Health and Community Services

Government of JERSEY

Review of Maternity Services Written Questions 19th April 2021

1. Current Maternity Facilities

1. At the Hearing on 13th April we were advised that a standalone MLU has been considered but rejected. Can you confirm the reasoning behind the decision?

A standalone Midwifery Led Unit (MLU) had been considered previously, it was not believed to be a financially viable option.

When planning the refurbishment of the current maternity unit, the construction of a modular unit outside of maternity unit connected to the delivery suite was considered. After exploring the different options, it was felt that the most financially and operationally viable approach would be to have the MLU co-located within the maternity unit. Positioning it here would allow midwives from both community and the hospital setting to work together to provide low risk midwifery care to women.

2. Is there suitable antenatal and perinatal MH care and services available to new parents?

2. Do you know how many women develop a mental illness during pregnancy or within the first year of having a baby in Jersey, and how does this compare in proportion to what might be expected using external benchmarks?

Data on how many women develop mental illness, either during or in the first year following the birth of a baby is currently not collected. An audit is in progress within the Community Midwifery Service to ascertain the number of women experiencing, or who are at risk of, developing mental health concerns. This is to help plan future service provision. Pathways are being developed locally in line with national guidance and whilst this is in its infancy the perinatal mental health clinic and other service provision will be aligned with the quality standards as set out in NICE Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance.

Public Feedback

3. A lot of the information you have provided us about the current service and the future service refers to support for the “women”. What support are partners/fathers currently provided?

There is no specific pathway for support for partners, however when issues are highlighted, they can be referred to support services, or counselling as appropriate. Partners can also attend debriefs regarding their experience within maternity services.

a. How is their mental health assessed?

A partner's mental health is not routinely assessed. If partners highlight issues when attending attend appointments, they are then appropriately referred/signposted to services support as required. This can be in the ante-natal or post-natal period.

Extra Support

4. We know that traumatic incidents in pregnancy (i.e. near miscarriage, assisted reproduction, physical ill health) and also previous baby loss/miscarriages can make people more vulnerable to developing mental illnesses. Is any additional (emotional) support provided to women/families during the antenatal period, who have previously suffered from a miscarriage/loss of baby? [and, if so, who provides this support]

Every woman who is booked in by a community midwife is assessed for the above and referred to the appropriate services to provide support. These include:

- Pregnancy in Mind (Provided by NSPCC)
- Healthy Child Programme (Provided by Health visitors.)
- Baby Steps (Universal ante natal programme, run by a team which includes midwives, health visitors and trained facilitators)
- Care of the Next Infant (CONI)

The Community Midwifery team will also support a family through their next pregnancy offering individualised care appropriate to an individual's need.

3. Is the care that is provided during the antenatal, intrapartum and postnatal stages of pregnancy delivered safely and effectively.

5. Multi-Disciplinary Teams or MDTs, have been discussed throughout the service – what training is in place or planned to ensure this approach is truly embedded to include all disciplines?

The PRactical Obstetric Multi-Professional Training (PROMPT) is provided to members of the various teams that may be called upon to attend obstetric emergencies. (e.g. Theatre staff, anaesthetists, obstetricians, midwives, health care assistants). This course is an evidence-based training package that teaches healthcare professionals how to respond to obstetric emergencies. The course has been found to be associated with improved clinical outcomes and reduced patient safety incidents

Learning and good practice from incidents that have arisen within the maternity unit are discussed at the Perinatal mortality and morbidity meetings.

Quality and Risk meetings are held weekly and attended by the multiprofesisonal team. These are minuted and learning from the incidents presented are disseminated to the wider

team. This information is available to all staff. Trends and themes are identified, and action plans developed.

Currently the maternity unit is undertaking a training needs analysis for all grades of staff and formulating a training plan.

6. At the Hearing on 13th April, the Minister advised that tensions between professional groups would hopefully be addressed by the JCM. Can you please confirm how, given that maternity was not part of the original discussions on the JCM?

JCM is a framework for future healthcare delivery and provides an opportunity to reshape maternity services for the future as part of the system redesign. The JCM creates the opportunity for all clinical and professional groups and providers to participate and collaborate to improve services for islanders. The interface between public health, primary and secondary care services is one of the major areas for development opportunity, with the aim to provide a seamless service with improved customer experience and improved outcomes. Early work in this area will set the groundwork for future multi-agency service development of maternity services.

