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Private and Confidential
Ms. Deputy Le Hegarat
Deputy Chair
Health and Social Security Scrutiny Panel

18 March 2021

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Dear Deputy Le Hegarat

Thank you for your letter dated 9 February 2021 informing of the Health and Social Security Scrutiny Panel launch of its review of Maternity Services in Jersey and for outlining some of the key issues and the Terms of Reference.

Thank you for your invitation to participate and for providing us with an opportunity to contribute at this stage. Although the letters were directed to the Associate Chief Nurse/Head of Midwifery and our Specialist Infertility Nurse, we would like to provide a response reflecting our collective voice as a leadership team. This is a welcome opportunity to share our views and that of the Maternity staff, providing a balanced response inclusive of the current challenges faced by the service that may impact on service users and their families.

Our responses are aligned with the Terms of Reference.

To assess current maternity care provision, with particular regard to the following:

Suitability and adequacy of current maternity facilities

The current maternity provision includes a seventeen (17) bedded antenatal and postnatal ward and six (6) birthing rooms, one of which can accommodate a birthing pool. We provide 24 hour obstetric and anaesthetic cover and access to a designated Obstetric Theatre. There is an eight (8) bedded Special Care Baby Unit (SCBU) and a bereavement suite.

The Hospital Antenatal Clinic, which is primarily for more high risk pregnancies, is located in the main Outpatients Department of the Hospital. Women that are considered low risk are seen by Community Midwives, either at The Bridge Child and Family Centre or their General Practitioner (GP) surgery.

A number of environmental issues within the Maternity Department have been identified that need to be addressed in advance of the new 'Our Hospital' project, these include:

- Upgrading of the delivery suites to include en-suite facilities. This will facilitate modern practices in terms of midwifery-led and consultant-led births;
- Improved temperature control throughout the Maternity Unit;
- Refurbishment/expansion of the Special Care Baby Unit (SCBU) which is located within the Maternity Unit to meet modern standards;
- The existing Maternity Unit does not fully comply with current infection control standards;
- The Maternity Unit does not have piped gas or a gas scavenging system;
- Upgrading of the nurse call system;

- All areas within the Maternity Unit require full refurbishment.

The refurbishment of the existing Maternity Unit is initially confined to the limitations of the existing ward footprint, however, as a result of changing practices in working methods and equipment, additional areas are required to be accommodated in accordance with requirements.

It is anticipated that refurbishment will commence June 2021 and will be completed in 2023. The main components of the scheme include the refurbishment of the existing birthing rooms to provide en-suite facilities, as well as providing a new larger Special Care Baby Unit (SCBU). In order to increase the size of the SCBU, it is proposed that a small single storey extension will be constructed within the existing first floor courtyard.

The refurbishment works will now incorporate 'hot patient' areas for women at higher risk of infection. A new designated birthing room with positive pressurised lobby has been introduced for the isolation of women with potential infections.

The works will be undertaken in a phased manner whilst the existing unit is maintained as fully operational. A phasing strategy has been identified on Morris Architects drawings 5210/111 to 122, which also identifies the main contractor working areas and site access, as well as patient and staff access.

Staff are aware there is a seasonal ant infestation, and all measures have been undertaken to address the issue. Estates Management are responsive and supportive to the problem when it occurs. The refurbishment would address this issue.

Maternity and housekeeping staff are working jointly to ensure Infection Prevention and Control measures are maintained in order to minimise risk to women, babies and families. These measures include cleaning rotas, hand hygiene audits, personal and protective equipment (PPE) audits and touch point cleaning (doors, handles and handrails). Midwifery staff carry out daily safety and cleaning checks of specialist equipment.

We have increased the hand sanitiser stations, which are strategically placed throughout the unit, alongside PPE stations in every room and entrance, to minimise the risk of infection transmission.

The bed capacity has been reduced to comply with Infection Prevention and Control measures from 20 to 17 beds in 2020. Decreasing capacity in each bay by one bed has increased the space between each bed.

The old Maternity Theatre on Labour Ward, decommissioned some years ago, has been adapted as a temporary delivery room for accommodating women with potential infections. The area is separate from the Labour Ward and inpatient ward areas. There are single rooms available on the Inpatient Ward, however, use of these rooms for infection prevention and control purposes reduces our capacity to offer women the option of a single room with en-suite facilities.

The Community midwifery team support women and their babies with early discharge home, which also supports the reduction in the risk of hospital acquired infection.

In 2016, the midwifery staff engaged with service users via the Maternity Liaison Committee to gather the opinions of service users regarding the refurbishment of the current Maternity Unit and proposed Unit within the new Hospital. Staff opinions have contributed to the planned refurbishment through midwifery representation on the refurbishment group.

The current Maternity Unit does not have a plumbed-in pool for birth. Midwives have worked with the Estates Management Department to ensure that provision for water birth is available.

The Community midwifery team are working hard to advocate for women and support women's choice regarding place of birth. The Community midwifery staff are delighted to offer the homebirth service and continuity of care which has seen the home birth rate increase significantly in the last few months. The increase in the homebirth rate has demonstrated the offer of choice for women and as a subsequence has reduced the footfall through the Maternity Unit, which in turn reduces the risk of hospital acquired infection.

The refurbishment will provide

- Six (6) new birthing rooms, four (4) new Private rooms and SCBU areas will include WC's / en-suites;
- Collas ward 1 & 2 will each have one (1) new bathroom/ wet room facility, per four (4) beds;
- Collas 3 will only have provision for one (1) new wet room for three (3) beds.

This is an improvement on the existing amenities, and fathers will no longer be expected to leave the Maternity Unit to access the ground floor toilet facilities.

The staff feel the Maternity Unit in its current state is not conducive to a comfortable and a positive experience for women, their families and their babies. Nor is it a conducive working environment for staff.

As much as we recognise the environment is not fit for purpose, staff are committed to providing individualised and evidenced based care to women and their babies.

Availability and quality of antenatal and perinatal mental health care

The Maternity Services recognise mental health problems are often associated with times of stress or change in our lives. Pregnancy and the first year after birth is a time where health professionals have a significant role in promoting positive mental health. Early identification of psychological and mental health issues facilitates the implementation of supportive interventions for women and families.

