The Birth Sanctuary

Quality Report

Hamill House
112-116 Chorley New Road
Bolton
BL1 4DH
Tel: 01204 498 042
Website: www.thebirthsanctuary.co.uk

Date of inspection visit: 10 January 2017
Date of publication: 12/04/2017

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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Birth Sanctuary is operated by The Birth Sanctuary Limited. The service provides care from the registered office in central Bolton, in the community in patients' homes or in local NHS hospitals.

The service provides maternity care.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 10 January 2017.

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

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

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

We found the following areas of good practice:

- Staff were up to date with mandatory training and had completed emergency midwifery skills training within the previous 12 months.
- The service followed best practice guidance in relation to infection prevention and control. The environment was visibly clean and staff had access to sufficient equipment which was serviced and calibrated regularly.
- Clinical risk assessments were completed for each patient. There was clear guidance in place and an escalation policy to ensure patients received care in the most appropriate clinical setting. Risk assessments were reviewed regularly, and when there were any concerns about the health of the patient or her baby, referrals were made to other providers.
- The service had an external supervisor of midwives (SoM) to support staff and patients.
- All staff had completed safeguarding adults training in line with best practice guidance. Staff had an awareness of issues relating to domestic violence and female genital mutilation.
- Records were maintained to a high standard and stored correctly. The service was registered with the Information Commissioners Officer.
- Caseloads were planned based on midwife availability. The service monitored the number of patients on its caseload to ensure there were sufficient staff to provide the level of care required.
- Care and treatment was provided in line with policies which reflected guidance from the National Institute of Health and Care Excellence (NICE) and Royal Colleges.
- Patients received education about choices for feeding their babies and they were supported by staff to feed their baby by their chosen method. A recent audit showed that 90% of patients were exclusively breast feeding their babies at six weeks. This was better than the NHS average of 24%.
- There were plans to work towards stage one accreditation of the Unicef Baby Friendly Initiative in 2017, a nationally recognised accreditation and mark of quality care designed to support breastfeeding and parent infant relationships.
- Staff had received an appraisal and had specific personal development objectives. Staff were well trained and maintained their skills and competencies including completing the NHS New born and Infant Physical Examination Programme (NIPE).

Summary of findings

- The Birth Sanctuary worked closely with a number of third party providers and ensured they communicated with other providers in an effective way.
- There was a 24 hour cooling off period following an initial free consultation before patients decided to sign the contract agreement. This was to ensure that each patient had the opportunity to consider the service and costs to ensure it was the right service for them.
- Staff were kind, caring and sensitive in the way they communicated. They spent time speaking with patients; addressing any worries or concerns. Care was individualised and patients valued the close relationships they built with the midwives.
- The service consistently received positive patient feedback. Patients described the care as “fantastic” and said they “couldn’t have been more satisfied with the care”. One patient described her midwife as her “voice during labour”.
- Staff supported patients to make decisions and choices about their care and treatment. Patients told us they did this in an unbiased and non-judgemental way. Families and people close to the patient were involved in planning care.
- Staff took time to discuss previous birth experiences and worries and fears about the current pregnancy. Women spoke very positively about the high level of emotional support provided and told us they felt more confident and reassured by the support they were given.
- Staff spoke with patients about their mental and physical well-being. They had access to formal assessments to use where there were concerns about post-natal depression or anxiety.
- Appointments were tailored around the needs of the patients and there was no limit to the number of appointments patients could access as part of the pregnancy care package.
- Staff ensured they considered any specific individual or additional needs for each patient. They understood the need to make adjustments for patients with additional needs. There was access to a telephone translation service if required.
- There was access to advice from a midwife 24 hours a day. Appointments could be arranged quickly and at mutually convenient times. Midwives were able to visit existing patients on the same day if requested and considered necessary.
- There had been no complaints about the service in 2016. Staff were able to provide examples of learning from previous complaints.
- There was a vision and strategy for the service that had been developed by the registered manager.
- Quality of care and outcomes were discussed at regular meetings. There was also discussion of incidents and risks at these meetings.
- There was a risk management policy in place that set out how risks should be monitored and mitigated and we saw examples of completed risk assessments.
- There was a positive, open and enthusiastic culture within the service. Staff were committed to provide the best service possible to their patients.
- The service gained feedback from patients via a feedback form. A patient user group met every three months where the service and new ideas for development were discussed.

However, we also found the following issues that the service provider needs to improve:

- Staff reported incidents and discussed learning from them however, there was no formal monitoring of the number or themes and trends in incidents.
- The consent policy did not reflect the Mental Capacity Act (2005) code of practice.
- There was no policy or formal system in place to support the storage and disposal of medications at midwives homes in preparation for a home birth.