Maternity were represented in the JCM design process (although not a major focus for the design at the time) and had good multi-disciplinary attendance at the PWC validations sessions for the JCM, of which much of the output has been taken forwards into the 2021 business plan for maternity.

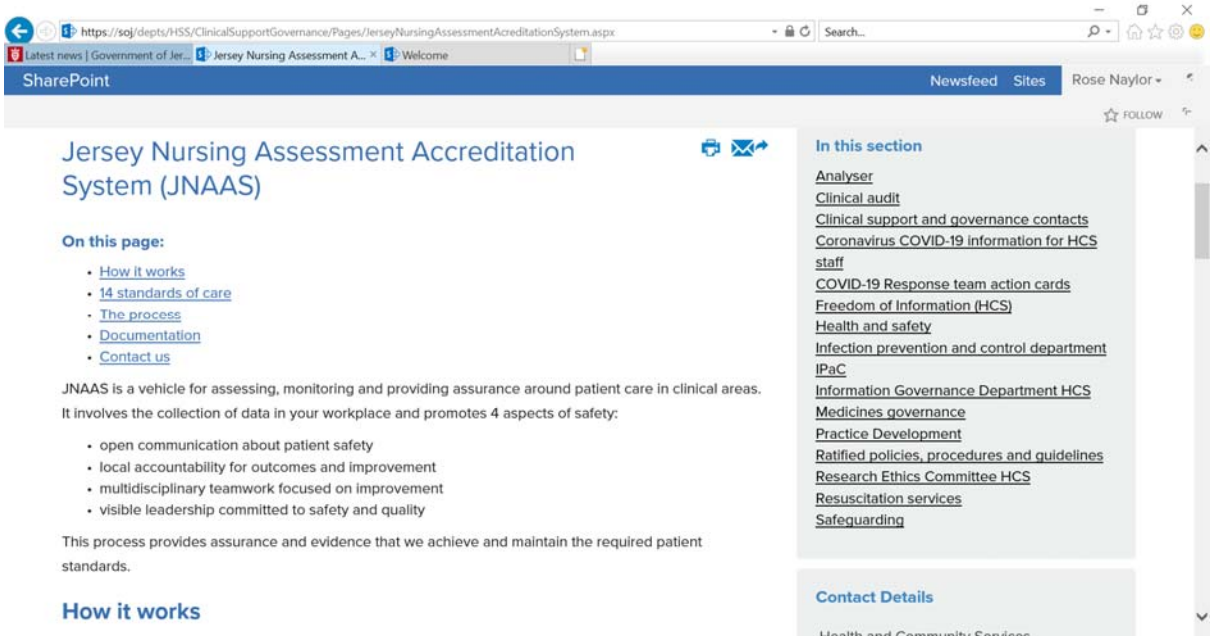
7. Please can you clarify whether KPIs have been determined for the maternity services?

    a. If so, have you decided how these will be benchmarked or is that a work in progress?

A quality performance report is completed and presented monthly; this aligns to the same quality indicators that are followed nationally. Maternity benchmarks themselves against those indicators and review this data as part of their governance structure, through both executive reviews, their governance meeting and the Quality and Risk Assurance Committees. The team are in the process of setting up a Channel Island Local Maternity System which will enable comparisons with small Island communities that have similar demographics and challenges to Jersey.

The department is also assessed against a number of standards including some service specific standards which are benchmarked against the CQC standards and cover 15

domains of practice. Reviews are unannounced and focusses on 4 aspects of safety.



b. If not, what is the timescale for this work to be completed?

Work is currently underway to align data sets with national indicators to benchmark themselves using NHS digital, the perinatal institute, and MMBRACE.

Although work has commenced on public health initiatives and benchmarking, this work is in its infancy but remains a high priority. It is envisaged that work will be completed on KPIs for public health in Autumn 2021.

8. At the Hearing on 13th, we were told that you were currently developing a culture summit. Have a set of shared values been agreed against which maternity services measure performance of the service and of individuals or is this something that will happen at the summit itself?

