Head Office - Neighbourhood Midwives

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Head Office - Neighbourhood Midwives is operated by Neighbourhood Midwives Limited. The service has a registered postal office in North London, a base in Waltham Forest for its NHS work, and a base in South West London where meetings are held. Midwives and the central support team (CST) work remotely and are based at home.

The service provides community maternity and midwifery services, including self-pay private services and a commissioned NHS service. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 11-13 April 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.

Services we do not rate

We regulate this service but we do not currently have a legal duty to rate it. 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:

- We saw evidence that incident reporting, investigation and dissemination of learning were well embedded with incidents being seen as a tool for driving improvement.
- The provider had a robust safer recruitment process in place to ensure that all safety checks were carried out before a member of staff commenced work.
- Compliance with mandatory training was high and was monitored by the central support team.
- Caseloads were capped at a level which ensured safe and consistent care for women
- Care and treatment was provided in line with policies which reflected guidance from the National Institute of Health and Care Excellence (NICE) and Royal College of Midwives.
- We saw that midwives had access to and used evidence-based guidelines to support the delivery of effective treatment and care.
- There was evidence of multidisciplinary working.
- Staff were competent in their roles and undertook appraisals and supervision.
- Women had 24 hour access to their midwives throughout their pregnancy.
- We observed that women were treated with kindness, dignity and respect by midwives.
- Women told us they felt safe in the care of their midwife.
- Feedback from mothers and those close to them was consistently positive.
- Women told us they were partners in care with their midwives and they felt involved in decisions and well informed at all times.
- Women's' individual needs and preferences were considered when planning and delivering services.

Summary of findings

- People for whom English was their second language were offered translation services.
- Service provision was flexible and provided choice and continuity of care.
- Complaints were managed and resolved in a timely manner.
- There was strong leadership provided by the central support team.
- There were risk management processes in place.
- Communication amongst staff was good and was facilitated by frequent meetings and the use of information technology.
- There was a high level of engagement with those who used the service.
- All staff shared a vision of high quality care and service provision and demonstrated a high degree of loyalty to the service.

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

- Fridges did not maintain temperatures which were within the range at which drugs should be stored.
- VTE scores were not consistently recorded.
- There was inconsistent quality of record keeping.
- The provider could not ensure that medicines were stored safely and the medicines management policy did not cover all aspects of medicines management for the service.
- The service did not have a safeguarding lead with level 4 safeguarding children training. However, the provider confirmed that the safeguarding lead was working towards level 4.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected maternity services. Details are at the end of the report.

Professor Edward Baker
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Maternity		The only service offered by Neighbourhood Midwives was maternity. We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Summary of findings

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Background to Head Office - Neighbourhood Midwives

Neighbourhood Midwives Limited (NM) is an employee owned midwifery social enterprise, which provides midwifery services through a self-management hub and spoke model. It was launched in 2013, as a self-funding service for women and their families. In response to the NHS maternity review report, 'Better Births', published in February 2016, NM was successful in agreeing a two year pilot continuity and homebirth service, commissioned by Waltham Forest Clinical Commissioning Group (CCG). This pilot launched in November 2016 and offers a service to women in the locality funded by the CCG and runs in addition to the privately funded part of NM. There were 15 practicing midwives in the service at the time of our inspection.

The Waltham Forest NM pilot offers a service to women with low risk pregnancies. They are offered the same two midwives (one primary and one secondary) throughout their pregnancy, childbirth and up to six weeks after the birth, and their midwives are available 24 hours a day.

The service includes midwifery care, booking appointments, blood tests, delivery of the baby and additional advice such as breastfeeding. Women can self-refer by telephone or online or be referred by their GP; they are supported to deliver their babies in their preferred place of birth. There were 28 births between November 2016 and April 2017 within the Waltham Forest NHS pilot service.

The self-paying women supported by Neighbourhood Midwives receive the same level of care as that offered to women in the pilot service. However, the pregnancies are not all necessarily assessed as of low risk and NM does not support women to have a planned home birth (up until September 2016 NM provided a private self-pay home birth service, but this has ceased since they transferred that part of the service to another private provider). All women who are self-paying are booked in to their local trust hospital. There were 95 births in the self-paying part of NM between April 2016 and April 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, two specialist advisors with expertise in midwifery, and one specialist advisor with expertise in obstetrics and gynaecology. The inspection team was overseen by David Harris, Inspection Manager.

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 found the following areas of good practice:

- We saw evidence that incident reporting, investigation and dissemination of learning were well embedded with incidents being seen as a tool for driving improvement.
- The provider had a robust safer recruitment process in place to ensure that all safety checks were carried out before a member of staff commenced work.
- Compliance with mandatory training was high and was monitored by the central support team.
- Caseloads were capped at a level which ensured safe and consistent care for women.

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

- Fridges did not maintain temperatures which were within the range at which drugs should be stored.
- VTE scores were not consistently recorded.
- There was inconsistent quality of record keeping.
- The service did not have a safeguarding lead with level 4 safeguarding children training. However, the provider confirmed that the safeguarding lead was working towards level 4.

Are services effective?