The perinatal period and the parent infant relationship is crucial for the health and wellbeing of the infant, both in the present and long term. Untreated complications can lead to slow foetal growth during pregnancy, low birth weight, neurodevelopmental delays, attention disorders and depression in childhood. The Midwifery staff have for the past two years been part of a multidisciplinary team, involving Adult Mental Health Services (AMHS), Health Visitors, Baby Steps and Child and Adolescent Mental Health Service (CAMHS) to develop a Perinatal Mental Health Pathway.

Women are screened as part of the pregnancy booking appointment and signposted, where it is indicated, to Adult Mental Health Services for acute / chronic mental health needs and for priority care. Comprehensive multi-disciplinary risk assessments are undertaken for factors such as drug and alcohol misuse to ensure relevant support is provided and safeguarding needs are met.

There can be a perceived stigma attached to mental health issues and since women have been attending appointments alone, there has been an increased rate of disclosure regarding their mental health. At a woman's first contact with primary care, or her booking

visit with the midwife, a general discussion takes place about a woman's emotional well-being and mental health and specific questions are asked to identify women at risk of developing depression.

The current pathway for severe mental health concerns women can be referred to the Adult Mental Health Service (AMHS) and should receive priority care. AMHS are happy to be contacted by telephone or emailed for advice.

The woman will also have access to a Consultant Obstetrician and ongoing midwifery/health visiting/GP support. As of 1 February 2021, a Consultant led Perinatal Mental Health Clinic has been launched in the Antenatal Clinic and this is held every six (6) weeks. This clinic has been developed to ensure that there is a multidisciplinary team approach to care, with guidelines that underpin the operational care delivery. As well as this Consultant clinic, there is provision for women to be seen by a mental health nurse/health visitor counsellor in the Antenatal Clinic.

Secondary mental health services and the Consultant Obstetrician will lead the care for women with severe mental health concerns, with the midwife having an important role in co-ordinating the care of the services involved. The role of midwives is to listen, advocate and offer support for the woman and their family. Midwives are in an ideal position to build a trusting relationship with women due to the frequency of appointments in pregnancy. Midwives can monitor well-being and make sure clear care plans are in place for pregnancy, labour and the postnatal period.

It is recognised that at present we do not have a dedicated Perinatal Mental Health Service in Jersey and this care is currently incorporated within the Adult Mental Health Service. It is acknowledged that this service is needed to fully support women. The development of the Perinatal Mental Health Pathway will improve service provision once staffing resources are available and provide significant quality improvements for the mental health of women and their families. An audit is in progress within the Community Midwifery Service to ascertain the number of women experiencing, or who are at risk of, severe mental health concerns to help plan future service provision.

The plan for the future is that the Perinatal Mental Health Pathway will be accessed through a single doorway with a streamlined referral process for all. The forum will meet on a regular basis to discuss individual women and adopt an appropriate and comprehensive care plan. In addition to this, a Mental Health Forum has recently been created to include midwives, obstetricians, health visitors, AMHS, CAMHS, perinatal psychologists, counsellors and other Island wide services. The Women and Children's (WaC) Care Group are fully engaged in the development of the Mental Health Forum.

Mental Health and well-being services available to women in Jersey

In Jersey we are fortunate to have many services to support emotional well-being. These include:

Pregnancy in Mind (PIM)

Pregnancy in Mind is a course offered universally to expectant parents by the National Society for Prevention of Cruelty to Children. This service promotes mental well-being for all with the aim of minimising the effects of anxiety and depression on parents and to support them in building a positive relationship with their unborn baby.

Healthy Child Program (HCP {Health Visitor Service})

The Healthy Child Programme is offered to all pregnant women, babies and families on the Island. Mental health is one of the six targeted areas within this programme. This universal service offers an antenatal visit, new birth visit, a six (6) week visit with a one (1) and two (2) year developmental assessment.

BABY STEPS - Family Nursing

The Baby Steps Universal Antenatal Programme is delivered by a trained team, which includes Health Visitors, Midwives and trained facilitators. The programme is designed to help people prepare for becoming parents and cope with the pressures of a new baby. It integrates approaches from health and social care with a strong emphasis on healthy relationships and social support. Pregnant women and their partners are offered the opportunity to complete a mental health assessment tool which identifies those requiring additional support.

JERSEY TALKING THERAPIES

Jersey Talking Therapies provide a range of short-term therapy/support to adults over the age of eighteen (18) with mild to moderate mental health issues. There is an exclusion criteria of high risk cases. The team consists of psychological therapists, well-being practitioners and counsellors. There is an option of self-referral. Midwives can also refer to Jersey Talking Therapies.

PARENT AND INFANT PSYCHOTHERAPY

Parent and Infant Psychotherapy helps support parents who struggle to relate or have positive feelings toward their baby. The aim of the service is to address the immediate presenting problems and to help the parent/s feel more positive about their interaction with the baby and focus on strengths as well as challenges.

THE LISTENING LOUNGE

The Listening Lounge is a service which aims to improve and support Islanders with their mental health and well-being. This is a free service consisting of counsellors and peer supporters and access to online support.

There are other private services offered on the Island. These include, but not exhaustive list:

- Jersey Aqua natal
- Mindfulness
- Pregnancy Yoga
- National Childbirth Trust
- Positive Birth Jersey
- Mama Mariposa Doula

One common challenge across all health economies is that often different information technology (IT) care systems do not communicate with each other. Information known about a woman in one part of a service may not be shared across IT systems in another service. Unless a women discloses she has a mental health problem, there is potential for this information to be unavailable.

Further training for midwives to include antenatal mental health screening, identification and knowledge of mental health conditions, treatments, pharmacology and referral processes should be integral to a midwives' continuing professional development. Ideally, specialist mental health midwives should be available to support women and staff.

Staff feel they offer a good service to women with mental health challenges, but that the care will be greatly enhanced once the Perinatal Mental Health Pathway has been ratified and once the consultant led Perinatal Mental Health Clinic is embedded.