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

Ellen Armistead

Summary of findings

Deputy Chief Inspector of Hospitals North Region

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Maternity		We regulate this service but we do not currently rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. Appropriate clinical risk assessments were completed to ensure care and treatment was safe. There were policies and procedures in place to ensure staff escalated care to other providers if required. Staff followed best practice guidance in relation to infection prevention and control. All equipment was serviced and maintained as required. Records were completed to a high standard and stored securely. However, neither of the midwives had completed safeguarding children to the appropriate level. The registered manager took immediate steps to ensure this training would be completed. There was no formal monitoring or reviewing of the number of incidents in the service. There was no guidance in place to inform midwives who may be required to store medications at their homes in preparation for a home birth. Care was provided by well-trained staff who followed evidence-based guidelines and policies. Staff provided advice and support in feeding their babies and a recent audit showed a high proportion of babies were being breast fed at six weeks. Staff liaised well with other providers. Staff understood the principles of informed consent and the Mental Capacity Act (MCA, 2005) however the consent policy was not in line with the MCA (2005) code of practice. Staff provided care in an individualised way, supported patients to make informed choices and respected their decisions. Patients told us staff provided a high level of emotional support and feedback was consistently positive. Patients were able to access advice 24 hours a day. There were no restrictions to the number of appointments they could receive to ensure they were fully supported throughout their pregnancy and for up to six weeks following the birth. Staff understood that some patients may have additional needs and there were facilities in place to support this for example,

Summary of findings

access to translation services. There had been no complaints about the service in 2016 and staff were able to give examples of learning from previous complaints.

The vision for the service was “to be recognised as the leading provider of maternity care in the UK, setting a new standard for quality whilst prioritising the needs of each and every individual”. The culture in the service was positive and enthusiastic and staff were dedicated to providing the best care possible. Staff met monthly and discussed key information such as clinical quality, care outcomes and key incidents or risks. A risk management policy was in place and we saw this had been implemented appropriately. Patient feedback was sought from every patient and a quarterly user group met who were involved in developing the service for the future.

Summary of findings

Contents

The Birth Sanctuary

Services we looked at
Maternity

Summary of this inspection

Background to The Birth Sanctuary

The Birth Sanctuary is operated by The Birth Sanctuary Limited. The service opened in October 2011. It is a private community midwifery service in Bolton, Greater Manchester. The service primarily serves the communities of the Greater Manchester area, but also accepts patients from other areas of the North West of England.

The service has had a registered manager in post since October 2011.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one other CQC inspector who is a registered midwife. The inspection team was overseen by Ann Ford, Head of Hospital Inspection.

Information about The Birth Sanctuary

The Birth Sanctuary provides a private community midwifery service. The service employs two midwives and offers a range of services including antenatal care and postnatal care for up to six weeks, home births including water births, preconception advice, parent education and aqua natal classes. Care is provided at the registered office near to Bolton town centre and at patients' own homes. Midwives also support their patients during appointments at local NHS hospitals. They support women during labour and birth at NHS hospitals in a Doula role, but do not deliver the baby or act as the primary care giver in this situation (Doulas support women during labour but do not take a clinical role).

The service is registered to provide the following regulated activities:

- Maternity and midwifery services

During the inspection, we visited the registered office and observed one home visit and one antenatal clinic appointment. We spoke with both midwives working in the service, one of whom is the registered manager. We spoke with 12 patients and two of their partners. During our inspection, we reviewed five 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. The service has been inspected two times, and the most recent inspection took place in November 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity

- In the reporting period January 2016 to December 2016 there were 24 patients booked for a full package of care from the service.
- There had been no home births during the same reporting period.

Track record on safety

- There had been no never events and no serious incidents between January and December 2016.
- There had been no complaints during 2016.

There were close links with a private scanning company whose services were used for three scans as part of the pregnancy care package, complimentary therapists and developmental specialists. These services were not inspected during this inspection.

Services provided under service level agreement:

- Clinical and non-clinical waste removal

Summary of this inspection

- Supply of medical gases
- Supply of medications
- Provision of pool for home birth
- Maintenance of medical equipment
- Pathology

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 regulate but do not currently rate this service.

We found the following areas of good practice:

- All staff were up to date with mandatory training. They followed best practice guidance in relation to infection prevention and control. The environment was clean and staff had access to sufficient equipment which was serviced and calibrated regularly.
- Clinical risk assessments were completed for each patient. There was clear guidance in place in the form of inclusion and exclusion criteria and an escalation policy to ensure patients received care in the most appropriate clinical setting. Risk assessments were reviewed regularly, and when there were any concerns about the health of the patient or her baby, referrals were made to other providers.
- Staff had attended training in emergency midwifery skills within the previous 12 months. This included the management of post-partum haemorrhage, breech presentation and shoulder dystocia. This also included basic adult life support and neonatal life support.
- The service had an external supervisor of midwives (SoM) to support staff and patients.
- All staff had completed safeguarding adults training in line with best practice guidance. Patients were asked if they had experienced any domestic violence at their booking appointment. Staff had received training on female genital mutilation (FGM) and understood their responsibilities to report this to the local safeguarding authority.
- Records were maintained to a high standard and stored correctly. The service was registered with the Information Commissioners Officer.
- Caseloads were planned based on midwife availability. The service monitored the number of patients on its caseload to ensure there were sufficient staff to provide the level of care required.

However, we also found the following issues that the service provider needs to improve:

- Staff had not completed safeguarding children Level 3 as set out in the Intercollegiate Guidance. The provider took immediate action and arranged the relevant training.

Summary of this inspection

- Staff were able to give examples of learning from incidents. However, they there was no mechanism for monitoring the number of these incidents or analysing themes and trends.
- There was no clear guidance for midwives to use when storing medications at home including in their personal domestic fridges in advance of a home birth. There was no guidance about the disposal of unused or expired medications.

Are services effective?