The first culture summit concluded on 14/04/21 and a local committee has been developed. A second summit is planned for May 2021. The committee will come together to develop the basis of the culture and behaviour strategy, which will include the organisational values. The Culture strategy will provide a framework that supports and promotes regular appraisals, one to ones, improving communication and enhancing interpersonal relationships within maternity services.

Continuity of Care

9. Would you consider a Parish based continuity of care taken outside the GP service and which 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.

A parish-based hub for midwifery will be considered as part of the future work on the Jersey Care Model as it could provide a service which is local and more accessible to women and their families.

4. Are women able to make safe and appropriate choices of maternity care for themselves and their babies?

10. What do you think can be done to ensure consistent evidence-based communication with all women about the choices they can make when accessing maternity services on Jersey?

To improve our communication with women the unit will update and refresh the Maternity website for service users to access links and to be sign-posted to all appropriately affiliated organisations to enable women to gain access to all the necessary information on one site.

The team would like to be able to offer women the choice of self- referral into maternity services. This would enable early contact with their midwife, and facilitate continuity of care throughout pregnancy, birth and in the post- natal period.

11. How do you ensure that choices for women are fully informed?

At their booking appointment women are given a large amount of verbal and written information. Most of the written information is contained within their hand-held Perinatal Institute maternity record (Green Notes).

There are a lot of online resources which ensure that women can access in their own time. These include the maternity section of the Gov.je website and signposts to NICE, RCM and RCOG websites.

Professional Midwifery Advocates (PMAs) hold “listening clinics”, where women provide feedback to the maternity unit and also get information about their care, past, present and future.

Community midwives hold a “Birth preferences” consultation at 36 weeks and all pregnant women have access to this. This allows a late opportunity to pose questions and seek clarification on any concerns. This goes towards ensuring that women are fully informed on the choices they make after this stage, particularly for the period of birth and postnatally. Women are encouraged to discuss their choices throughout their pregnancy.

Maternity undertakes documentation audits to check the quality of our documentation of what information we have given to ensure informed choice.

The Maternity Unit recognise areas of improvement. There is a need to provide written information and posters (e.g. PMA posters) in different languages.

a. Do you agree that funding methods for primary and secondary clinicians can skew the choices offered to women? If so, do you have plans to change this?

Yes, the Maternity Unit feel that the funding methods for primary and secondary clinicians can skew the choices offered to women. However, they appreciate that funding of services in itself is not within their remit but recognise the intention to focus on preventative measures in the Jersey Care Model.

12. There are a good range of antenatal education choices available to expectant parents in Jersey, but we have been advised that woman and not always made aware of all of their options. What steps do you currently take to ensure a joint-up approach between community midwives, GPs and organisations offering antenatal educational classes to ensure women are informed about all the choices available to them?

An Information leaflet is given out to expectant mothers at time of booking informing them of the educational choices available, including public and private ante-natal education options.

Community midwives are present in GP surgeries and offer information regarding the educational sessions available.

A Universal offer of Baby steps to all families is provided by the NSPCC.

During Labour

13. We heard from a number of women who felt that their choices of pain relief during labour were either not listened to or not respected by the staff in the maternity unit. What training is currently undertaken which provides staff with the skills in order to advise women appropriately but at the same time give the women confidence that they are able to make their own decisions?

Maternity were made aware of this as part of our debriefs at our Professional Midwifery Advocate (PMA) Listening clinics and as a result have reviewed staff training and development specific to pain relief in labour and provided personal development plans for the decision-making regarding the choice of pain relief for the woman in labour.

It is probably a reflection of the improvement's maternity have set out. Midwives on the labour ward are now assertive advocates of pain relief options for the woman in labour.

a. We are aware there are concerns about how integrated the anaesthetic staff are to the maternity team. How are you encouraging a good level of communication in all instances?

Our anaesthetist colleagues are involved in all our multidisciplinary activities, including the morning handover of care on the labour ward. This improves their awareness of the labour ward activity and provides an opportunity to support multi-disciplinary discussions with women in labour if required.

Maternity now have a named consultant anaesthetist as the Lead Clinician for Obstetric Anaesthesia. This colleague directs the activities of anaesthetists when they are needed for intrapartum analgesia. Concerns are also fed back and addressed through this route.