Safety and effectiveness of care provided during the antenatal (before birth), Intrapartum (labour) and postnatal (after the birth) stages of pregnancy

The Women and Children Care Group have adopted and follow the tried and tested 7 pillars of clinical governance. These can be described as:

1. **Clinical effectiveness**
2. **Clinical Risk management**
3. **Service User, Carer & Public Involvement**
4. **Education Training and Development**
5. **Clinical Audit**
6. **Staffing and Staff Management**
7. **Information and IT**

Healthcare is not risk free. There is always an element of risk which all healthcare providers work hard to minimise. Maternity services have recently been the focus of scrutiny in England with the Ockenden Report 2020. In the report, Donna Ockenden inferred that maternity services risked becoming organisations that lacked memory. The Ockenden Report was the fourth Public Inquiry into Maternity Services in England and sadly the themes and concerns raised were the same themes that ran through the three previous reviews into Northwick Park 2008, Morecambe Bay 2015 and Saving Babies Lives 2019.

The learning from the Ockenden report has been shared at our Maternity Risk meeting and the essential learning has been incorporated into our local Improvement Plan. As a team, we hold a multi-disciplinary weekly Maternity Risk Management meeting, where incident reports are presented along with cases of interest and new guidelines. This meeting is well attended by the multi-disciplinary team and attendees invited from other specialities. The minutes are disseminated across the department to all staff working in the Maternity Unit.

In January 2021, an Intrapartum Care Group was established to develop working parties who will lead on aspects of intrapartum care, for example, Caesarean section, third and fourth degree tears and instrumental births. The working parties will develop teaching packages and support demonstration of competency in the many aspects of care delivery.

The Maternity Dashboard, reviewed monthly, provides basic data sets on the number of births, modes of delivery, and perineal trauma. The Intrapartum Care Group will review the dashboard and develop local benchmarks to assess and measure outcomes which will drive quality improvements.

In November 2020, the Clinical Governance meeting was recommenced to oversee and receive reports from all maternity meetings, to review and make recommendations for service improvements.

Unexpected adverse outcomes for mothers and babies are routinely reviewed. A process has been formalised for learning through peer review meetings and the outcomes of these reviews is to make recommendations for improvement, as well as celebrating and highlighting areas of good practice.

The Senior Leadership Team within Maternity and the Women and Children Care Group are a newly formed team who have worked tirelessly to develop the governance and risk agenda. Whilst challenges remain with minimal administration support, the team have progressed and made a positive impact on risk and safety.

The Public Health Partnership Group will work across the health economies to better engage with Maternity and service users to reduce the harm from smoking and alcohol consumption in pregnancy.

All women meet with their midwives following referral and a comprehensive risk assessment is carried out at booking. Options for Maternity care/pathways are discussed dependent on needs and risks. This is constantly updated as pregnancy progresses.

Jersey currently offers home births or hospital births as an option for place of delivery. Once the Maternity refurbishment has been completed, care in a midwifery led 'alongside' Unit will also be available.

Continuity of care is crucial in building a rapport and enabling women to make informed choices about their care. It was recognised that due to the COVID-19 pandemic, being able to offer continuity of carer was affected and now that midwives are working back within GP surgeries, this is improving.

Public health messages are given to women such as smoking cessation. Currently we are not testing for carbon monoxide at booking due to COVID-19, however, this will continue to be reviewed in line with Government guidance. Women are signposted to various sites to obtain public health information, however, there is a lack of information locally and this is currently being addressed with the Public Health Partnership Group.

Wellbeing Wallets from Mama Academy, are given to expectant mothers. The wallets are a robust plastic zip-lock pouch in which mums can keep their handheld maternity records. The wallets ensure the notes are kept protected, but they are also colourfully printed with important advice regarding mum's health and that of her baby. This ensures that key messages, such as monitoring babies' movements, become second nature to the woman.

The pregnancy hand held maternity records have lots of information for women to consider in their pregnancy and for their birth. A Pregnancy and Wellbeing Service (PAWS) and a Fetal Medicine Clinic with access to tertiary advice and intervention is available to women who require additional support during the antenatal period.

Customised growth charts are generated for each woman and are contained within their antenatal handheld maternity record. By plotting the growth of the fetus on the chart, babies are identified that are small for gestational age and the women are then referred in for Consultant review and serial growth scans.

A care bundle is a collection of interventions based upon best practice and evidence which are applied to the management of a particular condition. Various care bundles are in use within the Maternity service such as Sepsis Care Bundle, Catheter Care Bundle, Epidural Care Bundle and Antenatal Risk Assessment Tool.

To improve communications and staff support within the department there has been increased visibility of the Senior Leadership Team in clinical areas, introduction of regular one-to-ones with staff and a focus on completing staff appraisals. This provides staff with an opportunity to raise concerns regarding safety and effectiveness and provide any feedback that may hinder or enhance their practise.

From 1st February 2021, a new Medical Workforce Model was introduced which provides a Consultant of the week for the Delivery Suite. This streamlines consultant activity through the antenatal clinic and labour ward which ensures women receive better continuity of care.

The Modified Obstetric Early Warning score system is well established within the Maternity Unit. This tool was implemented to identify the deteriorating condition of a woman and ensure concerns are appropriately escalated in a timely fashion for medical care. There is participation in reporting to national reporting systems such as the UK Obstetric Surveillance System (UKOSS) and Each Baby Counts (EBC), Mothers and Babies: Reducing Risk through audits and confidential enquires across the UK (MBRRACE) and Perinatal Mortality Review Tool (PMRT).

Professional Midwifery Advocates provide a 24/7 service. These are midwives who have received additional training and work within the A-EQUP (Advocating for Education and Quality ImProvement) model. They support midwives to advocate for women, provide direct support for women within a restorative approach and undertake quality improvement in collaboration with women. An example of this, is the Vaginal Birth After Caesarean Section Clinic where women are given time to discuss mode of birth, receive evidence based information and have concerns or questions addressed.

Appropriateness of current policies, relating to Maternity Services, and their application

Appendix 1 provides a listing of maternity specific guidelines and relevant Health and Community Services policies.

Two senior midwives lead on guideline management within the Maternity service. In recent years, guidelines have been allocated to the Midwifery and Obstetric team members to write or update. Currently there are:

- 24 current ratified guidelines on the Intranet
- 11 guidelines currently being worked on
- 10 guidelines out for internal consultation
- 2 guidelines awaiting input from relevant stakeholders

Completed guidelines are circulated to all Maternity staff, discussed at teaching sessions and at the Professional Midwifery Advocate meetings for comments.