We found the following areas of good practice:

- Policies and procedures were based on evidence-based guidelines. Care and treatment was provided in line with these policies which reflected guidance from the National Institute of Health and Care Excellence (NICE) and Royal Colleges.
- Patients received education about both breast and bottle feeding. They were supported by staff to feed their baby by their chosen method. A recent audit showed that 90% of patients were exclusively breast feeding their babies at six weeks. This was higher (better) than the NHS average of 24%.
- There were plans to work towards stage one accreditation of the Unicef Baby Friendly Initiative in 2017. This is a nationally recognised accreditation and mark of quality care for mothers and babies and is designed to support breastfeeding and parent infant relationships.
- Staff had received an appraisal within the preceding 12 months and had specific personal development objectives. Staff were well trained and maintained their skills and competencies. One member of staff had completed the NHS New born and Infant Physical Examination Programme (NIPE). This programme offersparents of new born babies the opportunity to have their child examined shortly after birth by a midwife.
- Another member of staff was a part time lecturer at a local university and worked as a supervisor of midwives which involves working in an advisory role in the clinical environment at a local NHS trust.
- The Birth Sanctuary worked closely with a number of third party providers.
- Staff often accompanied patients to appointments at NHS hospitals and liaised directly with hospital staff. Staff told us that clinical staff from some NHS trusts were supportive and welcoming; however in others working relationships were more difficult. The registered manager had taken steps to improve working relationships with these providers.

Summary of this inspection

- The service offered a free 30 minute consultation with all patients. There was a 24 hour cooling off period following this appointment before patients decided to sign the contract agreement. This was to ensure that each patient had the opportunity to consider the service and costs to ensure it was the right service for them.

However, we also found the following issues that the service provider needs to improve:

- Staff understood the principles of the Mental Capacity Act (MCA) (2005) however the consent policy did not reflect the MCA (2005) code of practice.

Are services caring?

- Staff were kind, caring and sensitive in the way they communicated. They spent time speaking to patients; addressing any worries or concerns. Care was individualised.
- The service consistently received positive patient feedback. Patients described the care as “fantastic” and said they “couldn’t have been more satisfied with the care”.
- Patients valued the opportunity to build a close relationship with the midwives, and told us the familiarity reduced their fears and anxieties.
- Staff supported patients to make decisions and choices about their care and treatment. Patients told us they did this in an unbiased and non-judgemental way.
- Staff involved patient’s partners, children and the wider family unit within the patients care. Fathers told us staff considered their needs.
- Staff took time to discuss previous birth experiences and worries and fears about the current pregnancy. Women spoke very positively about the high level of emotional support provided and told us they felt more confident and reassured by the support they were given.
- Staff spoke with patients about their mental and physical well-being. They had access to formal assessments to use where there were concerns about post-natal depression or anxiety.
- Patients told us that during labour staff were able to support them to express their birth preferences. One patient described her midwife as her “voice during labour”.

Are services responsive?

We found the following areas of good practice:

Summary of this inspection

- There was a one off charge to patients to use of The Birth Sanctuary as part of the pregnancy care package. Appointments were tailored around the needs of the patients and there was no limit to the number of appointments patients could access.
- The service aimed to maintain good working relationships with local NHS trusts to ensure that the patients received the best pregnancy and birth experience possible. In some instances this had been challenging, with some local trusts refusing the midwives access to their patients.
- Staff ensured they considered any specific individual or additional needs for each patient. They told us of an example of working with a patient with complex needs where they had worked closely with other services involved in her care such as social care and physiotherapy. Staff understood the need to make adjustments for patients in some cases. There was access to a telephone translation service if required.
- There was access to advice from a midwife 24 hours a day. Appointments could be arranged quickly and at mutually convenient times. Midwives were able to visit existing patients on the same day if requested and considered necessary.
- There had been no complaints about the service in 2016. Staff were able to provide examples of learning from previous complaints.

However, we also found the following issue that the service provider needs to improve:

- The complaints policy did not direct individuals who remain dissatisfied with the outcome of their complaint to the Independent Sector Complaints Adjudication Service.

Are services well-led?

We found the following examples of good practice:

- The Birth Sanctuary vision was “to be recognised as the leading provider of maternity care in the UK, setting a new standard for quality whilst prioritising the needs of each and every individual”. There was a strategy which included establishing links with other providers including gaining practicing privileges to deliver babies at their hospitals, working with NHS England to provide student midwifery placements and developing a Doula training programme.
- Monthly meetings were held where the quality of clinical care and outcomes were discussed. There was also discussion of

Summary of this inspection

incidents and risks at this meeting. There was a risk management policy in place that set out how risks should be monitored and mitigated and we saw examples of completed risk assessments.

- There was a positive, open and enthusiastic culture within the service. Staff were committed to provide the best service possible to their patients.
- Patient feedback forms were given to all patients on discharge from the service where patients were asked to rate the service provided and make comments about care and treatment. A patient user group met every three months where they discussed the service and provided feedback on new ideas about developing the service.

Maternity

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are maternity services safe?

Incidents

- Staff discussed incidents informally and agreed the course of action moving forward. Significant clinical incidents were discussed with the staff members' supervisor of midwives. The service had an incident book and accident book to report health and safety incidents. The provider told us there were no clinical incidents and there were no incidents documented in the incident book at the time of the inspection although staff gave us examples of incidents during our discussions with them.
- Staff were able to give examples of learning from incidents. For example following an incident where a laboratory had lost a blood sample, all sample request forms were photocopied by staff and filled as proof of samples before sending to the laboratory for analysis.
- Staff told us they often discovered concerns in care from other providers such as GP surgeries or NHS hospitals. They reported these incidents directly to other providers informally via telephone calls or for more serious incidents, via a "cause for concern" form. This was a paper record of the incident and concerns identified. We saw examples of completed forms that had been sent to other providers. There was no mechanism for gaining feedback from other providers in relation to incidents reported.

