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Health and Social Security Scrutiny Panel

Review of Maternity Services

Witness: The Minister for Health and Social Services

Tuesday, 13th April 2021

Panel:

Deputy M.R. Le Hegarat of St. Helier (Chair)

Deputy K.G. Pamplin of St. Saviour (Vice-Chair)

Deputy C.S. Alves of St. Helier

Deputy L.M.C. Doublet of St. Saviour

Ms. C. Warwick, Panel Adviser (1)

Mr. P. O'Connell, Panel Adviser (2)

Witnesses:

Deputy R.J. Renouf of St. Ouen, The Minister for Health and Social Services

Deputy T. Pointon of St. John, Assistant Minister for Health and Social Services

Ms. C. Landon, Director General, Health and Community Services

Mr. R. Sainsbury, Group Managing Director, Health and Community Services

Ms. R. Naylor, Chief Nurse

Dr. A. Muller, Director of Improvement and Innovation, Health and Community Services

Ms. D. Scott, Head of Midwifery and Associate Chief Nurse for Health

Mr. P. Armstrong, Medical Director, Health and Community Services

[10:39]

Deputy M.R. Le Hegarat of St. Helier (Chair):

Good morning, this is a public hearing in relation to the review of the maternity services with the Minister for Health and Social Services. We are a little bit later than anticipated and apologies for

that but, as always, with modern technology there are a few hiccups. I would like to just welcome all of those that are listening this morning and hopefully we will gain some knowledge from this event. The normal rules apply as if this was being made in public, and I will introduce myself. I am Deputy Mary Le Hegarat of St. Helier District 3 and 4, and I am the chair of the panel. I am going to ask the panel members to introduce themselves and then I will ask also the Minister and all of those people who will contribute to this forum to introduce themselves also.

Deputy K.G. Pamplin of St. Saviour (Vice-Chair):
Good morning, everybody. Deputy Kevin Pamplin of St. Saviour District No. 1. I am the vice-chair of the panel.

Deputy C.S. Alves of St. Helier:
Good morning, everybody. I am Deputy Carina Alves of St. Helier District 2 and I am a member of the panel.

Deputy L.M.C. Doublet of St. Saviour:
Deputy Louise Doublet of St. Saviour 2 and I have been co-opted to the panel for this review.

The Minister for Health and Social Services:
I am Deputy Richard Renouf of St. Ouen, and I am the Minister for Health and Social Services. I will pass over to my Assistant Minister who is on the call.

Assistant Minister for Health and Social Services:
I am Trevor Pointon, Deputy for St. John. I am the Assistant Minister for Health and Social Services responsible for mental health.

Director General, Health and Community Services:
I am Caroline Landon. I am the director general for Health and Community Services.

Group Managing Director, Health and Community Services:
I am Rob Sainsbury. I am the group managing director, Health and Community Services.

Chief Nurse:
I am Rose Naylor, and I am the chief nurse, Health and Community Services.

Director of Improvement and Innovation:
Good morning. I am Anuschka Muller, director of improvement and innovation.

Head of Midwifery and Associate Chief Nurse for Health:

I am Dana Scott, head of midwifery and associate chief nurse for Health.

The Minister for Health and Social Services:

I believe we will be joined by Mr. Patrick Armstrong, our medical director, but I do not think he is online yet. He is in theatre, he should be arriving with us shortly. Thank you, that is our team.

Deputy M.R. Le Hegarat:

Thank you. I will remind people that when speaking if they could put on their camera please and when not speaking if cameras and the audio could be turned off, it assists with our transmission. Also obviously we will see how it runs. Firstly, I would like to ask Deputy Pamplin to start with the questions.

Deputy K.G. Pamplin:

We are going to start with the current maternity facilities that are available and the works that have been mentioned needed. It goes further back, of course the maternity unit came in in 1987 having been transferred from what is now known as Le Bas Centre, and then just under 30 years later there were statements made by then, and in 2015 the Minister for Health and Social Services of that time and the hospital director at that time also, recognised that the maternity unit needed major investment already to bring it up to an acceptable standard. The first question, if you are able to answer this, Minister, is: why has it taken so long to bring forward proposals to refurbish the unit?

The Minister for Health and Social Services:

I believe that in those 30 years there have been elements of refurbishment carried out. Neither you or I were around in the States but there have been constant efforts to try and keep this building providing a fit-for-purpose excellent service. But of course there are limitations to this building. For the moment, we are very pleased to say that we have got a refurbishment contract in place, a very extensive piece of work which will be beginning in June. It has been very carefully planned and will provide the very best care within the limitations of this building.

Deputy K.G. Pamplin:

That proposed time, as you mentioned, is for the refurbishment to commence in June and we understand completed in 2023. Before I continue on, is that correct?

The Minister for Health and Social Services:

Yes, that is right. That does sound a long time but that is because the work is having to be phased because we still have to provide the service in situ while the work is going on. Very careful planning to avoid disruption to services but it does extend the length of the contract.

[10:45]

Deputy K.G. Pamplin:

I just want to go back a bit to the first part of the question why it has taken so long to bring forward the proposals to refurbish the unit. You are right, of course, it was a former Minister for Health and Social Services but the facility was the facility. Why has it taken so long to take what was said in 2015, and obviously known, to bring forward these proposals? Have there been delays? Were there other priorities? Why has it taken so long?

The Minister for Health and Social Services:

I have not delved back into the history. When I came into office I learnt about these plans to refurbish and I followed them and I am pleased that they are being implemented. I have not conducted an inquiry into what work was done in the past and whether it was sufficient for the time or not. I cannot really add anything.

Deputy K.G. Pamplin:

Is it a funding question because obviously that is going to be part of the next part of the questions? It will take about 2 years to undertake, have we got that right?

The Minister for Health and Social Services:

That is not because of funding, that is because of the need to continue the services in situ.

Deputy K.G. Pamplin:

Are there any concerns there about how a level of disturbance of a 2-year programme might cause to service users and the staff? This was obviously a big issue in the - I do not want to revisit it - Gloucester Street hospital site proposals, the works going around the working hospital. This has obviously been going on for years with current maintenance but is this not a concern?