There is a Maternity Risk meeting every Monday for case presentation where learning is shared and matters reported on Datix are reviewed. This is also one forum where guidelines deemed ready for ratification are brought and discussed. The minutes of these meeting are disseminated every week to all maternity users. Once the guidelines have been ratified, they

are shared on the Maternity Unit via handover and all staff are emailed to ensure they are aware that a new guideline has been uploaded to the Intranet for easy access and/or for reference guide. The guidelines are based on best available clinical evidence and are updated as new evidence evolves.

The recent allocation of a Lead Obstetric Consultant for Governance has provided 12 hours over a rolling 6 week period for Governance work. Four hours of this is for guideline development working with a small team.

Guidelines standardise practise ensuring safe care is provided and that all care given is equitable. All new guidelines come with auditable standards, in order to gain assurance that the guideline is followed and safe, evidenced based care is provided.

Service user opinion is taken into consideration, where relevant, for a particular guideline. Patient experience and feedback helps inform content of guidelines. A good example of this is the Infant Feeding guideline, which also evidences collaborative working with other stakeholders. This guideline ensures consistency of advice given to new mothers regarding infant feeding advice across both the Midwifery and Health Visiting Service.

Dashboards have been devised over the last year with Key Performance Indicators (KPI's) and the ratings reflect current practise. The guidelines to help achieve desired targets are currently prioritised and implemented along with any identified training needs.

Midwifery, Paediatric and Medical staff train in Obstetric emergencies (PROMPT – Practical Obstetric Multi Professional Training) together and this supports safe and effective care being provided when required. Theatre, Emergency Department and Anaesthetic staff also attend this training. We subscribe to a K2 training package with different training modules and Baby Lifeline regularly hold training sessions with us. Neonatal Life Support (NLS) courses are also run on-Island.

Adult basic life support is covered in the annual mandatory training, with excellent compliance prior to COVID-19. One of the challenges is that there is currently no electronic staff record system within the Maternity service and although work is underway to address this issue locally, at present there is no robust electronic training system.

At the quarterly Perinatal Morbidity and Mortality meeting, we undertake a shared learning exercise where previous cases are presented from a Paediatric and Obstetric perspective.

There has been a lack of administrative support due to long term sickness within the Maternity unit. We currently only have one Business Support Officer for the Care Group and we would benefit from additional dedicated administration support to help with the smooth running of our services. The Midwifery staff, in part due to covering sick leave, have seen a reduction in allocated time for management duties. Consequently, the lack of administrative support has hindered the development of the Governance process. This is in relation to 1:1 and appraisals and the introduction of new guidelines and quality improvements.

Experiences of women, fathers/second partners, support partners and families

The Maternity team recognise that the experience of women and their partners of maternity care impacts on their well-being. Their confidence and ability to positively develop loving and lasting bonds with their babies can be dependent on their experience of maternity care.

In 2020, the Maternity team launched the Patient Experience Champions Initiative in order to gain feedback from families and work in partnership with them to develop services that are responsive, accessible, transparent and open.

Moving forward, Patient Experience Champions will get involved with promoting and supporting the patient experience agenda.

Patient Experience Champions are a mix of trained and untrained staff.

- Make a real difference to patients, their families and carers
- Ideas in improving patient experience
- Passionate about patient and carer experience

A Patient Experience Champion -

- Champion patient experience data received for your specific area including My Experience survey, PALS, complaints, compliments and other
- Establish a staff resources folder and ensure resources available in area e.g. posters, leaflets etc.
- Keep team members aware of current patient experience trends
- Ensure patient experience data is shared with all staff and patients
- Promote the use of patient and carer feedback to make positive changes to the experiences of patients, families and carers
- Liaison with the patient experience team

Advantages to being a patient experience champion -

- Personal and professional development in terms of understanding and appreciating the patient experience agenda.
- Opportunity for 1:1 and group training from the patient experience team on patient experience data and initiatives.
- Ability to network and provide and receive support from other champions
- Regular patient experience champion meetings.

The opinions and interaction with service users has been sporadic over the year. In 2016, the Maternity Matters Group worked with women to gain their prospectus on refurbishment and women's voices were part of the current design and layout.

The Professional Midwifery Advocates (PMA) hold a listening clinic twice monthly. This is an opportunity for women and their families to raise concerns about care and treatment they received. Women and their families are not limited to one appointment when accessing this service.

We receive user feedback via the Patient Advisory Liaison Services (PALS) where complaints and compliments are logged.

In order to log a compliment, staff have to scan cards and letters to the PALS team to upload into the system. The feedback is used to inform the staff of service users' experience and reported in performance reports with learning identified and actions taken where necessary.

Any service user who raises concerns whilst receiving care and treatment, has their issues escalated to the senior midwife or Professional Midwifery Advocate (PMA) and/or Consultant/Clinical Lead. They are given the opportunity to discuss any concerns or offered a debrief at a time suitable to them.

All complainants are telephoned and encouraged to discuss their experience, the impact this has had on them, what resolution they are seeking and what recommendations or

adjustments could be implemented to improve the experience for others. Once a complaint has been received, the staff identified from the complaint are given the opportunity to respond to the complaint and the opportunity to reflect on the experience of the service user.

In 2020, there was a total of 864 births. The Maternity Unit received 8 formal complaints, the maternity ultrasound department received 11 formal complaints. There were two consistent themes which were care and treatment and attitude and conduct.

The current environment does not provide visitor or partner toilets on the inpatient ward. This impacts on the experience of visitors as they have to leave the Unit to access facilities and then may be left waiting to gain access on their return. An essential safety requirement of any Maternity Unit is a secure environment and, consequently, visitors have to wait to regain entry. The long term sickness of the evening receptionist has exacerbated this problem.

In early 2020, Maternity Voices Partnership (MVP) was started by Community Midwives. The initial group was recruited via social media, with over 50 respondents. The Midwifery Team were delighted to have had such response and a focus group was held in May. Unfortunately, the COVID-19 pandemic meant that the ongoing work on this programme was delayed. Work recommenced in Autumn 2020 and MVP recruited the first 10 women as core members. There is a plan to recruit a further 5 members, then elect a Chairperson. The MVP requires funding of £10,000 per annum and these monies have been identified for 2021 from the Maternity Gift Fund. The governance process around this is currently being developed with the support of the finance team. The MVP group are powerful advocates for change and the initial focus group identified service changes that would enhance care for mothers and families in Jersey. The service changes are in alignment with the proposed Midwifery Model of Care the maternity team would like to introduce. This includes Midwifery Led Care, increased continuity and Parish based and not GP based midwifery care, following the Jersey Care Model.