Mandatory Training

- All staff were up to date with mandatory training. Staff attended a one day training course from an external provider which covered all mandatory and statutory training such as moving and handling, fire safety and information governance.

Safeguarding

- There was a local safeguarding policy which set out the responsibilities of each staff member in relation to safeguarding adults and children. Contact details for the local authority safeguarding team were displayed within the office.
- Staff had completed safeguarding children Level 1 and 2 training (required for non-clinical and clinical staff that have some degree of contact with children). They were unable to provide evidence that they had completed safeguarding children Level 3. Level 3 should be completed by all clinical staff working with children, young people and/or their parents and carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding or child protection concerns. The registered manager took immediate action and arranged for an appropriate training course to be attended. We saw evidence that this had been completed by both members of staff.
- All staff had completed safeguarding adults Level 1 and 2 in line with best practice guidance. Patients were asked if they had experienced any domestic violence at their booking appointment. There was also information displayed with contact details of local agencies that helped victims of domestic abuse. One member of staff had attended specific training on domestic violence in June 2016 and worked with a local women's refuge.
- Staff had received training on female genital mutilation (FGM) and understood their responsibilities to report this to the local safeguarding authority.
- A lone worker policy was in place to safeguard the welfare of staff in the service.

Cleanliness, infection control and hygiene

- Staff were aware of best practice in relation to infection prevention and control. All staff had completed up to date infection prevention and control training. Staff

were 'arms bare below the elbows' and we observed staff cleansing their hands before and after contact with mothers and their babies. There was a local infection control and hand hygiene policy which staff adhered to although there had been no hand hygiene audit
- Staff wore aprons and gloves for clinical procedures. Alcohol gel was available.
- An external cleaning company cleaned the suite daily. A daily cleaning log was completed and we saw that this had been completed each day. The suite had also been recently deep cleaned and repainted.
- Pedal operated dust bins were used. An external company was employed to remove and replace any used sharps bins and clinical waste bags.
- If parents needed to change their babies' nappies, a changing mat was available to use. Parents were asked to take all used and dirty nappies home with them.

Environment and Equipment

- The Birth Sanctuary was located in an office building with access to off road parking. There was level access to the building and a lift access to The Birth Sanctuary area. There was a locally agreed fire policy and procedure for the building.
- On arrival at the offices, mothers reported to a shared staffed reception area on the ground floor. The Birth Sanctuary staff greeted their visitors at the reception and accompanied them to their work area.
- The Birth Sanctuary facilities consisted of a large combined office and clinical space, a meeting room, shared staff kitchen and a shared disabled toilet.
- All areas were clean, light, bright and well stocked. There were no formal cleaning schedules for equipment or environmental audits in use.
- Information leaflets, parent education equipment such as a doll and pelvis, birthing ball and imitation parenting baby doll were available.
- Infant feeding props such as breast milk expressing machines and powder milk for bottle feeding demonstrations were also available.
- Clinical equipment included an examination couch, weighing scales, pinard and Doppler devices (to listen to a baby's heartbeat) and a privacy screen. Equipment for urine testing, blood sampling, delivery and suturing packs, gloves and aprons were all readily available.
- Equipment that required calibrating was completed on an annual basis by an external company. We saw evidence of completed calibration tests and electrical safety testing for all equipment for 2016 and 2015.
- There was access to a basic first aid bag for any minor injuries or immediate first aid. This did not contain any medications or resuscitation equipment. An ambu pocket mask for cardiopulmonary resuscitation was available.
- Blood and urine samples from patients were delivered by a member of staff directly to the pathology laboratory at the local nearby trust. There were also arrangements in place for staff to take samples to a local health centre for collection.
- A monthly meeting was held where staff discussed any developments, improvements, concerns or issues associated with the premises and environment.

Medicines

- The Birth Sanctuary did not store medication on the premises. There was a service level agreement in place with a pharmaceutical company, who supplied Entonox if this was required for a home birth. The company delivered the Entonox directly to the patient's home in advance of the birth with instructions on how to store the gas safely until it was required.
- We were told that medicines such as vitamin K (given to babies at birth to help with blood clotting) and syntometrine (a medicine used to help in the delivery of the placenta and preventing or controlling a post-partum haemorrhage) for use at a home birth would be stored in the midwives own home or domestic fridge. There was no local policy in place to support the storage of medicines in this way or guidance for disposal. This meant there was a risk that these medications could be stored or disposed of incorrectly. However, there had been no home births since the service had been established in 2011.

Records

- The service used handheld care notes which were paper based. These were in addition to the NHS hand held maternity notes for those patients planning to give birth in an NHS hospital. Records were given to the patients to bring with them for every appointment. All documents in the handheld notes were photocopied to ensure the service also had its own record of care provided. These notes were stored in individual records

in a locked filing cabinet in the main office. The service was registered with the Information Commissioner's Office in line with the Data Protection Act (1998) and all staff had attended information governance training within the previous 12 months.