The Minister for Health and Social Services:

It would be a concern if it had not been addressed, so it is an issue and that is why the contract takes so long because we have to carefully put different parts of the facility around so that the workmen can get into areas. It has all been very well planned to avoid any disruption and services will continue. We will not be removing any provision that now exists and therefore we need to have no concerns about the provision of the maternity service.

Deputy K.G. Pamplin:

There is a theory though, would it not be simpler to instal a modular solution which could be far quicker and less inconvenient and obviously, as you mentioned the timescales, we are coming out of this phase of the pandemic - we do not know what is ahead of us of course - but in terms of the far quicker and less inconvenient version would be to do this version, and if the hospital goes through the final process to be approved for the new site of course.

The Minister for Health and Social Services:

When you refer to a modular build, Deputy, I do not know if you were referring to building on another site. We are moving services to Overdale but that will take 5 years. Meanwhile we need to refurbish our current facility. Options would have been considered. This was the realistic option to follow. We are safeguarding patients and their safety. This is doable and is the right thing to do, I believe.

Deputy K.G. Pamplin:

There are no realms of possibility that a midwife-led unit could be done offsite, for example? Go back to the original Le Bas Centre, if needs be, and use that in a time-limited period until the new hospital was built maybe. Was that ever considered?

The Minister for Health and Social Services:

It was considered. No, what came through is that the present programme of works is the best way. Again, I stress there is going to be no diminution in the service we offer. This facility is being improved at the same time as we continue to deliver and enhance our service to patients.

Deputy K.G. Pamplin:

Going to the cost thing, we touched on it just beforehand, how much is this going to cost? Can you give us that figure and how would we fund it?

The Minister for Health and Social Services:

I do not have the figure just at the moment but we will get that for you hopefully during the course of the meeting.

Deputy K.G. Pamplin:

Minister, just to confirm that the funding is guaranteed, it is locked in and, additionally, if more is required there is more available?

The Minister for Health and Social Services:

Yes, this is funding from our capital programme. It has been agreed and a contract is live and is about to start.

Deputy K.G. Pamplin:

In spending so much time and money on the refurbishment, why are you not using the opportunity to modernise the service itself rather than just the estate and use the opportunity instead of just covering over the cracks, to use that phrase, use this opportunity to do the whole thing, if that makes sense, before going up to the new hospital? Is that a possibility?

The Minister for Health and Social Services:

You use the phrase "modernising the service" and I wonder what you mean by that. We are constantly seeking to improve and driving improvements. We have an excellent women in care group that is headed by clinicians and midwives. They are constantly searching out what is best practice and trying to adopt that in Jersey. I would like to just tell you about the way we work, if I could pass over to our chief nurse to tell you exactly what improvements we are moving towards.

Chief Nurse:

Just in response to the question about modernising the service. There is a lot of work that the leadership team within Women's and Children's Services is doing at the moment in relation not just to midwifery care but also looking at the medical model of provision. I think in response to your question, why are we not doing it at the same time using the opportunity of a capital plan to do it, we can do both together. It is possible to continue to improve the service while the physical environment is being upgraded. The concern would be, from my point of view, is if we waited to do the full modernisation of the service, as you suggest, that could potentially put some delay into the much-needed refurbishment and upgrade, which is going to give women a much better physical environment, the staff a better working environment, until the new hospital build is available. So the work that we are doing at the moment will not be wasted. Women will feel the benefit of the work that the team are doing around how the workforce team operates, how we provide services to women, not just within the hospital but across the Island as a whole in relation to maternity care because much of maternity care happens outside the hospital as well. I hope that has gone some way to responding to your question. We do have our head of midwifery on the line if you would like her to contribute to the response, Deputy Pamplin.

Deputy K.G. Pamplin:

In a moment. Deputy Doublet wants to join in as well. But just very quickly: who is going to be overseeing this and where was the clinician lead and the department lead into this work? I guess those 2 strands will bleed into each other. Who is going to oversee this and be responsible for it and what involvement and lead in from clinicians and the department?

Chief Nurse:

The clinical leadership comes from the clinical leadership team of Women's and Children's Services. So the head of midwifery, the associate medical director and the clinical lead for obstetrics. So they work together supported by a general manager and the wider team within Women's and Children's. They are the key leadership team who are directly responsible for overseeing the capital programme of works alongside the changes that they are making to the workforce model and the way we deliver care now and in the future.

Deputy K.G. Pamplin:

Deputy Doublet I believe wants to come in with a question and I believe we have Cathy on the line.

Deputy L.M.C. Doublet:

Just quickly, and referring to what the Minister was saying about the fact that improvements were being made to the service and are continually being made. I suppose to set some context but also to highlight positive things because Scrutiny of course wants to highlight not just problems but the positives. I wonder if the Minister could outline or choose an officer to outline. So a woman who might have given birth 5 or 6 years ago what top 3 improvements would she notice giving birth today in the maternity facilities compared to 5 or 6 years ago?

The Minister for Health and Social Services:

That is an excellent question and I think that is best answered by somebody who knows the service thoroughly so I would like to pass over to Dana Scott, our head of midwifery.

Head of Midwifery and Associate Chief Nurse for Health:

I have been with the organisation since September 2020 so I do not think I am in a position to say from 5 or 6 years ago, but certainly from the improvements, so most of the service-led improvements have come along also in the time of the pandemic. A lot of what women are experiencing now has probably been a bit restrained. Women coming through the service currently, we have streamlined our medical model and we have aligned whereas previously we had not. We have aligned to consultants, to high-risk clinics, to medical morbidity clinics, to twin clinics to increase the level of continuity that women are getting. That is also still in the transition phase at the moment. That model only came in in February this year. We are growing and developing our home birth services for women and the education and support around staff in delivering primary healthcare services and signposting women earlier on are some of the bigger changes that we are making at the moment. Also looking at our new midwifery-led workforce model, our aim is to transition into more midwifery-led care in the community. Women get excellent service as continuity of care from the midwives but often if women are high risk that continuity was not as good so we are really focusing our efforts on building up better continuity. They are some of the subtle differences that are occurring at the moment.

Deputy L.M.C. Doublet:

I am just trying to put that into lay person speak. You feel that the continuity of care, so is that seeing the same midwife as often as possible? You would say that is something that a woman would have noticed has improved in the last 5 years and you said the home birth services, a woman would notice an improvement in those. I think the third thing you said was signposting earlier. Does that mean providing help earlier on in the pregnancy or earlier on after the baby is born?