We found the following areas of good practice:

- Care and treatment was provided in line with policies which reflected guidance from the National Institute of Health and Care Excellence (NICE) and Royal College of Midwives.
- We saw that midwives had access to and used evidence-based guidelines to support the delivery of effective treatment and care.
- There was evidence of multidisciplinary working.
- Staff were competent in their roles and undertook appraisals and supervision.
- Women had 24 hour access to their midwives throughout their pregnancy.

Are services caring?

We found the following areas of good practice:

Summary of this inspection

- We observed that women were treated with kindness, dignity and respect by midwives.
- Women told us they felt safe in the care of their midwife.
- Feedback from mothers and those close to them was consistently positive.
- Women told us they were partners in care with their midwives and they felt involved in decisions and well informed at all times.

Are services responsive?

We found the following areas of good practice:

- Women's' individual needs and preferences were considered when planning and delivering services.
- People for whom English was their second language were offered translation services.
- Service provision was flexible and provided choice and continuity of care.
- Complaints were managed and resolved in a timely manner.

Are services well-led?

We found the following areas of good practice:

- There was strong leadership provided by the central support team (CST).
- There were risk management processes in place.
- Communication amongst staff was good and was facilitated by frequent meetings and the use of information technology.
- There was a high level of engagement with those who used the service.
- All staff shared a vision of high quality care and service provision and demonstrated a high degree of loyalty to the service.

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

- The provider could not ensure that medicines were stored safely and the medicines management policy did not cover all aspects of medicines management for the service.
- The provider did not have a policy statement for when midwives worked outside of NICE guidance.

Maternity

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are maternity services safe?

Incidents

- There were no never events reported for this service the period January 2016 to December 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were 14 clinical incidents reported for the period January 2016 to February 2017. These included three admissions for treatment of jaundice and two transfers into hospital for retained placenta. There were other recorded incidents which necessitated actions, for example, a record keeping workshop was held when midwife recording issues were picked up. In other cases, where there was a delay in recording a baby's new born and infant physical examination (NIPE), the recommendation was for the date of NIPE to be added to the birth register, which we subsequently confirmed by reviewing the birth register; and a new policy ('Midwives Equipment and Responsibilities') was written in response to a midwife not having third stage drugs with her following a birth.
- Staff we spoke with were aware of how to report incidents and the importance of learning from them. They told us there was a culture of learning from incidents rather than the feeling that there was an emphasis on trying to apportion blame.
- The provider was able to demonstrate how they managed a recent incident concerning their difficulty with receiving blood results from a laboratory for their women due to coding recognition issues. They did this by communicating frequently with the laboratory, the local provider and CCG. They mitigated any risk to the woman which could be caused by delayed blood test results. This was done by midwives taking bloods to the laboratory where the woman's NHS number was manually entered into the system. The midwives then had to ring in for these results, rather than receiving them via a secure e-mail system.
- The provider took a number of actions in response to jaundice related incidents. These included a training session with all midwives on recognising and responding to treatment of jaundice in the community. A guideline was also written specifically related to jaundice levels and NICE guidance. Midwives showed us a laminated copy of this guideline which they carried with them.
- The Duty of Candour (DoC) 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.
- The registered manager demonstrated that they understood their responsibilities in relation to (DoC). They told us that since no notifiable safety incident had occurred, they had not had reason to perform this.
- Staff we spoke with were aware of the DoC and they explained how honesty and transparency was central to their relationship with the women they supported.

Safety thermometer

- The NHS Maternity Safety Thermometer allows maternity teams to take a 'temperature check' on the risk of harm and records the proportion of women who have experienced harm free care. It also records the

extent of harm associated with maternity care. It is intended for public display so that the public are informed about the level of harm free care they can expect.

- The provider did not have a formal safety thermometer in place. However, they were able to measure safety and outcomes for women who gave birth at home through their record-keeping and data which they added to the birth register. This included perineal trauma, post-partum haemorrhage and infection.
- The provider was in discussions with the CCG with which they had a contract for a community based midwifery service about the most effective way to initiate and utilise a safety thermometer.

Mandatory Training

- The provider told us they placed high importance on training and included a wide range of training as part of their mandatory training. Midwives were expected to participate in "skills & drills" training (neonatal resuscitation, maternal collapse, shoulder dystocia, post-partum haemorrhage (PPH), unexpected breech, cord prolapse, sepsis, maternal resuscitation, neonatal resuscitation, maternal antenatal screening tests and information governance on an annual basis.
- In addition, they were expected to undertake training in assessment and management of all types of perineal trauma, full midwifery physical examination of the new born, infant feeding, domestic violence, bereavement support and moving and handling every three years. Midwives completed training in mental health screening (to include as a minimum maternal mental health disorders) and infection control every two years.
- We reviewed training records which showed that training was up to date for all 15 midwives**.** We spoke with the governance and clinical lead who told us it was their responsibility to maintain the training register and ensure staff remained up to date with their training.
- Midwives we spoke with were positive about the quality and quantity of training which they received**.**