- The Birth Sanctuary midwifery care notes contained midwifery and supervision contact details, risk assessments, medical, family and obstetric history, current pregnancy details, laboratory and other investigation reports, antenatal appointments, staff signature page, support agencies details, an evaluation form, document check list, record of telephone calls and a birth preferences section for patients to complete themselves.
- A record keeping audit was completed in 2016. Five sets of notes were reviewed. Four sets of notes met all standards. One set of notes had the patients name missing from page one. The action plan was to ensure adequate patient name labels or clearly written patient details were documented on the top of each record page.
- We reviewed care notes for five patients. All patient details were seen when records were inspected during our visit. They were all complete and included risk assessments, consent forms, blood results, written scan results, reviews, records of telephone communications and signed contracts for using the service.
- During postnatal visits, midwives also completed the personal child health record or 'red book' to chart baby growth.

Assessing and responding to patient risk

- The Birth Sanctuary had an inclusion and exclusion criteria guidelines to follow when considering booking patients for appropriate care. Staff were also aware of the need to work within their professional code and rules (NMC 2013) which should provide safe and responsive care in an appropriate environment.
- The service did not book patients who were over 36 weeks pregnant. This was to ensure that staff had sufficient time to complete relevant risk assessments and to get to know the patient and their preferences for birth.
- The service had an external supervisor of midwives (SoM) to support staff and patients. SoMs help midwives provide safe care for patients and their families. They make sure that the care is given and received in the right place and by the right person.
- A patient risk assessment was completed at every booking appointment, includingvenous thromboembolism (VTE) risk assessments and patients were reassessed at every appointment. If a patient was identified as being at increased risk of complications or there were abnormal blood or scan results, patients were immediately referred to their NHS trust of choice, where they would attend for a booking appointment, if not already completed, and then be reviewed by a consultant or specialist team. This occurred simultaneously while remaining as a Birth Sanctuary patient.
- Staff used pinards and Doppler devices to listen to a baby's heart beat during antenatal appointments. If staff were concerned about the baby's wellbeing, they would be immediately referred to the patient's chosen booked hospital.
- Staff told us attended patients' homes when they were in early labour. Staff told us they performed abdominal palpation to assess the position of baby in the uterus, listened to the baby's heartbeat, assessed baby movements and if requested by the patient and appropriate, performed a vaginal examination to assess if the cervix was dilating.
- Both staff had attended training in emergency midwifery skills within the previous 12 months. This included the management of post-partum haemorrhage, breech presentation and shoulder dystocia. Both staff were up to date with advanced adult life support (ALS) and new born life support (NLS).
- Staff did not perform membrane sweeps (a procedure that can encourage contractions to begin) in line with guidance from Independent Midwifery UK.
- Women arranged their own transport to the hospital once they were in labour. If requested by the patient, The Birth Sanctuary midwives accompanied the patient during her labour at the NHS hospital in a doula capacity. Doulas do not take a clinical role and work alongside midwives and doctors. They support women to find unbiased information to make informed decisions. In this situation, The Birth Sanctuary midwives were not the primary carer and did not undertake any clinical duties as they did not hold practising privileges within the trusts.

- Staff told us in the event of a clinical emergency situation they would call 999, including during a home birth. They would also provide this advice to patients contacting them urgently if this response was clinically appropriate.
- Although midwives undertook clinical observation there was no formal early warning score system in use. Where observations were outside of the normal range, midwives used clinical judgement and made referrals to the NHS hospital services as required.

Midwifery staffing

- There were two midwives working within the service, one of whom was the registered manager. One midwife worked full time at The Birth Sanctuary and one worked part time. Normal working hours were Monday to Friday and Saturday mornings when required. There was always access to a midwife on call.
- Staff told us there was flexibility in the work load to be able to cover clinic appointments or home visits if one midwife was busy at a birth or had been awake overnight.
- Staff informed us that the usual caseload was approximately 20 patients. When booking patients, staff tried where possible to schedule in a gap between each patients due date to try to ensure staff availability of all births. Patients with expected delivery dates were sometimes booked close together but in this circumstance they were informed that there was no guarantee that the midwife could be present due to the unpredictability of labour and estimated due dates.
- Scheduling and booking of patients and arranging patient appointments was also determined around staff members other work commitments, staff annual leave and sickness. For example, annual leave was planned a year in advance to enable the service to plan when it was possible to book women who required a doula during the birth or a home birth.
- The service had not used any agency or bank midwives.

Major incident awareness and training

- There was no formal business continuity plan in place, however staff told us that if the service was unable to provide care to its patients, there care would be transferred to the NHS hospital and community midwives. Staff had not received any major incident training as this was not relevant to their roles.

Are maternity services effective?

Evidence-based care and treatment

- There were local policies and guidance in place that were in line with evidence-based care from the National Institute for Health and Care Excellence (NICE) and guidance from Royal Colleges. We reviewed five clinical polices including the escalation (referral to other services) policy, care of pregnant women with a BMI over 35, inclusion and exclusion criteria for booking clients and choosing a homebirth. We saw evidence in meeting minutes that staff made changes to policies or procedures in line with evidence-based care, for example changing birth plan to birth preferences after attending a conference on maternal mental health.
- Most policies and procedures had been reviewed and updated although we found that one policy, the guideline for the care of pregnant women with a BMI over 35, required a review in August 2016 and this had not been completed. Not all polices had version numbers documented.
- Where relevant, care was provided in line with NICE quality standard 22 (antenatal care) and 32 (postnatal care). These quality standards formed part of the routine care and treatment of patients of The Birth Sanctuary.
- Staff informed us that they followed guidance used by a local trust, they had acquired on a study day (Saving Babies' Lives Care Bundle, NHS England , 2016) regarding monitoring baby growth antenatally. Staff used a tape measure to measure fundal height however they did not use customised growth charts to record fundal height and estimated baby weigh as recommended by RCOG (2013). Staff informed us that they referred all causes for concern to the local trust for surveillance by serial scans. These scan results and baby weight measurements were recorded by the trust on customised growth charts, according to national guidance.
- We saw that local policies and procedures had been followed in the records we reviewed.
- One local audit of breastfeeding had been completed with positive results and a further audit of normal delivery was planned for 2017.