Head of Midwifery and Associate Chief Nurse for Health:

In the pregnancy but probably both. We have been working on a perinatal mental health pathway so the assessment for mental health and mental illnesses very earlier on, we have better signposting. As I said, it is still in a transition phase at the moment with having a lead consultant per clinic.

Deputy L.M.C. Doublet:

What does the signposting actually mean? I am just trying to understand from a woman's point of view what would that feel like for the woman?

Head of Midwifery and Associate Chief Nurse for Health:

Every woman is risk assessed. So based on an outcome of a risk assessment of health and well-being and previous medical history we would signpost to either an appropriate clinic or a service or perinatal mental health service, diabetic services. While a lot of these services were in place, what we feel is better, but it is still quite in its infancy at the moment, is the model itself was built on a medical model. Now we have got named doctors for each clinic. While women can get a named midwife you will now get a named consultant who is responsible for clinics. Say it is a twin clinic, so you should have better continuity throughout pregnancy.

Deputy L.M.C. Doublet:

Thank you. Just a final question, the named consultant: when did that start?

Head of Midwifery and Associate Chief Nurse for Health:

That was part of our new medical workforce structure. That started in February this year.

Deputy K.G. Pamplin:

Wrapping up this section, going on what has just been talked about there, the model of best practice being used to put together the planned refurbishments basically, do the plans for instance take into account of the modern demands of new families today? Will that include further facilities for partners, birthing partners and fathers?

The Minister for Health and Social Services:
Yes, it does. All of that is fully recognised in the schedule of works.

[11:00]

Deputy K.G. Pamplin:
Some of our submissions so far from the public, some families have written to us about the effects of not letting fathers and the second parent stay with the mother and baby in the hospital, and some fathers being told to leave very soon. I had a similar experience myself but that was in England, it was very distressing at the time. Will the policy evolve at the same time as these things are going on? So anybody who wants to stay to be there for their birthing partner will have the facility to do it in this interim period before we move to the new facility, wherever that will be?

The Minister for Health and Social Services:
We recognise that the partner of the birthing parent is absolutely crucial to all aspects of the care we want to give. That partner will be incorporated in all our plans. I would like to pass over to the chief nurse to give more detail.

Chief Nurse:
Based on the feedback that we have had from partners we are doing more to support individuals during this time. I will also caveat that with a comment about safeguarding so that we do have to be mindful of the type of unit that this is. But absolutely we do recognise, and we have heard it particularly in some of the feedback that people have given to this Scrutiny Panel review, that we need to do more to support partners at this time.

Deputy K.G. Pamplin:
How will you be measuring that success and listening to people pushing for best practice because is it not better to be doing that instead of waiting for feedback down the line and then making changes, if that makes sense?

Chief Nurse:
No, absolutely. I can hand over to Dana who can just talk about Maternity Voices Partnership, which will enable us to get that feedback in a timely manner.

Head of Midwifery and Associate Chief Nurse for Health:
So Maternity Voices Partnership was commenced, so that is service users. Currently people have been through the service, all of our team have recruited women and canvassed what they think how

maternity services should be, how we should structure it, what works well and what has not worked well. We just secured funding and we are just trying to sort out the governance process. But moving forward with Maternity Voices Partnership we are going to work very collaboratively with the service users to see how we should design the actual service and support partners better. But prior to Maternity Voices Partnership there was other maternity liaison service committees. The actual new build itself, the refurbishment process itself, was taken into account of service users at the time over the last 5 years as to what the new service should look like and what that refurbishment should be and how helpful and supportive it should be for both parents staying part of that pregnancy journey and birth journey.

Deputy K.G. Pamplin:

So you have that vision now. Are you able to share the specifics of what that will look like, of what is coming down the line? That would be very reassuring for future families coming into the unit knowing what is awaiting them. Do we have those specifics now?

Head of Midwifery and Associate Chief Nurse for Health:

Yes. Part of the refurbishment, and I do not know who has seen the ... the building is old, it is in need of modernisation so there will be better en suite birthing suites, which will have capacity for the birth partner to stay during that time. All birth partners stay on the labour ward currently and during the birth process and if we can provide a private room. So there will be more capacity, more single rooms for patients to stay over and partners to stay over. If the ward areas, we have reduced the bed capacity so there are less beds, so there will be more personal space for each couple.

Deputy K.G. Pamplin:

I am conscious of the time but I understand one of our advisers, Cathy, would like to come here.

Panel Adviser (1):

There were just a couple of little questions around the refurbishment that I had. I know when plans are made to help have a policy that enables fathers to stay perhaps overnight if a woman comes in antenatally and postnatally after the mother has had her baby, there needs to be quite a lot of preparation and planning with the midwives. I wondered how much discussion had gone on with the midwives about a change in policy and when will the policy actually start? When will community midwives be able to say to women and their partners: “You will be able to stay if you want to”? My second question is just around midwifery-led care and the policy of encouraging midwifery-led care. I have not heard a lot about whether there is going to be a midwifery-led unit in this newly-refurbished area or not.

Head of Midwifery and Associate Chief Nurse for Health:

Yes, there is a midwife-led area, so we are having 2 midwife-led birth rooms. There will be a separate area for that but it will be within the footprint itself. So that will continue. Once the refurbishment is done there will be a choice of traditional care, home birth care or birthing on the midwife-led birth units. When we transition to the new hospital there will be more private room facilities but we have still not quite come out of pandemic for visiting and people staying over at the moment, so we have to work with our I.P.A.C. (Infection Protection and Control) team for that. It is based on and, as the chief nurse rightly said, it is a bit more difficult in a ward-based area but to utilise the rooms we have until we are completely out of the pandemic. The single rooms, we have to safeguard those at the moment for isolation. Once the measures have lifted and the levels have gone down and we can go back to full visiting, that is something we can revisit at that point.

Deputy K.G. Pamplin:

Deputy Alves will take us into the next section and will take us on from here.

The Minister for Health and Social Services:

Can I just come back to a question you asked which was about the investment in the refurbishment? The figure of £6 million has been set aside to invest in this refurbishment.

Deputy K.G. Pamplin:

That was in the capital projects of the last Government Plan and secured going forward, yes?