Safeguarding

- The provider had a named lead for safeguarding. However, they had level 3 training instead of level 4 which is a requirement in accordance with the intercollegiate document; 'Safeguarding children and young people, roles and competences for health care staff' (published by the Royal College of Paediatrics and Child Health 2014).
- The registered manager told us this had been identified as a training need and the safeguarding lead was being supported to attain level 4 safeguarding training from a safeguarding lead within the local clinical commissioning group (CCG). We saw evidence to confirm that this was planned for the month following this inspection.
- The registered manager told us that the service linked in with NHS trust safeguarding leads, including the one where the NHS pilot programme is based, and also those trusts where all of their self-paying women were registered.
- Training records confirmed that all staff had were up to date with the required level 3 safeguarding children and level 2 safeguarding adults training, which included female genital mutilation (FGM) and Prevent training.
- Midwives we spoke with were able to describe to us ways in which they identified possible abusive situations. They told us that since they supported women in their own homes, they were mindful of ways in which, for example, an abusive relationship could be disguised. There was a discreet question which was asked at the booking appointment with the woman to determine whether she could be at risk of abuse. Midwives also told us they ensured that they saw the woman on their own for all or part of their appointments to give them a safe space to raise any concerns they might have.
- Midwives used a 'combined midwifery liaison form' to communicate with the provider's safeguarding lead and clinical coordinator and relevant external agencies as required. This highlighted any concerns they may have about the woman. All safeguarding concerns were discussed with the safeguarding lead, who logged them on a safeguarding spread sheet. The lead had recently initiated a monthly safeguarding forum to which midwives dialled in and discussed any safeguarding concerns or issues. We saw that safeguarding was a standing item on meeting agendas for midwives and also for clinical support team meetings.

- The employer had a robust system for ensuring that midwives were appropriately qualified and checked prior to starting work. A record was kept which included all NMC registration and disclosure and barring service (DBS) clearance dates. An administrator explained that they had established a system which enabled them to maintain an overview of renewal dates. We saw that all midwives had in date registration and DBS certificates.

Cleanliness, infection control and hygiene

- There was no system in place to monitor or audit infection control and hygiene since care was delivered in women's own homes rather than a clinical space such as that in a trust. To mitigate against this, regular training in infection control was completed. The provider told us they monitored infection rates in the home as a means of auditing the effectiveness of good infection control and hygiene practice.
- All midwives were issued with eye protection and had access to plastic aprons.
- We observed that midwives practised good hand hygiene when we accompanied them on home visits. They wiped the baby weighing scales before and after use with antiseptic wipes and they all carried hand gel.

Environment and Equipment

- Midwives carried their equipment with them in their cars, which included a sphygmomanometer (for measuring blood pressure), baby weighing scales, Doppler (for listening to the baby), Entonox (a medical nitrous oxide and oxygen cylinder) head (for administering analgesia during labour) and thermometer. We saw the equipment maintenance log and saw that each midwife's equipment was in service date and all scales had been recently recalibrated. We did a spot check of equipment when out on a home visit and confirmed that the equipment used by those midwives was within service date and scales had been recently recalibrated.
- Midwives delivered urine samples to the woman's local NHS hospital where they were booked into (for those having a planned hospital birth). Pregnancy remains following a home birth were taken to the local NHS hospital for safe and hygienic disposal.
- The provider had a lone worker policy which midwives we spoke with were familiar with and knew how to access. They told us that they had also completed online training around how to keep safe, and understood the reasonable precautions they needed to take to ensure their personal safety. In addition, they put all of their movements onto a shared calendar, accessible to all. There was a member of the central support team on 24 hour call in the event that they needed to contact them out of hours.

Medicines

- The provider's medicines management policy did not cover all aspects of medicines management for the service. In particular it did not address the service's expectations for the transportation of medicines, the process for managing a temperature failure or destroying expired medicines. There was also confusion between the use of brand names and generic names in the policy. Therefore, staff were not always supported by the policy to follow good practice.
- We found that the fridges in which medication was stored were not fit for purpose. There were two fridges, one was in the office used by the midwives working with the NHS pilot programme in Waltham Forest and the other was at the registered manager's house. Temperatures for both fridges were recorded, however, we saw that these were between 1c and 1.4c, rather than 2c to 8c as recommended for the drugs being stored. The provider's medicines management policy did not detail what action should be taken when the fridge temperature was out of range. There was a risk that medicines would become unfit for use.
- We brought this issue to the attention of the registered manager who acknowledged this was an issue and they would seek to remedy this as soon as possible. In addition, they said they would speak with a pharmacist and enquire about whether the efficacy of the drugs had been compromised, in which case, they would arrange for replacement drugs as soon as possible. Further communication from the provider following the inspection confirmed that new fridges had been purchased and delivered. They also said they replaced all the drug stock they had with new supplies as a precaution.
- We observed appropriate storage and transportation of Entonox.