In cases where there has been an unexpected outcome, or a safety event has occurred during care, the case or event is reviewed. All formal reviews are shared with the women and partners and recommendations arising are disseminated across the wider team with improvements monitored through action plans or the improvement plan.

The Professional Midwifery Advocates (PMA) hold a Listening Clinic twice monthly. This is an opportunity for women and their families to discuss or raise concerns about care and treatment they have received. Women and their families are not limited to one appointment when accessing this service.

Ability for women to make safe and appropriate choices of maternity care for themselves and their babies

The pregnancy journey for any mother and her partner is a partnership with midwives and, where required, obstetricians with the emphasis being on safe and effective care. The current antenatal handheld record has health information for women and their families, and the wallet provided for the antenatal notes includes information and guidance. Women are encouraged to complete birth preferences and discuss these with their midwife.

Health information, health promotion and health education is weak in regards to the Maternity services. There is no standard for accessible information for women and the sign posting of available services is unclear. In the absence of clear and robust public health guidance and information some women are making choices and decisions in the absence of evidenced based information.

Women develop good relationships with their midwife and women with low risk pregnancies get excellent continuity of care. The rapport between the primary midwife and the woman encourages autonomy, choice and birth preference. Women with high risk pregnancies and assessed as requiring Consultant led care have previously not had the same level of continuity from midwives or doctors. This is being addressed by the newly implemented Medical Model. This model is that Consultants are now aligned to clinics and women will be booked into clinics dependent upon their specific needs such as perinatal mental health clinics, fetal medicine clinics and high-risk pregnancy clinics. Women who need an anaesthetic review prior to labour and birth are referred to the anaesthetic clinic to enable them to discuss their choices with an anaesthetist and put plans of care in place prior to labour and birth. This supports women and their partners to make informed choice. Work is underway to align midwifery staff to clinics and promote continuity and advocacy for safe birth and to support women in their decision making.

We work with women to support the choices they make regarding their care and where there is a conflict or disagreement, senior midwives or PMA's can offer counsel to women if required, alternatively women are offered a second opinion from another consultant.

Availability of sufficient manpower/resources/skills to deliver the best care

The newly implemented Medical Workforce Model has streamlined clinical activity, providing a dedicated 'Consultant of the week' on Delivery Suite. This promotes continuity of care, decision making and the formulation of care management plans. The medical staffing model also includes specialist roles, with identified leads for governance, teaching and risk management. These roles are supported by Midwifery staff and work continues to develop associated specialist Midwifery roles.

We recently gained accreditation of the Baby Friendly Initiative (BFI) stage one. This was achieved without additional staffing resources, but rather by making a reasonable adjustment to the current workforce. We are committed to achieving level two within the next two years. Stage one is a level of commitment and stage two is designed to assess the level of knowledge and skills of the staff are providing care to pregnant women, mothers and babies. Our breastfeeding rates at discharge are circa 75%.

In September 2020, the Executive team of Health and Community Services placed the Women and Children's Care Group on a Task and Finish (T&F) Programme. Essentially, the T&F process was to assure the Executive team of the progress the care group was making, regarding implementation of the local improvement plan. The Care Group initially met with the Executive team weekly to provide updates. From January 2020, the meetings have been monthly.

It would be correct to say that the WaC Care Group have undertaken a lot of work in recent months but there is still a lot to achieve. Despite the lack of resources, staff have worked tirelessly to progress guideline development, review workforce requirements and recruit accordingly in order to drive quality and patient safety improvements as part of daily business.

It is the responsibility of the leadership team of the Care Group and, indeed the responsibility of all clinical staff, to ensure robust governance arrangements are in place to provide a rigid framework for our care provision. Maternity services are one of the highest areas of potential clinical risk and patient safety. Every incident is investigated with care by senior clinical and operational staff, cases are often complex and multi-factorial. There is an immediate review of all cases, however an in-depth and robust review is often delayed in its completion. We

believe this delay is due to competing demands and lack of administrative resources. We feel we are amiss of key roles i.e. Administration Support, Practice Development Midwife. We do have the most appropriate person completing the most appropriate reviews but the delay is hindered due to human and resource factors.
We are hopeful that job planning for medical staff and a workforce review based on acuity for our midwifery staff will take account of the huge burden of time involved in clinical administration duties that are essential for embedding quality, driving patient safety and disseminating learning. Together with the correct allocation of dedicated operational and support staff our timeliness of completing reviews and improvement initiatives will gather pace. However it must be noted that initial investigation suggests that a workforce review will still leave our aspiration of key posts not budgeted for.

The pathway from Best, Better to Brilliant is not only dependent on midwives, doctors and their relationships with women and their families. The journey is dependent on the operational and core business partners, supporting the smooth running and effective delivery of care at the point of need.

We are currently looking to develop our midwifery support staff (care assistants) and would like to train them to midwifery training entry level. There is also a plan to develop peer support for breastfeeding. Having this addition to the workforce will increase the patient experience and put us on the road from Best, Better to Brilliant services for women and their babies. Whilst promoting women's, maternal and child health as an excellent on Island career option.

Recruitment barriers and perceived prohibitive Island life factors (cost of living on Island and current travel restrictions due to the COVID-19 pandemic) mean that we often rely on agency staff to support the delivery of our services. Business partner resources are often stretched or operate utilising outdated process, as such are often not responsive enough to meet our needs in a timely manner. Recruitment processes are slow, reducing the capacity to release time to develop workforce, education and governance.

We are looking to build capacity for specialist midwifery staff to include an Infant Feeding Specialist, Practice Development Midwife, Perinatal Mental Health Midwife, Public Health Midwife and a Safeguarding Midwife. In order to develop services that are responsive to women and their families, we need additional capacity in the workforce to drive Public Health and Safeguarding agendas forward, improving expertise, experience and engagement whilst increasing efficiencies and effectiveness, thus providing a seamless pathway for women and their families.