The Minister for Health and Social Services:

Yes, that is definitely available and in the budget. As I said, the contract is live and is due to start in June.

Deputy C.S. Alves:

Dana mentioned briefly there the perinatal mental health services. We have seen the comprehensive business case that has been developed for the perinatal mental health service. Is the business case that proposes a comprehensive perinatal mental health model for Jersey going to be adopted in full?

Assistant Minister for Health and Social Services:

I think that is probably a question for me. Yes, the perinatal mental health pathway is active and the practitioners from various disciplines know their role and know that they are able to refer into the adult mental service or women who need both prenatal and postnatal assistance. There are though other facilities available at a reduced level, namely the Listening Lounge, and of course referral to the adult mental health Talking Therapies facility.

Deputy C.S. Alves:

Are you confident that it will ensure that all midwives, whether these are both community and hospital, and G.P.s (general practitioners) will receive the training regarding the emotional well-being of women and their families during and after pregnancy as they do for the antenatal care?

Assistant Minister for Health and Social Services:

I am assured that the programme is very much a part of the new model. In most instances, general practitioners will not necessarily need to be involved because the result will be that those other practitioners, health visitors, midwives and counsellors will be able to refer directly to adult mental health, as with other parts of the mental health services. The requirement to go to a G.P. is not within the programme albeit some people may prefer to go to their G.P.s. The G.P.s of course have a responsibility within their businesses to meet that need. If they need training assistance they will of course approach health and the mental health services to obtain those skills.

Deputy C.S. Alves:

Are you confident that you will be able to recruit capacity for a perinatal mental health midwife specifically?

Assistant Minister for Health and Social Services:

As with all recruitment in Jersey one is never certain that you are going to be able to target the individual that you need but efforts will be made and continue to be made to make sure the right people are in the right posts?

Deputy C.S. Alves:

In a recent letter to the panel you said that ideally specialist mental health midwives should be available to support women and staff. Is this not currently the case?

Assistant Minister for Health and Social Services:

We are in the early stages of developing this. Many of the components are ready and up and running but those specific specialist midwives have to be recruited. This is in part an aspiration in relation to getting the right people in the right place at the right time.

Deputy C.S. Alves:

What is the plan for that? How many staff are we looking at? Is there a timeline for this to happen, to be put in place?

Assistant Minister for Health and Social Services:

The exact detail, I think I will hand this over to Rob Sainsbury, who has been doing a lot of work in relation to this.

Group Managing Director, Health and Community Services:
Yes, this is definitely an area where we have a need. In 2021 we have been given some additional funding so one of our psychiatrists, Dr. Rachel Ruddy, has been working with our colleagues in Children, Young People, Education and Skills. She is going to be provided with some additional resource. We get an additional 2 sessions of doctor time to support the development of this pathway and we have had funding for an additional perinatal nurse to join that service. We are piloting that in 2021. The plan will be we then develop the business cases, as you mentioned, learn from the work that we are doing and then look to roll out the more comprehensive service going into 2022 as part of the Government Plan. We are working with C.Y.P.E.S. (Children, Young People, Education and Skills) to develop that. We are pretty confident that it will identify a need and we are pretty confident that this additional resource will make a difference. We want to build on that and, as the Assistant Minister says, that will require more practitioners, which we think we can recruit into.

Deputy C.S. Alves:
I have just noted that our adviser, Cathy, has a question so I am just going to let her ask her question.

Panel Adviser (1):
Rob has just answered it. I wanted to know was the business case going to be funded and Rob has explained that process, so thank you.

Deputy C.S. Alves:
According to the N.S.P.C.C. (National Society for the Prevention of Cruelty to Children) currently there are limited resources to meet the needs of expectant parents at the time that they need additional support. They also feel that there is currently a lack of preventative approach which often leads to crisis management. How would you respond to this and how do you intend to address it?

The Minister for Health and Social Services:
The public health aspects of maternity care are vital and something that has not been emphasised or given enough resource in the past. There is so much more we could do to improve that aspect of the service and we will want to. More widely, the Government is bringing forward its mental health and well-being programme in which there is a lot in there about preventative health and measures that can be taken. We need to address the issue of harm to children as a result of mothers consuming excessive amounts of alcohol or smoking during pregnancy?

[11:15]

Or the other risks that can arise perhaps through wider health determinates; poor accommodation or stress at work or stress arising through lack of income. All these things we recognise can affect the outcomes for a child. There are early plans, I think, for a programme which would involve more information to be made available and these issues to be addressed earlier. We would like to create a poster of a midwife who has a specific role in that preventative care and highlighting the risks to expectant mothers and helping them keep well during pregnancy to improve the chances for their babies. Can I pass over to Dana perhaps to talk more about that?

Deputy L.M.C. Doublet:

Can I just jump in to ask a specific question before Dana joins in? I wanted to know again what will the improved service look like to the average woman using the maternity services. What will she notice is different? For example, will there be routine screenings for postnatal depression, postnatal anxiety and P.T.S.D. (post-traumatic stress disorder) related to birth trauma? Those specific things. What will it look like for the average woman and what are you aiming for it to look like?

The Minister for Health and Social Services:

If I can pass over to Dana to answer that detail. She has good vision of what we would like to achieve.

Head of Midwifery and Associate Chief Nurse for Health:

In order to answer your question what would the service look like. The perinatal mental health pathway has been an accumulation of almost 2 years work, which we have had midwives collaborate on that. We have had midwives who have been instrumental from the start of that process. So that pathway for women, there is the screening. It will tease out mental health and mental illness and the screening will be done at subsequent visits from booking. We are introducing a new public health section into our booking process so women will get an additional public health appointment with their midwife to go through the health prevention, health promotion and health protection process for pregnancy. The mental health element of that, women will be screened and subsequently screened. It is part of our business plan to have a perinatal mental health midwife who will link in and be a support and be able to help women with the referral and help other midwives manage expectations and help them manage those referral and processes. Postnatally the process will be the same. There will be more robust interviews, motivational screening, to tease out those women who feel more vulnerable and that continue in that pathway under the guise with the whole team but with the perinatal mental health midwife. That service, in itself, we are doing that in part currently but our aim is to get the perinatal mental health midwife in, which has been widely used and adapted across the U.K. (United Kingdom). It really does promote well-being.