Records

Maternity

- The provider had a record keeping policy which clearly set out expectations of good and safe record keeping. However, we reviewed 18 records and found that they were not all maintained as per this policy. For example, it was not possible to ensure that recording was contemporaneous since not all entries were dated and timed. Several pages in the records lacked the woman's name and NHS number, and documentation of the condition of the baby not always recorded post birth. There were some records where the midwives' writing was difficult to read.
- The provider sent CQC the results of an audit which they carried out in the week following the inspection. This audit was reviewed in accordance with NICE standard 22 and midwives' notes were reviewed against the 11 quality statements.
- 12 sets of notes of women whose babies were born in January, February and March 2017 were audited. Of these, six sets of notes were assessed as excellent, four as good, one as needing attention and one as poor.
- The main themes found in the audit reflected our findings from reviewing notes during inspection. This included not writing the woman's name on the top of each page, and not always printing the midwife's name. Recommended actions following this audit included meetings between the governance and quality lead and those midwives with 'poor or needing attention' record keeping.
- Women kept their own hand-held records kept with them. Upon discharge, the midwife ensured that the completed notes were scanned into the provider's secure document management system, and the hand held notes were returned to the woman.
- Midwives' work mobile phones were linked with the provider's encrypted system. The e-mail address was also encrypted as was their virtual fax machine.
- Midwives told us they completed the red book (personalised child record given to each parent/carer at the child's birth to record the child's health and development). It was unclear as to whether there was a handover to the health visitor at the end to the midwife's involvement with the mother and baby.

Assessing and responding to patient risk

- The provider had clear inclusion and exclusion criteria in place which identified those woman to whom a service would be provided. The Waltham Forest pilot programme offered a service to those women assessed as low risk only.
- Women who were self-paying and who were assessed as high risk were offered a service, These risks were assessed and placed on the provider's risk register. These risks included women with high BMI; older women; a woman who had a 3rd degree tear which meant there was an increased risk of recurrence; a woman with a diagnosis of gestational diabetes and raised blood pressure.
- NM did not employ their own obstetricians. All women booked with NM privately had to be booked in with their local NHS hospital and we saw evidence of communication with the woman's responsible consultant where queries arose.
- Midwives completed a clinical risk assessment form if they identified risks to a woman or baby. They told us that this form was completed following a discussion with the clinical coordinator and /or clinical risk lead. These risks were placed on the clinical risk register. We saw that some of the identified risks related to depression, alcohol or drug dependency. One midwife told us of an environmental risk assessment they did where they believed the environment could impact on the woman when in labour.
- Women were asked a series of brief focused questions as part of a general discussion about their mental health and wellbeing at time of booking, and at other times during their pregnancy. This was a means of determining levels of depression and was in accordance with NICE guideline CG192.
- Accurate weight of the woman during pregnancy is important in order to assess their BMI and to accurately assess their risk of venous thromboembolism (NICE guideline CG192). Midwives did not weigh women at time of booking or at any other time during the pregnancy. Instead, they relied on the women to self-report what they weighed. Midwives we spoke with said they did not carry adult weighing scales with them. There was no facility to weigh women when they came for their scan to the community base.

- We discussed this with the registered manager who acknowledged that midwives were reliant upon women having an accurate knowledge of their weight during their pregnancy, which may not always be possible. They told us that this would be discussed at the next clinical support team meeting and a plan to mitigate the risk would be formulated.
- Venous thromboembolism (VTE) is the formation of blood clots in the vein. The provider's policy stated that a VTE assessment score was done at time of booking and again at 36 weeks.
- Data submitted by the inspection for January to and September 2016 showed that 57 out of 80 women (71%) seen had their VTE risk scored at time of booking. This rose to 90% for October to December 2016. We saw that VTE risk assessments were completed at time of booking on all those records we reviewed which were randomly chosen by us. However, we did not see evidence of repeat VTE risk assessments as per the provider guidelines for those women who were over 36 weeks pregnant.
- When midwives had concerns about a deteriorating woman, they utilised the SBAR method (situation, background, assessment, recommendation) to facilitate prompt and appropriate communication. Midwives told us that any concerns they had about a woman were initially discussed with a member of the clinical support team and an ambulance would be called as necessary. An intrapartum transfer form was completed to escalate the clinical problem which required attention which facilitated an efficient handover of women between clinicians or clinical teams.
- Midwives told us in cases where they suspected that a baby may have jaundice, they did not do a blood test (serum bilirubin or SBR) to check for levels of bilirubin in the blood, which they told us was outside their remit. In such cases, they referred the woman to her GP, health visitor or NHS trust as appropriate.

Midwifery staffing

- Women were booked according to availability of midwives and no further bookings were taken until space became available on a midwife's caseload. Staff told us this principle of safe staffing was rigorously maintained. The provider did not employ agency midwives as it did not fit with the philosophy of the organisation. We confirmed that this was the case from all midwife schedule records that we reviewed.
- Midwives told us their caseloads were capped at 35, and not all were up to that maximum figure at the time of the inspection. When women were booked, they retained that midwife for the duration of their pregnancy. The provider told us that this lower caseload reflected the fact that they were available 24 hours a day.
- The provider told us that a back-up midwife would be introduced at 16 weeks. Whilst we found that the introduction of the second midwife did not always happen at this stage, we noted that there was a back-up midwife later into the pregnancy and visits usually alternated between the two midwives in order to develop a relationship with the woman. This ensured continuity of care in the event of the primary midwife being unavailable.

Medical staffing

- The provider did not employ any medical staff. The registered manager told us that all of their privately booked women were booked with their local NHS trust. It was a preference of the provider to use the services of NHS obstetricians when the need arose. They told us they had developed good relations with staff in local hospitals and valued the opportunities this presented, in particular, good service delivery to women.
- We were assured that midwives contacted women's obstetricians as required. Staff told us they had built up relationships with obstetricians in NHS hospitals with whom they could discuss matters of concern. We observed a midwife making an appointment for one women about whom they had some concerns.