They have found having a responsible person (Clinical Lead) in place has improved the channels and effectiveness of communication.

14 Do you have formal procedures in place with either hospital midwives or community midwives to ensure that women are given de-briefs of their labour if they want them? (offered rather than waiting for a request).

a. Is everyone aware of the 'listening clinic' regarding women receiving debriefs about their labour?

A referral procedure is in place to PMA listening clinic and women are given a leaflet about the service ante / postnatally. Referrals are accepted from GPs, health visitors, baby steps facilitators.

A banner is present on the maternity unit, detailing how to contact a PMA, however it is recognised that this is currently only available in English. Women are able to self-refer. Midwives /obstetricians can also refer to high risk anaesthetic clinic if further information is required.

15. What support is currently available on the island for a tongue-tied baby?

The tongue tie service in Jersey is modelled on the NICE "Division of Ankyloglossia (Tongue tie) for Breastfeeding" [IPG 149] Dec 2005. This Interventional Procedure Guidance remains current and is most recently referenced in the "Post Natal Care" NICE Guideline (NG 194] APRIL 2021.

Should a parent or carer express concerns that their baby has a tongue tie or if there has been difficulty establishing feeding in an otherwise well baby, a referral is made to the community midwife team who perform a validated tongue tie assessment (Bristol Tongue tie assessment tool). Should a tongue tie be found, they offer specialist lactation support, demonstrating the exaggerated latch technique, and observe the baby breastfeeding. If there is no improvement in feeding efficiency, or ongoing discomfort, the baby is referred for frenulotomy tongue tie division). Parents may choose to persist using the new lactation techniques, deferring the procedure to a later date. There is general breastfeeding support from community midwives, health visitors and Breastfeeding Buddies. Where the parents have opted for frenulotomy, the baby is reviewed in Jersey General Hospital by a trained Paediatrician or ENT consultant. Following further confirmatory assessment, informed written consent is taken from parent and the tongue tie is snipped.

5. Are the relevant policies appropriate and are they utilised in a suitable manner?

16. Would it not be easier to have an approach that states we will use NICE (or another Regulator's policies) unless there is a justification not to?

Maternity have developed guidelines for most aspects of their clinical conditions, particularly common conditions and emergencies, even if rare. These are updated either in a review cycle (all have review dates) or when new guidance becomes available from the relevant regulatory body, whichever comes first. However, in the few instances where they have not yet developed

a guideline for a condition, they revert to the national/international guideline, e.g. NICE, RCOG, RCM etc for dealing with the condition.

There are also some conditions or circumstance for which there are no national guidelines or rarely, the national guideline is deemed not to be applicable to Jersey. In such cases, local recommendations are used, with a narrative to explain the non-compliance with national or international guidance.

National (UK) recommendations also become available from time to time, e.g., recent Ockenden Report, that of their own require to be partly or whole adopted.

The maternity services continue to work on and ratify guidelines to cover all aspects of maternity care.

17. What is the timescale to appoint a Practice Development Midwife to help with the development ratification implementation and audit of guidelines? Are there any plans to ensure GPs are aware of policies and guidelines?

A business case needs to be developed to acquire the funding for a practice development Midwife. In anticipation of this being accepted a job description and job specification have been prepared.

Community midwives currently update GPs in regard to relevant maternity updates or guidelines.

6. Are sufficient manpower/resources/skills available to deliver the best care?

18. What plans are in place to review workforce across the maternity services, is there a workforce strategy to address:

Work is currently underway to look at service provision and how they manage care. Different ways of working have been highlighted during the Covid 19 pandemic and some of these practices have been continued, for example the post-natal hub at the Bridge family centre. This model has been received positively by women and their families as it is appointment based. It also releases midwife's capacity due to eliminating travel time. This is now individually assessed and if visits are required then they will happen on an individualised basis. Workforce planning is currently in process.

Birth Rate Plus assessment has been commissioned and results are being reviewed. A new medical workforce staffing model has been implemented and evaluation is ongoing. Early results indicate it has been well received and is making a positive contribution to the wellbeing of mothers and babies.

a. an ageing midwife workforce and a reliance on interim medical staff to ensure roles are agreed and understood

Following retirements, the demographics of the workforce has changed with a greater number of younger midwives applying for roles.