Deputy L.M.C. Doublet:

Thank you. Just to follow up. So the public health appointment, that is before birth, have I heard that correctly?

Head of Midwifery and Associate Chief Nurse for Health:

Yes, it will be after the booking appointment. There is going to be a separate appointment to look at the public health elements.

Deputy L.M.C. Doublet:

That sounds great, thank you. You mentioned screening for mental health problems. So those 3 issues that I mentioned, will those 3 mental health problems be routinely screened for after birth as well for each woman?

Head of Midwifery and Associate Chief Nurse for Health:

Yes.

Deputy L.M.C. Doublet:

Could you just briefly address the waiting times? What is the target for waiting times to access mental health support please?

Head of Midwifery and Associate Chief Nurse for Health:

I am not sure actually. I do not have that information what the waiting times are.

Deputy L.M.C. Doublet:

Perhaps, Minister, if you could forward that to the panel after the hearing we would be grateful for that please.

The Minister for Health and Social Services:

Certainly, Deputy. We will get those waiting time details.

Deputy C.S. Alves:

Is there a written strategy for maternity services which describes the framework for the current maternity service and outlines objectives for the future?

The Minister for Health and Social Services:

I will pass over to our chief nurse.

Chief Nurse:

At the moment, this is something that the team are developing for the service provision going forward which will take into account the new hospital build and also the Jersey Care Model. It is something that our relatively new leadership team in Women's and Children's are working on.

Deputy C.S. Alves:
When do you think you will have this strategy written up by and who specifically is doing it?

Chief Nurse:
It is under the leadership of the Women's and Children's Care Group so this is in our new model of clinical leadership that we have for the organisation. The clinical lead for obstetrics, who is a doctor, the head of midwifery, the associate medical director who is a doctor, and supported by a general manager, they will be working with the wider team. Of course organisations and also Maternity Voices Partnership forum in relation to what the service looks like going forward in the future. We anticipate that work will start this year in earnest and we will have a strategy in place next year.

Deputy C.S. Alves:
Do you have any standards and benchmarks that you will be looking at to pin that framework to and when next year; quarter one, quarter 2?

Chief Nurse:
We are hoping to have something out early next year. In relation to standards and benchmarks we do collect information around activity in maternity services at the moment and the team are working on how we look to benchmark ourselves across other comparable organisations and national standards. So they have been developing quite a comprehensive list of standards, which is over 240 that they are looking at, at the moment, in considering how they prioritise that information going forward. So we do have some information at the moment. But obviously those standards and that activity is one element. It is really important that we capture the voice of people who use our services as well and include that going forward in structure.

Deputy C.S. Alves:
Can I just clarify something then? Is there benchmarking in place currently and has there been in the past?

Chief Nurse:
We have been measuring activity. We have been looking at other organisations. The U.K. is a good area to start for us from an N.H.S. (National Health Service) point of view. So we have been looking at a data. We have had some of this in place for a considerable time within maternity and across a range of our services. I just want to add to that, Deputy Alves, that we do have individual dashboards

for all our service lines across the organisation, Women's and Children's being one of those that we review regularly as in the executive team on a monthly basis.

Deputy C.S. Alves:
Our adviser, Cathy, would just like to chip in with a question so I will hand over to her.

Panel Adviser (1):
I just was a bit anxious about how the strategy will progress given that at the moment you are advertising for the head of midwifery. I understand from our interviews that the lead obstetrician is also a post that will be vacant. Can you guarantee that there will be good progress despite not having that senior leadership team in place?

Chief Nurse:
We anticipate that those posts will be filled in due course. Dana is with us at the moment and is part of that senior leadership team but also, in relation to development of the strategy, it is not just about those in leadership roles that will be involved in developing it. It will be much wider than the leadership team. Under my leadership, as part of my role as the chief nurse, I will be supporting the W.A.C's (Women's and Children's) leadership team in the department in the development and delivery of a strategy.

Deputy C.S. Alves:
Does the way that the system is set up help or hinder the development of high quality joined-up services?

The Minister for Health and Social Services:
I find that a difficult question to answer; does it help or hinder. The system is under constant review and all people working in it seek to improve the services we offer. I see a constant move towards improvement. There are twice monthly reviews where the Women's and Children's Care Group report into the executive and progress is monitored. We have an improvement plan so this service is under constant review and improvement. If I can pass over to Rose; would you wish to add anything more to that?

Chief Nurse:
I think it is fair to say that we have a very good working relationship across all of our organisations so whether that is within Government or across the Island as a whole and certainly something Dana has found since she has come to Jersey is the real positivity of the working relationships. I think there is good opportunities for maternity services under the Jersey Care Model to look at what we

do at the moment with a review, with the intent of doing things differently, taking everything into account that we have previously touched on and discussed.

Deputy C.S. Alves:
I think our adviser would just like to come in again on that.

Panel Adviser (1):
Sorry to come in again so soon but I just wanted to clarify. I think some of the thinking behind this question came from some of the discussions we have had around the separate systems that exist. The health visitors sit in one place, the G.P.s are in another place, the maternity services are in another place. I wondered whether there was any thought being given to setting up more of a maternity system that broke through all those different silos and enabled more collaborative thinking as you move forward.

The Minister for Health and Social Services:
That is a very perceptive question and we share that sort of vision. We recognise the risks of the service falling into silos and those silos not communicating well. This is precisely what we want to do in the Jersey Care Model, to bring together all those organisations working in the sector and make sure we have a joined-up service which is there for the patients and those using our services that works in the best way for them, regardless of who might be providing different parts of the service. We must co-ordinate and the Jersey Care Model work will bring that forward.

Panel Adviser (1):
Do you think there are any really vital tensions in that element? I note the desire to move to a more midwifery-led model of care but at the moment I think I saw that something in the order of 90 per cent of women, their first point of contact is with G.P.s and I just wondered how much tension there was going to be between different service providers as you move towards a different model of care and how that would be addressed.

[11:30]

The Minister for Health and Social Services:
We have to work that through. Yes, I acknowledge that at the moment the system is set up such that it is only through a G.P. referral that you come into the service but there is no reason why that should continue to be the exclusive route in. I think it is perfectly proper that people should be able to refer themselves in and see a midwife early on, as soon as they learn that they are expecting a child. But there should always remain that choice and we need to negotiate that with the G.P. We need to determine the best model for the Island, putting the patients, patient mothers or expectant

parents, first rather than any one profession or business. The care model is being set up to force these conversations through. We are not just going to say it is not doable. There is a lot of investment and a lot of work and a lot of resource going into the care model to create this new way of working.

