth and child loss. The service donated to the charity for every care package or item bought from their online store.
- Managers actively engaged with staff daily through the social media page, which was closed to the public. We reviewed the page and saw it contained key messages and communication updates. Staff engaged with each other through the page offering peer support, advice and guidance. They shared positive stories as well as learning. Staff we spoke with told us they found it a useful communication tool and supportive way to share information.

- The service held joint training between their staff and NHS midwives. For example, the service held suturing training and gave free places to staff from hospitals with whom they had a collaborative agreement.
- Managers demonstrated commitment to sharing information and working across the health care system to make improvements. The service had collaborative agreements with nine NHS trusts. The collaborative agreements meant that women could have a hospital birth in one of these hospitals but remain under the clinical care of their private midwife. We reviewed one collaborative agreement and saw it was comprehensive and set out terms and conditions, services and nominated officers, fees, quality control and monitoring procedures and the service specification. All collaborative agreements had been approved by both parties' legal teams and the service's insurance company.
- Senior managers engaged with relevant partnerships regionally. For example, they attended the NHS Cheshire and Merseyside Women's and Children's Services Partnership local maternity systems meeting. They engaged with Cheshire and Merseyside sustainability and transformation plan through the women's and children's workstream.

## Learning, continuous improvement and innovation

- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.
- Managers actively promoted additional role specific training to staff and this was confirmed in the staff survey 2018, where 97% of staff said they had opportunities to access free training sessions.
- The service had received an award from a national mother and baby magazine. It was voted Best Midwifery Service 2018 - UK in their Parent and Baby Awards.

# Outstanding practice and areas for improvement

## Outstanding practice

### We found the following examples of outstanding practice:

- Staff provided personal extra touches to show women and families they were cared for. Midwives knitted soft toys for new babies, baked cakes for women, made worry bead garlands from beads donated by other women and designed mood boards with women and their families. Midwives used pool thermometers that were also rubber ducks that women could keep following a water birth.
- Maternity support workers stayed overnight in hospital with women who had a private caesarean section. They provided non-clinical support such as help to care for the baby and support with breast feeding.
- The service provided post-delivery hampers which contained gifts for mother and baby to women following a private caesarean section.
- Staff provided intensive birth and breast-feeding support at home and hospital, often staying overnight post-delivery to support mother and baby.
- Staff provided 'home maker' support to women after birth. This included emotional and practical support such as a listening ear, breast-feeding support, help with housework and cooking and childcare.
- The service provided care and treatment to women who were not entitled to NHS care due to nationality or residency.
- The service employed a specialist perinatal mental health nurse through its own bank. This meant staff could access expert guidance and advice on supporting women with mental health issues and phobias.
- The service held joint training between their staff and NHS midwives.
- The service invited external scrutiny of clinical outcomes and incidents through members of the quality and safety board.
- The service had collaborative agreements with nine NHS trusts. The collaborative agreements meant that women could have a hospital birth in one of these hospitals but remain under the clinical care of their private midwife

## Areas for improvement

### Action the provider SHOULD take to improve

- The service should assure itself that all midwives receive supervision from a suitably qualified supervisor in line with national best practice.
- The service should work to embed the leadership development plan for senior managers.