Interviews are taking place to recruit into permanent positions for medical staff.

b. achieving consistent recruitment for hard to recruit because of geography, cost, range of cases?

In relation to recruitment, the Maternity Unit has worked closely with the HR department within the Government of Jersey to try and improve the recruitment processes. Information is available for potential candidates regarding working in Jersey, cost of living, what it is like to relocate to schools etc. on the Government website. HCS has also managed to secure improved housing tenure for clinical staff.

HCS have in place a pre-registration degree programme for midwifery. The numbers are small but it does add to our sustainability in terms of encouraging an on-island workforce.

19. What options are being developed to maintain competency amongst obstetric juniors, which is a concern due to small caseloads?

The maternity Unit is providing more consistent consultant supervision. The job plans of consultants from 1 February 2021 have been formalised into a 'hot week' pattern, with a consultant on call for the labour ward and Gynaecology acute admissions and in-patient care. Having a consultant dedicated for labour ward every week, with no other scheduled clinical commitments helps to support junior doctors, midwives, nurses and the wider MDT.

Consultant presence at Caesarean section, instrumental births and other procedures will improve the competences of the juniors as well as the quality of care they provide for the women under their care.

They believe in shared learning for all. The Monday morning risk management meetings examine adverse incidents and outcomes. The open discussions lead to shared learning. Some of the themes that have emerged and been addressed include: broken down perineum from episiotomy repairs, complications from instrumental births and Caesarean section, massive obstetric haemorrhage. Rare cases, e.g. eclampsia also get discussed.

Individual discussions and feedback to juniors is undertaken when necessary, including by the risk management/governance team.

Friday afternoon teaching sessions also contribute to the maintenance of competences of the multi-disciplinary team.

20. What plans are in place to ensure leadership competencies are held by all of those in key leadership positions?

HCS is currently sourcing an appropriate external clinical leadership programme which will support all clinical professionals employed in key leadership roles. In addition to this the Govt Jersey run a range of programmes including a world class leadership programme.

21. Inter- professional issues appear to still get in the way of developing the services and impact on the quality of care. How do you plan to give greater voice to the maternity workforce (midwives and medical) within the Care Group?

The maternity Unit plans to give a greater voice to our maternity workforce by:

1. Regular meetings and updates with staff.
2. Regular one to ones and appraisals.
3. The newly formed intrapartum care group which includes all grades of midwives who will lead on quality improvement projects
4. Ward to board communications
5. Head of Midwifery and AMD are members of the HCS Senior Leadership Team

22. What is the structure of the HCS Quality Improvement Team, can you give examples of recent projects and the impact that it has had to date?

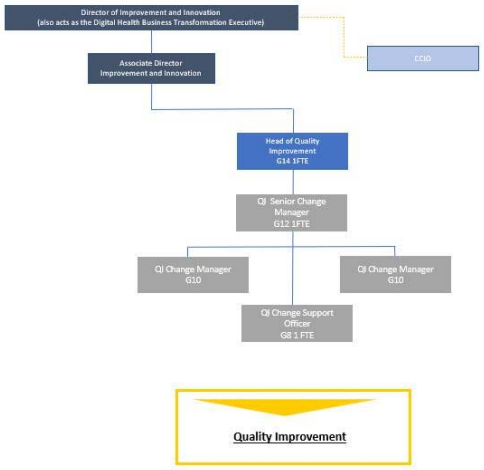
The HCS Quality Improvement team was disbanded a few years ago, following the TOM team members were matched to Change Managers and worked on the efficiency programme. The Improvement and Innovation team (I&I) is a newly formed directorate within HCS in 2021. Its purpose is to provide the right support across HCS to enable and drive effective and efficient business management, facilitate continuous improvement with a person-centred approach and encourage productive working with partners.

The I&I team has five main functions:

1. Strategic Planning and Reporting - creates a robust operational planning and reporting culture and leads on development support for new strategies.
2. Portfolio Change Management Office – provides the holistic overview of all change activities with considerable impact and provides project management and change support for improvement projects (including JCM)
3. Quality Improvement (QI) establishes and embeds a QI approach whilst creating a positive QI culture across the department and with partners.
4. Commissioning and Contract Management – leads on the establishment of an outcome focused framework to create a purposeful approach to partnership working.
5. HCS Business Intelligence – provides operational performance information to drive high quality services and excellent patient experience and outcomes, supporting the continuous improvement of services with data and insight with particular focus on each care group.