Deputy C.S. Alves:

The next set of questions are going to be taken by our advisers so I am going to hand over to Paul.

Panel Adviser (2):

My name is Paul O'Connor. I am one of the advisers that works for Attain, who are commissioned to support the panel. Just before going into the next set of questions I just wanted to push the Minister a little bit more. In your final answer it is clear that you recognise there are some difficulties to getting the degree of integrated co-ordinated care that you are talking about. Are there any particular big hurdles that you would identify now that will need significant challenging in you being able to bring services more connected together?

The Minister for Health and Social Services:

Yes, I think there is a challenge fiscally, is there not? We need to have or to move towards having just one budget to provide for the service and sharing that budget between all working in it rather than it begins with G.P.s charging a fee and then moving into the service we offer here at H.C.S. (Health and Community Services) and then the Family Nursing and Home Care who are commissioned by C.P.AS. to provide health visitors postpartum. There are all these different pockets with money sitting in them that need to be brought together to provide a seamless service. That has been a challenge in the past and we expect it will not be a walk in the woods but that certainly would lead to better care, I believe, and we must move towards that.

Panel Advisor (2):

I understand you picking out funding as a particular difficulty. It is always difficult to change major funding issues. Would that include the split between privately-funded and publicly-funded services as well?

The Minister for Health and Social Services:

Yes, it would. We need to be transparent about that and ensure that the publicly-funded service, that the money allocated to that is sufficient and there is no merger or lack of transparency when it comes to the private service. So we still want to offer that choice and that private service for those who wish it but we want to enhance the public service. I would like to call on our medical director, if I may, who has just arrived in the meeting to address that.

Medical Director, Health and Community Services:

I do apologise for being late to the meeting, I was in theatre. I would just echo what the Minister has just said. We need transparency around what is provided privately and what is provided publicly I think, certainly from our perspective as executives, and I know the Minister supports this, is we want equity of access. So people may wish to have health insurance but we need to make sure that there are high quality safe services for everybody.

Panel Adviser (2):

Can I just push you? Transparency is a thing that everyone would argue for, what do you mean by transparency specifically in terms of payments for maternity-related services?

Medical Director, Health and Community Services:

It is just being very clear. I mean from the perspective of the doctors who are providing that service it is being very clear over when they are working doing public work and when they are providing private services so that there is no confusion between the 2. If a clinic is a public clinic it has public patients on it. We encourage consultants to do private work but it needs to be very clear that they are doing that in time that is not publicly funded.

Panel Adviser (2):

My final question on this aspect, we may come back to it later, but if you are recognising at the moment that there is not that degree of transparency when would you expect there to be the degree of transparency that you wish about the division between privately-funded and publicly-funded secondary services in maternity?

Medical Director, Health and Community Services:

We have already taken that approach with inpatient services, particularly with theatres. We have made it very clear to the medical workforce around outpatients what is expected. So we will be monitoring that and I would expect over the next 2 or 3 months that we would be at a point where we have more confidence that we have that clear and transparent split.

Panel Adviser (2):

That was very clear, thank you. Just moving on now, in terms of the quality of performance of the whole of the maternity service how would you define acceptable performance for your maternity services?

Chief Nurse:

We are aspiring to deliver excellent services for women and their partners on this Island and, as we have articulated previously, we are on an improvement journey in terms of our service provision

across the organisation but obviously in relation to maternity. We keep very close contact with the leadership team within maternity services. We have dashboards, we have data that we review and that the team are using to drive improvements in their services. So not just in relation to activity but also in relation to users.

Panel Adviser (2):
Can I just come in there please? You have referenced before how you were looking at data and there is a lot of data that is around but how do you know if that data tells you whether or not the service is good enough? In other words, what are you comparing it to? Where are your benchmarks now that define what really good service looks like so you can measure where your current service is performing against what good looks like?

Chief Nurse:
We have been developing our benchmarking data so that we can compare ourselves against other jurisdictions but also, very importantly, that we do have the voice of people who use our services in Jersey. It is a challenge to compare like with like when you have a low birth rate, you are geographically isolated in terms of the service that you deliver, but we are working very closely with the leadership team to make sure we have benchmarks that we use for comparison.

Panel Adviser (2):
What are those benchmarks? Which other places are you looking at to make comparisons between? We keep hearing that you are starting to look at these.

Chief Nurse:
We have a quality performance and risk review and we basically follow U.K. standards in terms of our practice. It is those standards that we are benchmarking services against.

Panel Adviser (2):
Is there another community or another maternity centre or unit or another specific-named place that you can identify now that you compare yourselves to?

Chief Nurse:
We are doing some work with other jurisdictions, so Guernsey and the Isle of Man in particular. I had a midwifery set up a local network with those services when she joined us last year. Dana could give us an update on the information in relation to that if she is able to come in.

Head of Midwifery and Associate Chief Nurse for Health:

Yes, thank you, Rose. Our dashboard indicates we are benchmarking ourselves from sort of national N.H.S. data and, more recently, the Perinatal Institute and M.B.R.R.A.C.E. (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries). Because we are quite a small sort of isolated service, we are sort of working out what our key performances should be and how we can start to benchmark ourselves. That is a recent piece of work that we have just undertaken.

Panel Adviser (2):
As a result of that, what I am not clear on, can you say now definitively, having done some of that early comparative work, where Jersey sits in terms of the quality of its maternity service or are you not able to say that yet?

Head of Midwifery and Associate Chief Nurse for Health:
I am not able to say that yet. But in terms of the local maternity system, as I previously said, it started in September last year. We are in the process of setting up a local maternity system which will cover the Isle of Man and Guernsey, who have slightly lesser birth rates and we are working with the Royal College of Midwives to start to see what that process would look like because we are outside the jurisdiction of the N.H.S. and so are the other islands, to sort of benchmark ourselves, so that is really an early piece of work. We have had a couple of meetings regarding that and we are just developing the terms of reference and what the benchmarking would look like. I feel confident moving on it will develop well.