Major incident awareness and training

- The provider had a business continuity plan in place. This included an assessment of risk in a variety of areas such as care delivery, business management and data management. The business continuity plan identified impact and mitigation in each of these areas.

Maternity

Are maternity services effective?

Evidence-based care and treatment

- The provider did not take part in national audits at the time of our inspection. However, they informed us that they were working towards submitting information to some national audits, for example screening.
- 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 College of Midwives.
- There was evidence available to demonstrate that women were receiving care in line with the National Institute for Health and Care Excellence (NICE). For example, routine antenatal care was delivered in accordance with NICE standard 22, including screening tests for complications of pregnancy.
- However, we found evidence that some practice was outside of guidelines. Guidance from the Royal College of Obstetricians and Gynaecologists (RCOG: Reduced fetal movements, Green-top Guideline No. 57) does not recommend giving women a range within which they should experience fetal movements. This is because there is insufficient evidence to support specific amounts of foetal movement as an indicator of a healthy fetus or a fetus in distress and thus is of poor predictive value. We discussed this with them and were told that whilst they understood this to be the guidance, nevertheless, women frequently asked for advice about their baby's movements as a form of reassurance. In such cases, the midwives ensured that women understood that there was no set amount of movement to indicate a healthy fetus.
- We also found that midwives were routinely listening in to the fetal heart (auscultation) during all of the antenatal checks. NICE guidelines (CG62 Antenatal care for uncomplicated pregnancies) states that auscultation of the fetal heart may confirm that the fetus is alive but is unlikely to have any predictive value and routine listening is therefore not recommended. However, when requested by the mother,auscultation of the fetal heart may provide reassurance**."**
- The provider had a policy for occasions when midwives operated outside guidance.
- Women with risk factors for gestational diabetes were identified and offered glucose tolerance testing.
- Records showed that baby growth was measured from 24 weeks by recording the symphysis fundal height. Whilst this was written down, it was not additionally plotted on a growth chart, which would provide a visual check of when to refer for growth scans.
- The provider carried out local audits in a number of areas, mostly linked to the use of guidelines. We saw the provider had a review and audit schedule and noted that reviews and audits were carried out in a timely manner. Audits completed in 2016 included postpartum haemorrhage at homebirth (PPH), vitamin K administration, care in pregnancy and fetal auscultation.

Nutrition and hydration

- Midwives were trained to provide breast feeding advice and offered support with breast feeding at home. One midwife was an international board certified lactation consultant for breastfeeding support. They were available to give additional advice and support to mothers and midwife colleagues.
- Ninety-five per cent of mothers were breast feeding their babies when discharged by the service, which was in line with the provider's target.
- The information pack given to women booked with NM included advice on the importance of eating a healthy diet during pregnancy and gave guidance on food groups.

Pain relief

- Midwives discussed options for pain relief during labour and provided mothers with information to make informed choices. Women we spoke with told us they were made aware of the different sorts of pain relief they could use during labour.

Patient outcomes

Maternity

- We saw data maintained by the provider based on 108 births between January and December 2016. The low birth numbers skewed comparisons with the national average which affected the provider's ability to benchmark outcomes.
- There was one stillbirth and one neonatal death recorded which was higher when compared with the national average of 0.3 for both. However, as stated above, the data was not comparable due to the low number of births. We saw investigation reports for both of these, which were done in conjunction with the woman's local NHS hospital and noted that they were comprehensive.
- Royal College of Obstetricians and Gynaecologists (RCOG) guidance is for providers of maternity care to consider the use of a Maternity Dashboard to plan and improve their maternity services. This serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance. The scoreboard can help to identify patient safety issues in advance so that timely and appropriate action can be taken.
- Neighbourhood Midwives maintained a dashboard for their self-paying women and had initiated a dashboard for the recently established Waltham Forest pilot programme. The dashboards included clinical indicators for all births such as type of birth, third degree maternal tears, shoulder dystocia and infection. The dashboards also included workforce matters such as caseloads and attendance at training. The private service dashboard was RAG rated. The provider informed us they had agreed with the CCG with the CCG not to initiate RAG ratings for the Waltham Forest NHS pilot service until it had been operating long enough to gather sufficient data to base them on.
- Neighbourhood Midwives Limited (NM) maintained separate birth registers for the NHS pilot project and for those births of self-paying women. There were 28 births (one of which was an elective and one an emergency caesarean section) between November 2016 and April 2017 within the Waltham Forest NHS pilot project. Of these, 12 mothers had identified home as their preferred place of birth, 10 of whom had their baby at home.
- For those self-paying women who chose to have a home birth, NM midwives supported them as part of another independent midwifery service (this was since November 2016). These women are excluded from this inspection as that service is not part of this current inspection.
- NM midwives supported self-paying women up to the point of transfer to the hospital or birth centre they were booked into. Their role became one of support only to the women, rather than clinical once the women was admitted to hospital. Between November 2016 and April 2017, there were 68 births, of which 18 resulted in an emergency caesarean section. This represented 26.5% of births, which was higher than the national average of 14.7%. Five of these women were assessed to be of high or intermediate risk at time of booking. At the onset of labour, there was a total of 11 women risk assessed as being of high or intermediate risk at onset of labour.