The newly developed QI structure is as follows:

Quality Improvement Structure



To support the work that collectively the teams will be undertaking, we are actively recruiting additional staff to support all five functions of our service. It is expected that all vacant posts will be recruited into and persons in post by the end of August 2021.

Two of the projects that the team have worked on previously under its predecessor, the Modernisation Team are outlined here:

1. Mental Health Jersey Talking Therapies Partnership

To alleviate pressure on services it was decided that partners should work together to support people. Mind, Liberate and Listening Lounge were selected for partnership working. Partnership pathway were established with shared referral forms, outcome measures and initial assessments. Referral forms were made available in different languages. Diversity monitoring was introduced at JTT and a tracker put in place at JTT to monitor activity. Capacity and demand modelling were undertaken and reviewed leading to a directory and options paper being put forward.

The outcomes included the following:

- Waiting list were reduced
- Group offers reviewed and updated.
- Equipment was purchased for the Decider Skills course, jointly delivered with listening lounge.
- An App containing local services (Hub of Hope) was made operational.
- JTT IT system enabled to accurately report on waiting lists.
- Improved coordination with Alcohol and Drugs service.
- Improved guidance to GPs on JTT vs psychology referrals.
- Improved working relationship with partners were established.
- Listening Lounge contract reviewed and updated.
- New pathway reviewed by expert by experience (EBE).

2. Retinal Screening

- Diabetic retinopathy is a complication of diabetes affecting the eyes. Retinal screening of patients with diabetes has been shown to reduce the risk of sight loss by the prompt identification and treatment of diabetic retinopathy. There are around 4,300 patients with diabetes in Jersey. A review and relaunch of the retinal screening service was undertaken following a Serious Untoward Incident (SUI). This provided a systematic quality assured screening programme which aims to parallel UK screening programme performance.

  As a result, the following was addressed:

- Implementation of a more efficient screening programme which will only offer screening to patients who require it; suspending patients already under Ophthalmology care for retinopathy from recall and excluding those who are unsuitable
- Introduction of Failsafe systems which avoid duplication of ophthalmology referrals thereby reducing administrative demand on ophthalmology service
- Employment of a clinical lead to support Failsafe and ensure good governance
- An external contract with Gloucester hospital was set up for the grading of Photographs
- The entire retinal screening pathway is supported by a specialised software package in use by numerous programmes (both in the UK and other countries). This enables accurate data collection so that jersey outcomes and performance can be benchmarked.

23. How many locum staff work within the maternity team now and what are their positions? (please provide figures for the last 3 years)

The table below sets out the number of locums who worked within the maternity team over a three-year period from 2018 to 2020.

Grade Grouped	Job Reason	From	To
Core Trainee	Vacancy	01/04/2018	06/08/2019
StR (3-8)	Vacancy	01/04/2018	31/03/2021
Staff Grade	Vacancy	02/04/2018	13/01/2021
Staff Grade	Vacancy	03/04/2018	19/04/2018
Staff Grade	Vacancy	03/04/2018	22/04/2018
Staff Grade	Vacancy	17/04/2018	31/03/2021
Staff Grade	Vacancy	23/04/2018	13/07/2018
Staff Grade	Study Leave	08/05/2018	18/05/2018
Staff Grade	Vacancy	04/06/2018	26/04/2019
Staff Grade (agency locum)	Vacancy	03/09/2018	23/10/2018
Staff Grade (agency locum)	Vacancy	04/10/2018	23/10/2018
Staff Grade	Vacancy	05/07/2018	31/03/2021
Consultant	Vacancy	15/10/2018	28/06/2019
Staff Grade	Annual Leave	14/12/2018	11/01/2019
Consultant	Vacancy	17/12/2018	25/01/2019
Staff Grade (agency locum)	Vacancy	01/04/2019	
Staff Grade	Vacancy	14/01/2019	31/01/2019
Staff Grade	Vacancy	04/02/2019	22/03/2019
Core Trainee	Vacancy	01/04/2019	20/09/2019