Panel Adviser (2):
At what point do you think you would be able to publish comparative data that defines the level of performance, the level of quality of performance of the Jersey maternity services against those other places and whether or not, as a result, action needs to be taken? When do you think you would be able to define that?

Head of Midwifery and Associate Chief Nurse for Health:
I think that is going to take a little bit more time and I think that would probably go hand in hand with our strategy. Probably to the latter part of the year that we could start really looking and developing and really getting some results of the data that we have now set and what that looks like.

Panel Adviser (2):
Okay. I want to make sure that I am really understanding what is being said here. Correct me if I am wrong but what I am taking away from this at the moment is that at the moment there is not the comparative data to say whether or not the Jersey maternity service is operating at a high enough quality but that is something that you aspire to but you cannot say it at the moment. I am hearing there is lots of data, so I am hearing that you can identify where you are improving or you are not

improving but not against, necessarily, a particular level that you have defined as acceptable or good for Jersey.

Head of Midwifery and Associate Chief Nurse for Health:
That is correct and the data, the work that we have just recently done and benchmarking with the Perinatal Institute and M.B.R.R.A.C.E., that is going to take a little while for us to see because we have only just set those indicators, so we are not there yet but it will come.

Panel Adviser (2):
Okay, thank you, that is helpful. If there was a significant problem today, how would you know about it?

Director General, Health and Community Services:
Can I jump in here, please, Dana? Thank you for your input. Paul, we have a quality performance report that we do monthly, that has the same quality indicators as the N.H.S. and we benchmark ourselves against those indicators. We use that report, which is reviewed as part of our governance structure, through our executive reviews and through our governance committee, in order for our medical director and for our chief nurse to be able to ascertain whether we are delivering a qualitative service. Of course indicators are not the only way that you demonstrate that you have a qualitative service. We are in regular conversations both with our staff and we are seeking to engage more with our patients. We recognise across the whole of H.C.S. that that is not one of our strongest endeavours but we are seeking to remedy that. I refute the assertion that we do not know if we are delivering a qualitative service because I think we have the same indicators as the N.H.S. currently does. However, we have much more smaller percentages here on Island and we have to tailor our information accordingly. I think it might be valuable for the medical director to talk about quality.

[11:45]

Medical Director, Health and Community Services:
Yes, I would agree with what Caroline has said. We have lots of measures and lots of metrics that we do compare it with the N.H.S. We probably do not do it in the same way as an N.H.S. Trust because we can pick and choose and look at different metrics that are more appropriate for a small service on a small island, so there is no point in comparing it with a tertiary referral centre in a large city because it is not really comparable. But in looking forward we are starting to look at more and more metrics and we will develop what is appropriate for the services that we provide in our own context.

Panel Adviser (2):

Thank you, that is very helpful. Can I just bring Cathy in, who I think has a question?

Panel Adviser (1):
Yes, I have 2 things I just would be grateful for some clarity on, thank you. The first question relates to the last point, Patrick. I mean I completely understand that Jersey is a much smaller service and it, in some ways, is very different from a big inner city hospital service. But I suppose in terms of the quality indicators I would be interested in, the issue really is not about size, it is about what is the population that is receiving the service? I suppose I would just suggest that despite being small there would be some potential for comparing a population with another similar population, regardless of where they live. Dana mentions the M.B.R.R.A.C.E. and perinatal review tools and I guess they would be able to help with that, so perhaps that is more of a comment than anything else. My other question was to Dana, I think I heard you say that you were doing the work with Guernsey and the Isle of Man linking with the R.C.M. (Royal College of Midwifery) and I just wanted to make sure that any look at quality indicators would involve the R.C.O.G. (Royal College of Obstetricians and Gynaecologists), perhaps the Royal College of Anaesthetists and the entire professional team that is involved in high-quality maternity services delivery.

Head of Midwifery and Associate Chief Nurse for Health:
Thanks, Cathy, absolutely. As I said, it is still in its infancy, so we are just sort of looking at terms of reference and that terms of reference is about the inclusion of who should be in that group.

Panel Adviser (1):
Thank you, so it will be the entire and not just preliminary team. Yes, thank you.

Head of Midwifery and Associate Chief Nurse for Health:
Yes, it will, yes.

Panel Adviser (2):
Thank you. Just sort of wrapping up this qualitative element and try to do that. If you are highlighting the one or 2 key things where you felt that quality was really good in the maternity services and maybe a couple of things that you would really want to work on and improve, what might those be? What are the things that are at the really good end of the quality scale and those that still need improvement in the service overall, do you feel?

Chief Nurse:
Should I start with that answer? Just in relation to the things that we think we do very well at the moment, so we deliver person-centred care for our women and in relation to access for services, particularly beyond the walls of the maternity unit within this department, access for services to

support women after they have had a child as well. In relation to areas that we are looking for improvement, we are closely monitoring our c-section rates at the moment and the work that we are doing in relation to that particularly connects with the work that we do with carers. This is really around making sure that women have all the available information to make the appropriate choices, not just in relation to how they plan their birth, also in relation to lifestyle choices when they start to plan a family. I will invite Dana if she wants to come in on that response.

Head of Midwifery and Associate Chief Nurse for Health:
Yes, thank you, Rose. Yes, we have set up a public health partnership group because we recognise, as midwives, that the public health information about how protection, prevention and promotion is missing across the board. The working party that we set up, we are probably 3 months in, it is a very new group, is working with a lot of N.G.O.s (non-governmental organisations), it is working with government organisations and different leads in different parts of professions that are going to come together. We are going to develop some accessible standards of information and literature. There is a maternity website which we are going to expand upon but for the people if they are thinking of getting pregnant, when to come, what dietary advice to follow. We have got really good representation in public health. The public health team are part of that process in that public health group to develop that. I think that is going to have an enormous impact but it is going to take time to come to fruition. The things we do really, really well, we have excellent breastfeeding rates within the department and breastfeeding attrition rates, that and skin to skin, so we are doing that very, very well.

Panel Adviser (2):
That is very helpful, thank you. Just a very final question of this, obviously maternity services feel very much in the public arena at the moment with the interest from this panel and a lot of submissions being made. When you look at those submissions, are there any particular areas that you would want to consider first and foremost in terms of addressing the issues that have been brought forward by a number of the women who have given birth?