Education and staff training programmes within the department have been reduced due to COVID-19, especially the need to social distance, which in clinical training is prohibitive. However, we have continued with some Multidisciplinary Team (MDT) skills and drills and teaching sessions in the Maternity Unit when the workload allows. We currently do not have a Practice Development Midwife / Lead so lessons learnt from incidents are slow to embed. There is no capacity within the current budget to have a Practice Development Lead and this is recognised as a priority across Maternity and the Special Care Baby unit. Clinical care and safety is our priority. Resources and acuity are reviewed on a daily basis, to ensure clinical areas have sufficient staffing.

We are currently reviewing our acuity and workforce establishment to determine how we may utilise current funding to deliver the patient safety and quality gains that will come from new posts such as the Practice Development Midwife, Peri-natal Mental Health Midwife, increased Safeguarding Midwife provision and Public Health Midwife to name but a few. As part of our improvement plans we are in the early stages of a change to the long established shifts patterns across the Women's, Children's and Family Care Group. This will align shift

patterns to the needs of the service and ensure that staff are adequately rested. As a result it is anticipated that some of our new quality delivering roles may be funded through this process.

Our Community midwives have been providing a home birth service with a 6-7% homebirth rate for the past 3 months. As part of the refurbishment of the Maternity Unit, 2 midwifery led birth suites will be commissioned; this will provide women with an additional choice of birthplace in a less clinical environment.

Our Hospital midwives have been providing 1:1 care in labour as a gold standard.

Our SCBU (Special Care Baby Unit) team work alongside the Maternity department and a transitional care model has been developed. Essentially, the aim is to keep mums and babies together and avoid a neonatal admission to SCBU, with SCBU nursing staff providing care at the mother's bedside. The implementation of this model has been delayed due to the capacity with staffing as a result of long term sickness.

We are also launching a Neonatal Assessment Pathway (NAP) that ensures a rapid review of babies at 2 and 4 hours post birth. This is a recognised best practice pathway and is hoped to ensure that only those babies requiring overnight admission receive this. The next phase of this initiative is Neonatal Outreach, enabling parents and nurses to provide excellent community based care for babies before and after discharge.

Determine the impact of COVID-19 on the provision of maternity services and the resulting effect on mothers, fathers/second partners, support partners and families

It is without a doubt that the COVID -19 pandemic has created potential for harm to all; service users and staff alike. The restraints imposed by lockdown and the socio-economic impact on the whole community will be felt for some time to come.

There was much more acceptance for reducing partners or significant others at scan appointments, clinic appointments during the first wave of the pandemic. No father has been excluded from attending a birth unless COVID-19 positive, and postnatal visits, whilst reduced to partners only, have continued.

A specific pathway for COVID-19 positive patients was developed to keep both women and staff safe. A woman who was Covid positive and laboured without the support of her birth partner shared her experience on the local news. Her experience of receiving excellent support and midwifery care helped to allay anxiety for other women who may have found themselves in the same position.

The Maternity service recognised that the decision for women to attend antenatal scans by themselves was not popular with the public and whilst the National Health Service (NHS) did support partners attending antenatal scans, it was not possible in Jersey. It is important to state the NHS guidance was not following the guidance from the Royal College of Obstetrics and Gynaecology and the Royal College of Midwives. The scan provision in Jersey was also based on the guidance of the local Health and Safety and the Infection Prevention and Control teams. In conjunction with having one sonographer at that time, it was considered to be a single point of failure for the whole of the maternity scanning service should the sonographer have contracted COVID-19 and been unable to work.

Attending appointments alone had a significant impact on the mental health and wellbeing of families. Public discontent was evident from feedback received, however, many women

reported positively in regards to attending alone. Their perception was that they received extra attention on themselves and their babies. Feedback was also received regarding how supportive and kind staff were. Many women disclosed general anxiety and concerns which they felt unable to share when their partners were present.

Restricting visitors postnatally has had a positive impact on some new parents. We understand the eagerness of families to celebrate in the first hours and days of the new arrival, but women and their partners felt the breastfeeding bonding and attachment without interruption had a positive impact.

In line with government direction, swabbing of birth partners and women on admission to the Labour Ward was introduced to keep partners and labouring women together. Consideration was made to swab women and partners in the antenatal period so attendance by partners at scan and antenatal clinical appointments could continue, however, the logistic of this and the additional cost element meant this was not a viable option.

PPE worn by staff impacted negatively on women because non-verbal cues were missed or misinterpreted. PPE is formal and less approachable and it sends a strong clinical message which inhibits the relationship formed between the woman and her midwife.

Women reported greater isolation, as most baby groups have been closed and peer support reduced. This is especially difficult for first time mothers, who often benefit greatly from community support and developing friendships through integration with other families.

Financial hardship due to the work restriction, which increased parental anxiety and the impact on DE socialisation on babies and young children, is reported with mixed emotion. Whilst more family time was received positively, reduced social contact and increased isolation had a negative impact.

Parental leave and allowance increased, which had a positive impact as many families live in Jersey with no extended family for support

Provision was made to extend postnatal visiting by midwives for isolated/anxious families.

Consider how current maternity care provision could be improved to better meet the needs of mothers, fathers/second partners and their babies

- The current provision of maternity care would be greatly enhanced with the scheduled refurbishment, offering a more relaxing and welcoming environment for service users, their families and staff alike. Staff that feel valued and supported provide high quality care to the women and families of Jersey.

- MVP Advocate Parish based continuity of care will be taken outside the GP service and is midwifery-led. There is a current cost for women seeing their GP for maternity care and women are keen to move away from this model, which would be in line with the Jersey Care Model and more accessible to women and their families.

- The development of a Public Health Midwifery team, to work with and across all local health economies and specialities will include midwives with roles in smoking cessation, reducing drug and alcohol intake, perinatal mental health and an increase in hours for the safeguarding midwife. This will improve education, literature and health prevention, to better empower women in the care of their families and to support vulnerable women on the island.

- The appointment of a Practice Development Midwife within Maternity and SCBU who will lead on responsive and experiential learning from service user feedback and evidenced based practice, putting guidelines into action and standardising practice through competency assessment frameworks will be of benefit to women and their families as well as the staff.

- Information and Public Health Awareness that is accessible and educational for women and their families promotes autonomy and health prevention. Early childhood health prevention and protection would greatly enhance the wellbeing of the family unit, with exposure to public health messaging and available educational literature. Great partnership working with wider health economies and joint training reiterates the public health messaging from health professionals and can create measurable reductions in poor health outcomes.