Competent Staff

- The registered manager told us they did not employ newly qualified midwives as they would not be able to support their preceptorship programme. The Nursing and Midwifery Council defines preceptorship as 'a period to guide and support all newly qualified practitioners to make the transition from student to develop their practice further'. The registered manager said that the autonomous way in which midwives worked would not be safe or supportive for those recently qualified. All midwives employed were between three and fifteen years post qualification as a midwife.
- Midwives we spoke with told us they felt very well supported in meeting their training needs. They attended a training day every 9 weeks which included a range of topics and updates related to their work or any arising issues. Training records showed there was 100% compliance with training. Examples of training included support in bereavement, antenatal stillbirth, sepsis, risk management, safeguarding and information governance.
- We saw evidence which demonstrated that those staff who had been part of Neighbourhood Midwives for one year or more had an annual appraisal (development review) with the human resources director, who was also a part-time practising midwife. Prior to their annual

development review, the midwife submitted two pieces of reflective practice which contributed to the discussion within the review and out of which a development plan, including training needs was agreed.

- Each staff member had personal development objectives directly related to their work set during their annual development review, which also informed their future training needs. We saw records of development reviews and noted that these were interactive and midwives were encouraged to consider training to further develop their skills. For example, one person expressed an interest in maternal mental health and we saw this was subsequently included in one of the regular training days.
- We saw registration data related to all midwives on the provider's revalidation record. This included the midwife's revalidation due date, the name of their confirmer and their intention to practice reference. The provider supported midwives to gather contributory evidence for revalidation. This included two reflective practice pieces which they used in their development review.
- The provider told us they were developing a process of supervision in line with the National Midwifery Council (NMC) changes to clinical supervision which came into effect on the first of April 2017. The NMC model of clinical supervision changed from a statutory model of supervision to an employer led model. Changes were also made to the role of supervisor of midwives (SOM) which was replaced by a professional midwifery advocate. The provider's current SOM would continue to offer support and guidance whilst undertaking the necessary training for changes to their role.

Multi-disciplinary working

- The provider worked with a private ultrasound scanning company which performed all their scanning functions. Midwives told us there was a good relationship with this company.
- Midwives often accompanied women to appointments at NHS hospitals and liaised directly with hospital staff. When referrals to other services were required, the midwife completed a formal referral form detailing the reasons for the referral.
- The registered manager told us they placed a high level of importance on good multi-disciplinary relationships and as such, strove to make links with obstetricians and midwives in local NHS trusts and neighbourhood CCG teams through meetings and telephone calls.
- A letter was sent to the GP and health visitor of each woman 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 mother and her baby to these clinicians.

Seven-day service

- Midwives were available to their booked women 24 hours per day, seven days per week for the duration of their pregnancy and appointments were arranged times convenient for the woman and their partner. If a midwife was going to be unavailable they would ensure that the women's second midwife was available.
- Women we spoke with told us they derived a high level of comfort and security from this.

Access to information

- In most cases, midwives did not have access to women's' medical history and relied on the women to relay any information to them. There were exceptions to this within the Waltham Forest NHS pilot, when some of these women were referred by their GP.
- There was a range of information to support the delivery of effective care available to midwives on the provider's secure intranet. This included policies and procedures, resource files, guidance text books and the most recent evidence based guidelines.
- Midwives carried copies of policies and documents relevant to their practice with them at all times.
- Mothers to be were given a resource pack which included information on nutrition and aspects of pregnancy and birth.
- Midwives communicated via a group chat on their mobile phones. They told us this was a valuable way to confirm any questions or queries they might have.

Consent, Mental Capacity Act and Deprivation of Liberty

- The service offered a free consultation with all prospective parents. At this consultation, they were given information about the service provided, costs and were given the opportunity to ask questions. The service did not allow prospective parents to agree to the package of care and sign the contract agreement at this appointment. This was to ensure they had the opportunity to consider the service and costs to ensure it was the right service for them.
- We saw that consent was recorded during the booking appointment and where relevant during the pregnancy.
- Midwives we spoke with demonstrated an understanding of the Mental Capacity Act and the importance of gaining consent. We observed midwives taking verbal consent from women, for example when performing an examination.

Are maternity services caring?

Compassionate care

- The provider had a privacy and dignity policy in relation to clients, which was available to all midwives on the intranet. This set out how midwives should interact with clients to ensure their privacy and dignity was respected at all times. The provider also had a privacy and dignity policy which related to employees. This gave guidance around establishing a working environment which is non-threatening and in which the dignity of individuals is respected.
- We observed midwife interactions with women who came to the Neighbourhood Midwives base in Waltham Forest for their scans, and during home visits. We saw that they were kind, caring and sensitive in the way they communicated. They spent time speaking with the women; addressing any worries or concerns. One woman told us, "I had concerns one evening and texted my midwife; she contacted me back straight away."
- Women we spoke with were positive about their care. They told us their midwives were kind, caring and compassionate and described the care they received as wholly individualised. They said they particularly valued the opportunity to build a close relationship with their midwives, and told us the familiarity reduced their fears and anxieties. One woman told us, "seeing the same midwife means they get to know me I don't have to repeat myself." Another said, "my midwife makes me feel that my baby and I are the most important people to her."
- Midwives told us they established what women's preferences were for sharing information with their partner and family members and ensured they respected this.
- CQC sought online feedback from women who had used the service and had approximately 20 responses. Comments left were consistently positive and included, 'unique and individual care that makes you feel extra special', 'I would recommend them to anybody who wants a fantastic service' and 'the midwives were kind, patient and willing to go to the ends of the earth to reassure and comfort.'