Nutrition and hydration

- Staff were trained to provide breast feeding advice. If requested by patients staff assisted with breast feeding while accompanying a patient on delivery suite. Staff also visited patients on postnatal wards to assist with feeding as well as providing support with breast feeding at home.
- The registered manager told us they planned to work towards stage one accreditation of the Unicef Baby Friendly Initiative in 2017. The Unicef UK Baby Friendly mark of accreditation is a nationally recognised mark of quality care for mothers and babies and is designed to support breastfeeding and parent infant relationships by working with public services to improvestandards of care.

Pain relief

- Staff discussed options for pain relief during labour and provided patients with information to make informed choices.
- One member of staff was trained in acupuncture and offered this service for pain relief. This member of staff was also trained and provided hypnotherapy for childbirth sessions to aid with relaxation and subsequently pain relief.

Patient outcomes

- The service completed a breast feeding audit in 2016 which showed that 90% of mothers were exclusively breast feeding at six weeks post-delivery. This number exceeded national findings for NHS patients of 24%. All mothers had been provided with information about the benefits of breast feeding and 90% were helped to initiate early breast feeding by the midwife attending the birth.
- Staff told us there was no formal mechanism for benchmarking their service because the service they provided was different to that from other providers. The service used oral and written feedback from patients to monitor the effectiveness of the care they provided. Staff told us they were confident that they were providing an effective service as patients returned for subsequent pregnancies, referral of patients was often through word of mouth from previous patients and the positive outcome of their breastfeeding audit.
- The service was not eligible to participate in any national audits or the Royal College of Obstetricians and Gynaecologists quality indicators due to the type of services provided.

Competent Staff

- Staff had received an appraisal from their supervisor of midwives in 2016. In addition to this, each staff member had personal development objectives directly related to their work at The Birth Sanctuary.
- Staff received regular training to maintain their skills and competencies in midwifery and develop their knowledge. We reviewed the training records of both members of staff and saw that they had attended a range of courses over the previous 12 months.
- One midwife maintained her clinical skills through evidence based teaching and facilitation of skills in the simulation suite at the university. She also worked as a SoM, which involved her working in an advisory role in the clinical environment at a local NHS trust.
- Another member of staff maintained clinical skills and requirements for revalidation by working clinical shifts on a delivery suite for a midwifery agency. Both members of staff received regular clinical supervision.
- Staff had attended a training session at the pathology laboratory at the local trust about correct techniques for obtaining blood samples; correct labelling of samples and completion of request forms. Staff had also been trained in cord stem cell collection and had received Human Tissue Act and UK Biobank training. Staff told us that patients arranged and organised the procedure for donations directly with the company and the Birth Sanctuary collected the stem cell samples at the time of delivery.
- One member of staff was trained and insured to provide hypnotherapy for childbirth, aqua natal classes and acupuncture.
- One midwife had completed the NHS New born and Infant Physical Examination Programme (NIPE). This programme offersparents of new born babies the opportunity to have their child examined shortly after birth by a midwife.
- One member of staff was a part time lecturer at a local university.

Multi-disciplinary working

- The Birth Sanctuary worked closely with a number of third party providers. Other providers included nutritional experts, a private ultrasound scanning company and complementary therapists. The midwives told us there were good working relationships with these providers.

- Staff often accompanied patients to appointments at NHS hospitals and liaised directly with hospital staff. When patients were referred to other services, the midwife completed a formal referral form detailing the reasons for the referral.
- Staff told us that clinical staff from some NHS trusts were supportive and welcoming; however they reported that they also faced negativity in some areas towards their service which led to difficult working relationships. The registered manager had taken steps to improve working relationships with other providers including formal and informal meetings and invitations to training or social events.
- Patients told us that communication between the service and other teams had been good and that the handover of care had been effective.

Seven-day service

- Clinic appointments and home visits were routinely available Monday to Saturday. Post-natal home visits were available on a Sunday if this was required.
- There was a midwife on call at all times, to support patients in labour or for urgent advice if a patient was concerned about another aspect of pregnancy.

Access to information

- There was a range of information to support the delivery of effective care available within The Birth Sanctuary office. This included policies and procedures, resource files, guidance text books and the most recent evidence based guidelines.
- Staff were able to access hand held notes relating to the current pregnancy including details of scans or consultations carried out in the NHS setting.
- A letter was sent to the GP of each patient booked with the service, explaining the care that would be provided and contact details for the service. A letter was also sent to GPs and Health Visitors on discharge from the service; transferring the care of the patient and her baby to these clinicians.