- The Community midwifery team would like to expand and offer early labour assessment at home to all women. This will support women in the latent phase of labour, reduce anxiety and promote normality and build trusting relationship with women during the birthing process.

- Our current IT system is outdated and difficult to navigate. A future aspiration for women and midwives would be to have an interactive IT system where women can access their own pregnancy records and information about the pregnancy journey. This could be via an App on their mobile phone. Women being in control of their records would boost and promote professional partnerships between women and midwives / doctors, enabling the women to feel more empowered throughout their pregnancy journey.

As a newly formed Senior Leadership Team within the Maternity services, we feel proud of the achievements we have made to date. We are, however, aware of the challenges that lay ahead. The response and information to you provides a snapshot of where we are currently but should give an indication of our direction of travel and desire to build upon and continually improve the maternity care provision for the women and families in Jersey.

Kind Regards

Women's, Children's & Family Care Group Senior Leadership Team.

Appendix 1

The following phases are:

Phase 1:

- 1A Create a new Bereavement Room and
- 1B New HDU Isolation Room with lobbies, Clean Utility and new Learning and Development Room.

Phase 2:

- Decant Bereavement room to new completed Phase 1A area.
- Completed Phase 1B High Dependency Unit to be designated as Hot Birthing Room & Old Obstetric Theatre to be designated as Hot SCBU area. Hand over SCBU 2 and Edward Rooms to main contractor.
- Create a new SCBU area including new courtyard extension.

Phase 3:

- Decant old SCBU into completed Phase 2 area
- Main Contractor to take possession of old SCBU
- Create 2nd new Midwifery Led Unit Delivery Rooms with en-suite as well as temporary Nurse Station
- Undertake Service renewal within existing Staff WC & Kitchen in accordance with Mechanical Electrical Plumbing specification

Phase 4:

- Create new Consultant Led Unit 03 Birthing room with pool within old Obstetrics theatre, a new on call doctor's room, Dirty Utility and Blood Gas room.

Phase 5:

- Phase 5 A - Create 2nd New Consultant Led Unit Delivery Rooms 01 & 02 with en-suite and new nurse station
- Phase 5B - Turn redundant Delivery Room 02 into New Store 02.

Phase 6:

- Create new Female and Male Staff changing room areas and refurbish existing offices.
- Sub-phases required to ensure staff retain changing areas throughout phase.
- Decant ex Lockers temporarily into completed Store 02 & Staff to use existing Wet Room & 2no Staff WCs on the unit whilst new locker rooms are created.
- Existing Offices are to be decanted temporarily into the Learning & Development Room.
- Undertake service installation works within existing lift lobby and replace existing ceiling.

- On completion of new Lockers - Temp locker room/ Store 02 to be changed permanently into a Store.

Phase 7:

- Refurbish existing Collas 3 ward including new en-suite

Phase 8:

- Refurbish existing Staff Room to create new Collas 7 (private room) with en-suite.

Phase 9:

- Phase 9A Create a new Private Room 04 and refurbish existing Collas Room 3.
- Phase 9B - Refurbish existing Private Rooms Collas 4 & 5.

Phase 10:

- Refurbish existing Collas 2 ward
- Refurbishment of the Breakout space for New Baby Exam Room
- Refurbish Clean Utility Room 03

Phase 11:

- Refurbish existing Collas 1 ward
- Refurbish Medical records store for new Doctor's On Call Room 02

Main Contractor co-ordination and communication is key to the successful delivery of the project. One of the key risks will be undertaking works adjacent to the existing and new SCBU Neonatal areas which contain new born premature babies. These areas are very sensitive to noise and vibration and works will need to be co-ordinated with key department personnel to minimise disruption.

We are working with the Estates and Facilities department to mitigate any risk during the lifetime of the refurbishment project. Current risks related to the maternity environment are regularly reviewed and will remain on the risk register until refurbishment work is completed.

Appendix 2

Maternity Policies Status

HSS-GD-CG-0564-02	Inpatient management of Covid-19	All HCS
HSS-PP-CG-0565-01	Management of oxygen policy Covid-19	All HCS
HSS-PP-CG-0566-01	Management of Hypoglycaemia in Term Infants	Paediatrics
HSS-PP-CG-0505-1	Medical Priority Dispatch Obvious – High Risk Pregnancy	Ambulance
HSS-PP-CG-0411-04	Spiritual Care Policy	Chaplaincy
HSS-PP-CG-0480-01	Clinical audit and effectiveness policy	Clinical Audit
HSS-PP-HG-0001-04	Management of Serious Incidents within HCS	Quality & Safety
HSS-PP-CG-0238-02	Consent to care and treatment policy	Quality & Safety
HSS-PP-CG-0482-01	Duty of candour policy and procedure	Quality & Safety
HSS-PP-CG-0534-03	Central alert system CAS procedure	Quality & Safety
HSS-PP-CG-0153-02	Interpreting Policy and Procedure	Interpreting and Translation
HSS-PP-IC-0510-1	Routine decontamination Method for Birthing Pool	Infection Prevention and Control
HSS-PP-CG-0574-01	Visiting in ward / department area guidance during Covid-19 Level 2 JGH	Infection Prevention and Control
HSS-GD-CG-329-01	Guidelines for the management of infants born to women with Group B Streptococcus	Neonates
HSS-GD-CG-331-01	Management of prolonged jaundice	Neonates
HSS-GD-CG-335-01	NICE Guidelines on neonatal jaundice	Neonates
HSS-GD-CG-336-01	NICE neonatal jaundice treatment threshold graphs	Neonates
HSS-GD-CG-0375-01	Newborn Life Support	Neonates
HSS-GD-CG-0377-01	Examination of the newborn	Neonates
HSS-GD-CG-0379-01	Meconium Stained Liquor Guidance	Neonates
HSS-GD-CG-0380-01	Hypoglycaemia in newborn	Neonates
HSS-GD-CG-0382-01	Neonatal Abstinence Syndrome	Neonates
HSS-PP-CG-0101-02	Safeguarding Adults Policy	Policy
HSS-PP-CG-0551-01	Patient safety learning event, Datix policy	Quality &Safety
HSS-PP-CG-0482-02	Duty of Candour Policy	Quality & Safety