Consultant	Vacancy	29/04/2019	31/05/2019
Core Trainee	Vacancy	10/06/2019	06/08/2019
Consultant	Sick	24/06/2019	28/06/2019
Consultant	Vacancy	25/06/2019	25/06/2019
Staff Grade	Annual Leave	01/07/2019	16/08/2019
Staff Grade	Vacancy	01/07/2019	12/07/2019
Consultant	Annual Leave	03/07/2019	19/07/2019
Consultant	Vacancy	05/07/2019	17/07/2019
Consultant	Vacancy	22/07/2019	13/03/2020
Staff Grade	Annual Leave	22/07/2019	26/07/2019
StR (3-8)	Vacancy	29/07/2019	27/09/2019
Consultant	Sick	10/09/2019	27/09/2019
Staff Grade	Sick	23/09/2019	04/10/2019
StR (3-8)	Vacancy	01/10/2019	31/03/2020
Consultant	Sick	06/11/2019	22/11/2019
Consultant	Vacancy	08/11/2019	26/03/2021
Core Trainee	Sick	03/02/2020	13/02/2020
Staff Grade	Vacancy	17/02/2020	01/03/2020
Core Trainee	Vacancy	17/02/2020	28/02/2020
Core Trainee	Vacancy	19/02/2020	04/02/2021
StR (3-8)	Vacancy	01/03/2020	20/03/2020
StR (3-8)	Vacancy	02/03/2020	31/03/2020
Staff Grade	Vacancy	02/03/2020	13/03/2020
Core Trainee	Vacancy	09/03/2020	01/04/2020
Consultant	Vacancy	16/03/2020	31/03/2021
Core Trainee	Covid-19	23/03/2020	02/04/2020
Consultant	Covid-19	23/03/2020	03/04/2020
Staff Grade	Covid-19	23/03/2020	05/04/2020
Consultant	Vacancy	01/09/2020	25/09/2020

Currently there are five locum doctors working within the maternity unit to cover vacancies.

a. How much was spent on locum staff in 2019 and 2020

The following are the costs for Obstetrics & Gynaecology for internal locums and agency medical staffing for 2019 and 2020:

Obstetrics & Gynaecology- agency staffing and internal medical locums

	2019 (£)	**2020 (£)**
Agency staffing	948,173	841,630
Internal locums	99,242	174,609
Total	**1,047,415**	**1,016,238**

24. Given the challengers recruiting both midwives and junior doctors to the island, is work going on to consider developing roles which might either support midwifery roles or substitute for junior doctors e.g. maternity support workers, specialist/advanced midwifery roles?

We currently offer degree and Masters programmes on Island which is affiliated to Chester University. The Non-Medical prescribers' course is also offered.

Maternity are developing midwifery led services and are developing the non registered workforce/ maternity support workers (RQF modules) to support the service.

7. How can maternity services be improved to meet the needs of families?

25. What training do midwives/health care professionals currently receive in respect of talking to and supporting women and families who have experienced miscarriages and baby losses?

In 2019 midwives and neonatal staff had the opportunity to attend SANDS training.

In addition, in-house training- which included bereavement/pregnancy loss pathway have been offered.

Baby Lifeline Training – reducing stillbirth

26. Do the lead midwife and lead obstetrician adopt and implement a bereavement Care Pathway?

    a. Do you liaise with any charities to help support those going through early miscarriage?

Maternity liaises with the charity Phillips Footprints. However most early miscarriages are managed with and followed up by Gynaecology and not maternity.

27. We understand that the hospital used to provide a counselling service for bereaved parents but that this is now run by Jersey Hospice. Is that correct?

    a. If so, why did it stop?

There was a hospital counselling service however this is no longer available due to retirement of the counsellor. Phillip's Footprints fund counselling on a sessional basis at Hospice for bereaved parents.

28. We have heard from women who never received follow-up care following a miscarriage] Do you have a formal process in place with midwives that ensures that women and their partners are contacted following a miscarriage/loss of pregnancy to check on their physical and emotional well-being?

If a woman has a miscarriage on whilst on maternity, she will be supported by either the midwife that has cared for her or her named community midwife. Women who suffer early miscarriage are seen on the gynaecological ward.