Consent, Mental Capacity Act and Deprivation of Liberty

- The service offered a free 30 minute consultation with all patients. At this consultation, patients were given information about the service provided, costs and were given the opportunity to ask questions. The service did not allow patients to agree to the package of care and sign the contract agreement at this appointment. This was to ensure that each patient had the opportunity to consider the service and costs to ensure it was the right service for them.
- We observed staff taking verbal consent from patients and written consent when required, for example when performing a blood test on a baby.
- Staff had an awareness of the principles of the Mental Capacity Act (MCA) (2005) and were able to give examples of when the Act would need to be considered when seeking consent. However, we reviewed the services consent policy and saw that although there was reference to the Mental Health Act (1985) and temporary incapacity, there was no reference to the MCA and the policy did not reflect the MCA code of practice. Similarly, there was no reference to specific consent considerations such as Gillick competence for young people under the age of 16 although staff had received training in this test of competence to consent.

Are maternity services caring?

Compassionate care

- We observed staff during an antenatal clinic appointment and during a home visit. We saw that staff were kind, caring and sensitive in the way they communicated. They spent time speaking with the patients; addressing any worries or concerns.
- Patients told us staff were kind, caring and compassionate. Privacy and dignity was respected at all times and maintained using privacy screens during consultations. Patients described the care they received as individualised.
- The service consistently received positive patient feedback. We saw numerous examples of letters and cards of thanks for the service they had provided.
- We saw five patient feedback forms and saw that all of these patients had rated their satisfaction with the care they received as “very satisfied”. Patients described the care as “fantastic” and said they “couldn’t have been more satisfied with the care”.
- Patients valued the opportunity to build a close relationship with the midwives, and told us the familiarity reduced their fears and anxieties.

Understanding and involvement of patients and those close to them

- Staff provided patients with information and advice to enable them to make informed decisions and choices about their care and treatment. Patients told us they did this in an unbiased and non-judgemental way.
- Staff involved patient's partners, children and the wider family unit within the patients care. Partners told us staff considered their needs throughout the pregnancy and post-natally and their views and opinions on birth choices and plans were sought and respected. They felt that the midwives' presence during the birth of their child had relieved their anxieties and reduced the pressure they felt when supporting their partner.
- Staff encouraged and supported skin to skin contact at birth.

Emotional Support

- Staff told us some of their patients had experienced unsatisfactory care or traumatic experiences during previous pregnancies. They took time to discuss previous birth experiences and worries and fears about the current pregnancy. In some cases, they reviewed previous medical notes jointly with the patient to discuss sequences of events and how situations may be dealt with better in the future.
- We observed staff spending time speaking to patients about their mental and physical well-being. Staff had access to formal assessments to use where there were concerns about post-natal depression or anxiety. When required, patients were referred to relevant services including counselling.
- Women spoke very positively about the high level of emotional support provided by staff at all stages of their pregnancies. They told us they felt more confident and reassured by the support they were given.
- Patients told us that during labour staff were able to support them to express their birth preferences. One patient described her midwife as her "voice during labour".
- We observed staff completing an invasive test on a new born baby. The staff member was very sensitive to the patient's emotional well-being during this test and showed care and professionalism when completing the procedure.
- There was access to hypnotherapy as an additional way to reduce stress and relieve anxieties about the birth. Patients who had used this service reported this was a positive aspect of the care they received. Staff had undertaken additional training in stress management and relaxation techniques and used this when required.
- A user group met three monthly and provided patients with the opportunity to build social relationships and share experiences with other users of the service.

Are maternity services responsive?

Service Planning and delivery to meet the needs of the local people

- The was a one off charge to patients for the use of the Birth Sanctuary. The pregnancy package offered included a booking appointment, care notes, three ultra sound scans, blood tests; antenatal and postnatal appointments at the premises or patients own homes and parent education classes. Appointments were tailored around the needs of the patients and there was no limit to the number of appointments offered. The service had planned in this way to ensure patients contacted the midwives when they were needed, rather than the patient being discouraged due to the financial implications of an additional appointment.
- Payment for the service was also offered as a flexible payment plan over three instalments. All patients signed a written contract, which included free withdrawal at any time if the patients required.
- Patients could also access the service for one off appointments or a reduced package of care, for example a doula service or postnatal care only. This type of service was also available to patients who required preconception health assessments. This was agreed with patients on an individual basis.
- At the time of our inspection the service was only available to patients on a self-paying or insurance funded basis. There were no plans to engage with local commissioners to extend the service.

Meeting people's individual needs

- The service offered home birth as a choice for patients booking at the service. There had been no home births since the service had opened in 2011.

- There was access to a telephone translation service if this was required. This would be identified during any initial contact with the service and arranged for use at the booking appointment where any further discussions about the use of an interpreter would be held.
- Staff ensured they considered any specific individual or additional needs for each patient. They told us of an example of working with a patient with complex needs where they had worked closely with other services involved in her care such as social care and physiotherapy. There had been close working with the local NHS trust to enable to patient to deliver her baby safely and with the correct level of support, for example arranging for a carer to be able to stay overnight at the hospital.
- There was ramped access to the building and access to a lift and a disabled toilet.
- Staff were aware of adjustments that may need to be made for patients with a learning disability; although there had not been any patients with a learning disability using the service. There was access to additional pictorial support material for use with this client group to aid communication if required.
- Staff had attended training to develop their knowledge in relation to meeting individual needs, including a perinatal mental health study day and a conference on maternity services for patients with a hearing impairment.
- Staff provided parent education about infant feeding. Information leaflets were available and breastfeeding and bottle feeding props were available for demonstration purposes.