Understanding and involvement of patients and those close to them

- Once booked into the service, women were given a handbook which contained extensive information about pregnancy and birth and the support they could expect from their midwife. Midwives provided women with information and advice throughout their pregnancy to enable them to make informed decisions and choices about their care and treatment. Women told us this information was given in an unbiased and non-judgemental way.
- Midwives involved partners, children and the wider family in accordance with the woman's wishes. Partners told us their midwife considered their needs throughout the pregnancy and their views and opinions on birth choices and plans were sought and respected. One woman's partner told us it was apparent that the midwife prioritised the woman's needs at all times, which he said was reassuring.

Emotional Support:

- Midwives told us some women they supported 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 and considered ways in which things could be different this time around.
- Women spoke very positively about the high level of emotional support they experienced at all stages of their

pregnancies. They told us they felt more confident and reassured by the support they were given. Their midwife had given them a thorough explanation in advance of their anomaly scan, which checks the development of their baby and were prepared that there could be bad news.

- All midwives had undertaken training on bereavement which they told us helped them to break bad news. The provider was also planning to run a training session on perinatal mental health.
- Midwives told us they got support from each other and during staff meetings to help them reflect on upsetting experiences they may have encountered during the course of their work.

Are maternity services responsive?

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

- Neighbourhood Midwives offered a service to both self-paying and NHS-funded women, all of whom could self-refer. Those offered a service via the NHS were part of a recently established clinical commissioning group (CCG) pilot programme in Waltham Forest. The provider told us that since midwife caseloads were capped, they sometimes had to either refuse new referrals or place women on a waiting list.
- Midwives told us they managed their caseloads independently, which helped them to plan their work. For example, they would not book a woman whose due date was during a time when they had booked a period of annual leave (which was expected to be planned 12 months in advance). The practice of introducing a second midwife ensured that shorter periods of absence due to sickness or the needs of another woman on their caseload were covered by a midwife familiar to the woman.

Meeting people's individual needs

- The provider booked women whom they assessed to be low risk only as part of the NHS pilot programme. For those who were self-paying, women with all levels of risk were accepted.
- Women we spoke with told us they did not feel pressured into giving birth in a particular environment or in a particular way. They said they were presented with the facts and could continue to discuss these throughout their pregnancy. They firmed up their birth plan at 36 weeks pregnancy, but they were assured that they could change their minds as they wished. One mother told us they had started off their pregnancy fully committed to the idea of a home birth. However, she told us she had recently changed her views on this and had received full support from her midwife to rethink her plan.
- We looked at women's hand-held records when we spoke with those who had come for their scan and also when on home visits. We reviewed notes of discharged women which had been scanned in their entirety onto the provider's secure virtual filing cabinet. We saw that these records showed that their antenatal, labour, birth and postnatal needs, where applicable, had been assessed and provided according to their individual needs.
- For example, we saw that midwives worked collaboratively with a local diabetes clinic to manage the individual needs of a woman with diabetes. In another, we witnessed a midwife as she made a telephone referral to an obstetrician in the woman's NHS trust. The midwife suspected that there was too much amniotic fluid around the baby and requested that the obstetrician see the mother.
- We accompanied a midwife on a home visit where English was not the woman's first language. The midwife had arranged a telephone translator for the duration of the appointment. Despite the fact that communication was done through a third party (telephone translator), this did not affect the quality of the interactions between the midwife, the woman and the extended family who were also present.
- We spoke with midwives about how they would support a woman who had a learning disability or complex mental health needs. They told us that assuming they were best placed to offer support to the woman, they would work in conjunction with other support the woman already had in place with local social services or CCG, including community psychiatric nurse or community learning disability team.

Access and flow

- Appointments were arranged at a mutually convenient time with flexibility offered by the service to fit around the woman and their family's lifestyle and commitments. Midwives told us they were able to visit existing patients on the same day if requested and considered necessary.

Learning from complaints

- The provider had a system in place to deal with complaints. The clinical co-ordinator was the lead on investigations, and liaised closely with the registered manager and governance lead. The registered manager was responsible for concluding the process and signing the complaint off.
- There had been no recorded complaints for the reporting period January 2016 to January 2017. We saw the complaint log which showed previous complaints including follow up actions. There was one complaint in March 2017, and the log detailed actions taken. However, the log did not note the response dates of any correspondence sent to the complainant.
- The provider had a complaints policy which was made widely available to those who used the service.

Are maternity services well-led?