HSS-PP-HS-0001-04	Health & Safety Policy	Health & Safety
HSS-PP-CG-0107-02	Lone Worker	Health & Safety
HSS-PP-HS-0110-04	Safe Handling	Health & Safety
HSS-PP-HS-0009-03	Fire Policy	Health & Safety
HSS-PP-HS-0467-01	Personal Protective Equipment	Health & Safety
HSS-PP-0275-02	Control of Substances Hazardous to Health	Health & Safety
HSS-PP-CG-0106-04	Prevention and Management of Violence and Aggression	Health & safety
	HCS Information Governance Policies	Information Governance
	HCS Infection Prevention and Control Policies	Infection Prevention and Control
	Government of Jersey Human Resource Policies	Government of Jersey
	Government of Jersey Risk Management Strategy	Head of Risk Government of Jersey
	Safeguarding Policies	Safeguarding Partnership Board
	Multi Agency Procedures Child Deaths	Safeguarding Partnership Board

Status	Current Document Registration	Short Title	Type of Document	Target Audience
	HSS-PP-CG-0229-03	Intrapartum Care	Guideline	Maternity
	HSS-PP-CG-0562-01	Fetal Growth Assessment	Guideline	Maternity Staff
	HSS-PP-CG-0566-01	Management of Hypoglycaemia in term infants	Guideline	Maternity and Neonatal Unit
	HSS-PP-CG-0276-03	Obstetric Cholestasis	Guideline	Maternity
	HSS-PP-CG-0307-04	Water birth	Guideline	Maternity
	HSS-PP-CG-0304-04	Shoulder Dystocia	Guideline	Maternity
	HSS-GD-CG-0372-02	Massive Obstetric Haemorrhage	Guideline	Hospital Staff

	HSS-PP-CG-0228-04	Pre-Labour Rupture of the Membranes (PROM) at or after 24 weeks gestation	Guideline	Maternity
	HSS-GD-CG-0374-02	Fetal Anomaly Referral	Guideline	Maternity
	HSS-GD-CG-0470-02	Reduced fetal movements	Guideline	Hospital
	HSS-GD-CG-0241-01	Midwifery Coordination of Delivery Suite	Guideline	Maternity
	HSS-PP-CG-0571-01	Antenatal Fetal Monitoring	Guideline	Maternity
	HSS-PP-CG-0570-01	Handover Policy	Guideline	Maternity
	HSS-PP-CG-0569-01	Diabetes in Pregnancy	Guideline	Maternity
	HSS-PP-CG-0218-03	Intrapartum Fetal Monitoring	Guideline	Maternity
	HSS-PP-CG-0220-05	Induction and augmentation of Labour	Guideline	Maternity
	HSS-GD-CG-0265-05	Antenatal Corticosteroids	Guideline	Maternity
	HSS-CP-CG-0419-04	Multiagency pathway for pre-birth assessment and referral	Pathway	All HCS
	HSS-PP-CG-0217-03	Fetal Blood Sampling and paired cord blood sampling	Guideline	Maternity
	HSS-PP-CG-0278-02	Group B Strep	Guideline	Maternity
	HSS-PP-CG-0227-02	Assisted Vaginal Birth	Guideline	Maternity
		Maternity Clinical Escalation	Policy	Maternity
	HSS-PP-CG-0434-01	Maternity Operational staffing and Escalation Policy	Policy / Procedure	Hospital
	HSS-GD-CG-0293-02	Infant feeding guidelines	Guideline	All HCS
	HSS-PP-CG-0267-01	Anti-D	Guideline	Maternity
	HSS-GD-CG-0239-01	Obstetric Ultrasound Protocols	Protocol	Sonographers, Obstetricians, Midwives
	HSS-PP-CG-0281-01	Maternal Death Communication Guideline	Guideline	Maternity
	HSS-PP-GG-0280-02	Uterine Inversion	Guideline	Maternity
	HSS-GD-CG-0283-02	Perineal Assessment Repair	Guideline	Maternity
	HSS-PP-CG-0305-01	3rd and 4th Degree tear repairs Inc. anal sphincter injuries	Guideline	Maternity
	HSS-GD-CG-0242-02	Treatment and prevention of Thromboembolism	Guideline	Maternity

	HSS-PP-CG-0277-02	Caesarean Section	Guideline	Maternity
	HSS-PP-CG-0269-02	Antibiotic Prophylaxis at C-section	Guideline	Maternity
	HSS-GD-CG-0359-01	Management of multiple pregnancies	Guideline	Maternity
		Homebirth	Guideline	Maternity
	HSS-GD-CG-0341-03	Emergency Transfer of Women or Babies from Community to Hospital	Guideline	Clinical staff
	HSS-PP-CG-0279-01	Haemoglobinopathies Pathway	Guideline	Maternity
	HSS-PP-CG-0288-02	Hypertension in pregnancy	Guideline	Maternity
	HSS-GD-CG-0272-04	Breech guideline	Guideline	Maternity
	HSS-PP-CG-0290-01	Pre-term Labour (22-26 weeks Gestation)	Guideline	Maternity
	HSS-PP-CG-0306-01	Tocolytic Therapy	Guideline	Maternity
	HSS-GD-CG-0537-01	Magnesium sulphate in preterm delivery	Guideline	Maternity
	HSS-PP-CG-0284-01	Cord blood stem cell banking	Guideline	Maternity
	HSS-PP-CG-0289-01	Routine Examination of the Newborn	Guideline	Maternity
	HSS-GD-CG-0469-01	PAWS	Guideline	Hospital
	HSS-GD-CG-0240-01	VBAC Guideline	Guideline	Maternity
	HSS-GD-CG-0285-04	Cord prolapse	Guideline	Maternity

Status	**Title of Guideline**	**RESPONSIBLE OFFICER**
	Bladder Care	Midwife
	Obesity in Pregnancy Guideline	Midwife
	Epilepsy & Seizures in Pregnancy	Midwife
	Sepsis	Midwife

Key	**Status**	
	Current	22
	Current/due review within 3 months-ALLOCATE	0
	Ratified and sent to Information Governance	0
	Completed and awaiting ratification	1
	Awaiting input from relevant stakeholders	3
	Out to consultation	9 (reduced to 7)
	Allocated, in progress and Deadlines range from 11/05/20-01/07/20	14
	Remove altogether	0

END