Access and flow

- There was no waiting list for appointments for an initial consultation. Appointments were arranged at a mutually convenient time with flexibility offered by the service to fit around the patient's lifestyle and other commitments. Midwives were able to visit existing patients on the same day if requested and considered necessary.
- Patients were only accepted by the service if they were less than 36 weeks pregnant. New mothers could access the service for up to six weeks following the birth of their baby. On discharge, care was handed over to the NHS health visitor.

Learning from complaints

- There had been no complaints received by the service in 2016. The registered manager told us there had been only one formal complaint since the service was established in 2011.
- Staff were able to give examples of learning from a complaint. The development and implementation of a "discontinuation of care" form was an example given by staff as a result of a complaint about the service provided post-natally, where an informal conversation had taken place between a staff member and a patient. All staff had attended complaints and conflict resolution training in the previous 12 months.
- There was no information displayed about how to make a complaint and no complaints leaflets available although patients were given information about how to make a complaint as part of the booking process. The registered manager told us if a patient wanted to make a complaint, they would be provided with a copy of the services complaints policy.
- We reviewed the complaints policy and saw that there was a formal process in place with associated timescales for responses. However, the policy incorrectly stated that if a patient remained dissatisfied with the response to their complaint they should contact CQC. The process should refer patients to the Independent Sector Complaints Adjudication Service (ISCAS) who investigate in these circumstances. The provider took action to amend the policy, directing patients to the ISCAS.

Are maternity services well-led?

Vision and Strategy for this core service

- The Birth Sanctuary vision was "to be recognised as the leading provider of maternity care in the UK, setting a new standard for quality whilst prioritising the needs of each and every individual". There were five core values embedded at the service which were people and service focus, respect and dignity, caring, honesty and integrity and professional competence and business focus.
- A service strategy had been prepared in March 2016 which included establishing links with other providers including gaining practicing privileges to deliver babies at their hospitals, working with NHS England to provide student midwifery placements and developing a Doula training programme.

- The registered manager told us the service had recently been approved by NHS England to provide placements for student midwives which had been part of the service strategy for 2016.

Governance, risk management and quality measurement

- Monthly meetings were held and attended by both staff members with the company shareholders in attendance. A set agenda was used including business management, health and safety and professional issues. We reviewed the minutes of these meetings and saw that both the quality of clinical care and outcomes were discussed at these meetings. The meetings also covered topics such as training, staff competence and incidents. There was also discussion of incidents and risks at this meeting.
- There was no formal risk register in place however there was a risk management policy that set out how risks should be monitored and mitigated and relevant risk assessments had been completed for example, a risk assessment for the aqua natal classes run at a local school.
- The service managed patient risk by ensuring there were clear inclusion and exclusion criteria and that patient risk assessments were completed at the time of booking and regularly reviewed.
- The service had reviewed the findings from the breast feeding audit and identified the key factors in the positive results of this audit. This demonstrated that the service monitored these factors to enable it to continue to provide a high level of quality to care with regards to breast feeding.

Leadership of the Service

- The service was led by the registered manager. The business function of the service was supported by the company shareholders.
- The registered manager was a supervisor of midwives and lecturer at a local university and therefore respected in the service and in local NHS trusts. She also had access to peer support in this setting.

Culture within the service

- There was a positive, open and enthusiastic culture within the service. Staff were committed to provide the best service possible to their patients.
- There was a whistleblowing policy in place which provided information for staff including information about protection under the Public Interest Disclosure Act (1998).

Public and staff engagement

- Both members of staff were involved in the development of the service and worked closely together, for example they were both involved in the development of a Doula course.
- A patient feedback form was given to all patients on discharge from the service where patients were asked to rate the service provided and make comments about care and treatment.
- A patient user group met every three months. The aim of the group was for patients to remain in contact following the birth of their baby with each other and staff, especially those who lived in more rural areas. The group also discussed and provided feedback on new ideas about developing the service. Examples given by staff included the service applying for the Baby Friendly Initiative programme. Patients had also been involved in the development of the homebirth guideline.

Innovation, continuous improvement and sustainability

- There were early plans in development with a local NHS hospital and a private hospital for midwives from The Birth Sanctuary to be granted practicing privileges or honorary contracts to allow them to deliver babies at these sites. Patients told us they would see this as a positive development.
- Due to the small nature of the service, staff had been unable to provide aqua natal sessions for a number of months due to an unrelated staff injury. The registered manager had considered the sustainability of the service at this time and concluded that the provision of the midwifery service took priority over the aqua natal service at this time.

Outstanding practice and areas for improvement

Outstanding practice

- The results of a breast feeding audit in 2016 showed that 90% of mothers were exclusively breast feeding at six weeks post-delivery. This number exceeded national findings for NHS patients of 24%.
- Women spoke very positively about the high level of emotional support provided by staff at all stages of their pregnancies. Patients valued the opportunity to build a close relationship with the midwives and had access to advice and support 24 hours a day. Patients described the care as “fantastic” and said they “couldn’t have been more satisfied with the care”.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure there are systems and processes in place to safely store and dispose of medications in the midwife’s own home in the event of a planned home birth.
- The provider should ensure that the consent policy reflects the Mental Capacity Act (2005) code of practice.
- The provider should ensure that information about how to complain should be displayed and that the complaints policy refers patients who remain dissatisfied with the outcome of complaints to the Independent Sector Complaints Adjudication Service. The provider should consider how to monitor and analyse themes and trends from incidents.
- The provider should consider the use of a formal early warning score system.
- The provider should consider the use of a formal risk register.
- The provider should consider how to monitor patient outcomes in the event of a home birth.