Leadership of the Service

- Neighbourhood Midwives was based on the principle of self-management and was an employee-owned social enterprise. There was a registered manager who was the chief executive officer (CEO). The service was run by the clinical support team (CST) which oversaw the development of the business, governance and strategy. The CST included the CEO, clinical director, HR director, and the governance and quality lead. There was a board meeting every three months which reviewed the business and any arising concerns or trends.
- Staff we spoke with said they felt well-supported by the CST and all their colleagues.

Vision and Strategy for this core service

- The service had a clear vision and strategy. The provider told us their organisational model was based on the Teal principles of self-managing teams.
- They used a hub and spoke structure of support and learning which was designed to ensure the midwives had the support and governance framework they needed to deliver safe and high quality care. This model promotes a sense of inclusiveness and ownership for practice staff in the process of developing practice learning experiences for the whole team as a whole.
- Staff at Neighbourhood Midwives had a shared view of the sort of service they wished to provide. This included women having the same experienced midwife throughout their pregnancy. They also expressed a desire for all women to have access to the type of pregnancy support which they provided.

Governance, risk management and quality measurement

- We found that there were reliable risk management processes in place including systems for learning from incidents, sharing the learning and implementing change from related action plans. Responsibility for governance, risk management and quality measurement lay with the CST.
- The CST had a conference call every week. There was a set agenda which included an update on recent incidents. In addition, the CST reviewed all incidents and risks on a monthly basis. We saw minutes which confirmed that there was a robust review and discussion about incidents.
- The provider had a critical incident reporting policy and maintained a risk register. We saw that all identified risks were risk assessed, and any that scored as significant or high entered onto the risk register. We saw in meeting minutes that all risks were reviewed by the clinical risk lead and CST at their weekly meetings and at Board meetings which were held quarterly.
- Women's records were audited once they had been uploaded onto the virtual filing system, post discharge. The provider had no system in place to audit notes contemporaneously.
- We asked members of the CST how they were assured that midwives delivered care in a safe and effective manner. They told us that the second midwife system

meant that there was always professional oversight of records and practice. In addition, there was case discussion at team meetings and they sought feedback from women about their satisfaction with the service.

Culture within the service

- Midwives told us they believed the success of the service they provided was as a result of good internal team working. They spoke of a non-hierarchical style of management which facilitated openness and honesty and gave rise to a safe environment in which to challenge and be challenged.
- Staff told us that the CST was always available to them and offered support and encouragement at all times.
- 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

- The provider encouraged people who used their service to complete an online survey to register their feedback following discharge. Results from their 2015-16 survey recorded a response rate of 50%. Of these, 93% said they felt very involved in planning their care and 91% said they felt their decisions were always respected. Other scores included 98% felt that their midwife was approachable and 94% rated their care during pregnancy as excellent. 94% would recommend Neighbourhood Midwives to family and friends.
- Results from the staff survey carried out in January 2016 demonstrated that 100% of staff would recommend the service to family and friends. 68% of staff agreed that they had appropriate training and equipment to do their job whilst 22% were less sure.100% of staff said they were encouraged to report errors, accidents or near misses; 89% of staff strongly agreed and 11% agreed that they were informed of changes made in response to accidents and near misses.
- Midwives who worked as part of the NHS pilot programme organised tea parties for women as a means of introduction to each other. They told us they hoped to facilitate an environment in which women could support each other and share mutual experiences.
- There was a weekly staff meeting for those who worked as part of the NHS pilot project. There was a staff meeting for all staff every three weeks. Midwives told us they placed a high value on these meetings and used them to discuss their work and raise any concerns they might have.
- The registered manager sent a monthly newsletter to all staff. We saw that this was a mix of business updates, news and notifications. Staff told us they valued this form of communication.

Innovation, continuous improvement and sustainability

- Following the National Maternity Review report, 'Better Births', published in February 2016, Neighbourhood Midwives was successful in agreeing a caseload continuity and homebirth service two-year pilot commissioned by Waltham Forest CCG. They were one of the seven pioneers selected within the Maternity Transformation programme to provide innovative solutions to increase choice and personalisation to women.
- The registered manager told us that the pilot placed additional demands on the business as they endeavoured to recruit midwives to respond to the increase in referrals. Recruitment was placed on their corporate risk register.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all medication is maintained at temperatures according to manufactures guidelines.
- The provider must ensure the medicines management policy is robust including details of what action staff should take if medicines are stored outside of the safe temperature range for any length of time. This includes fridge storage and storage in cars.

Action the provider SHOULD take to improve

- The provider should ensure that women's weights are accurately recorded.
- The provider should improve on the recording of VTE scores.
- The provider should ensure that all record keeping meets NICE standard 22.
- The provider should consider contemporaneous auditing of women's hand held notes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not being stored at the correct temperature. Records showed the temperature of the fridges to be between 1 and 1.4 degrees Celsius instead of the required range of 2-8 degrees Celsius. Care and treatment must be provided in a safe way for service users. The registered person must ensure the proper and safe management of medicines. Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were inadequate systems to monitor the safe storage of medicines. The provider did not carry out medicines management audits in line with their policy. The provider's medicines management policy did not detail what action should be taken if problems with medicines storage were identified. Systems or processes must be established and operated effectively to enable the registered person to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Regulation 17(1)(2)(a)