Chief Nurse:
I will take a lead on that response and if Dana wants to come in, feel free. Just to say that the responses from members of the public to the Scrutiny Panel reviews have been really helpful to us and we are very grateful to those responses describing their experiences, some of which have been very moving for us as a team. We want to make sure that we absolutely do credit to those women who have taken the time to put their experiences on paper and learn from those as a department. I think some of the themes that have come out, aside from those we have already discussed today, obviously the environment has been a particular feature in those but also in relation to continuity of care, bereavement support and also aftercare support. Many of the things that we have been talking

about as part of the panel review today have come through the voices of people who have shared their experiences. Continuity of care is something that we are looking at at the moment. We have done some work with Birthrate Plus last year and Dana is reviewing that work with the wider team to have a look at how we can strengthen that further in relation to the services that we already provide to our women. In terms of support and aftercare for families who have been through a very tough time and need some bereavement support, certainly the very first start of that in terms of the physical environment, which is right at the forefront of our capital programme. We recognise that the environment does not help but also in relation to the stories that we have heard, we want to make sure that women feel very supported and their partners, at what clearly is a very difficult time. That is a piece of work that has already started within the team as well.

Panel Adviser (2):
Thank you very much indeed, that is great. That is all from me but I believe that there are 2 other questions coming in from Deputy Doublet.

Deputy L.M.C. Doublet:
Yes, I just wanted to ask along the lines of data. Do you make incident reports or incident logs when something does go wrong? Is any data extracted from those? How is that data tracked and analysed to see where improvements should be made?

Chief Nurse:
We have an incident reporting system, which is web-based and live. Any incidents that occur, whether they are near misses or actual incidents themselves, are captured and recorded at the time by the clinical staff or the member of staff that is closest to the incident. Those incident reports also have a notification list attached. The key people will be on the notification list, such as the head of midwifery, the clinical lead for obstetrics, the lead midwife and various other names, individuals who have a responsibility, not only for ensuring that we understand what has happened in a very timely manner and put any immediate measures in place if we need to to reduce the risk of that happening again but also so that they have got oversight and are able to support any colleagues if need be in that incident as well. In relation to the monitoring and oversight and assurance around that, our Datix reports come up on a live dashboard, which are Women's and Children's leadership team, share with us the care group performance reviews; it is a live dashboard. If an incident had occurred that morning while you were in the meeting it would appear on the dashboard. It collates themes, you can put it any which way you want. You can put it according to the type of incident, according to the level of harm, according to the level of investigation and so on and so forth. It captures the learning and enables us not only to make sure there is learning in practice but to be able to monitor any trends arising from it. Within maternity itself they have a risk management group and they meet every Monday morning for an hour. It is a multi-professional meeting; myself and the medical

director have attended it also. It is a really fruitful meeting where everybody has an equal voice. People are able to talk about any incidents that may have occurred, any learning that needs to be put in place immediately and any feedback we have had from users in general over the course of the week as well, so whether that is complaints, feedback or compliments, they will be discussed in that meeting as well. There is a very clear process in terms of managing any incidents.

Deputy L.M.C. Doublet:

Thank you so much for the answer. Just again I am trying to get the kind of real-life perspective on what happens. Could you give an example of perhaps something recently that arose from an incident log and through this process you have just described, what improvements were made?

Chief Nurse:

Okay, I am going to hand over to Dana for that one, Deputy Doublet, just because she will have more detail on the incidents.

Head of Midwifery and Associate Chief Nurse for Health:

As with all the Datix, as Rose said, it is a Datix system that we use for incidents, one of the key things is when we start to see a trend or lots of incidents come through, we would do a deep dive. We will put in all the incidents, we will do mini audits, we will look at all the issues that have arisen. We had a spate a while ago, which we have not got now, of the incorrect labelling on a blood sample on a blood bottle, which then could not be processed. We looked at all the incidents that had been logged and there was a little spate. It was a training issue. We developed a training package. We worked with the individuals and we presented the training package at the risk meeting and disseminated that across the board and that incident process stopped through that level of education; that is how we use that process.

Panel Adviser (1):

I had one question, shall I come in now? It is Cathy.

Deputy M.R. Le Hegarat:

Yes, please, Cathy.

Panel Adviser (1):

Thank you. I just wanted to pick up on the issue of person-centred care for all women, which strikes me as a fantastic aim and one we should all be striving for. Having looked at some of the submissions that have come in, I think there is no doubt at all that many, many women in Jersey are getting fantastic care. But I have also picked up that there are a significant few who are not rating their care quite so highly. The issue that seems to come through in the submissions I have seen is

about concerns not being taken seriously and really it boils down to communication and compassion. That is not from any one group of staff, it is from all professionals. I just wondered how much work was being done on the culture that is needed to deliver a truly person-centred approach for all women, where they feel listened to, involved and taken seriously. I mean I do underpin this with there are a lot of women who are getting fantastic care obviously but I am worried about this smaller group but perhaps the most significant group in terms of getting an improvement. Any comments on that point, I wonder?

Chief Nurse:
I absolutely agree with your comments about the feedback that we have had from some of the women who have used our services. You are absolutely right, while we are pleased to say that we strive to deliver personalised care for a small few, they have clearly not had that experience. That is why it is really important that in our design of new services and our new strategy moving forward that we absolutely base it around the voice of experience.

[12:00]

There is nothing more powerful than hearing from people who have issues with services and, as, you say, it cuts right across all professional groups. One of the pieces of work that absolutely is at the forefront of maternity services at the moment is getting the Maternity Voices Partnership up and running and to make sure we have much better engagement and involvement in service planning from people who know best because they have experienced it.

Panel Adviser (1):
I suppose what I am really pushing a bit harder at is, if there is a consistent theme of specific staff members who do not seem to kind of understand that change from a more paternalistic or even maternalistic culture to one that is women-centred, what specific work would you do with staff to try and improve on that?

Chief Nurse:
Some of the specific works that we are doing is in relation to culture work with Team Jersey across the government, and the maternity services are included within that. But also there is absolutely the specifics around individual experiences that have to be fed back to individuals as well. You are right in relation to how do we change a culture whereby everybody has a positive experience of an interaction with someone when they come into services. There are a range of ways in which we can do that. There are some specifics also within the maternity service themselves that Dana is leading on with the team in the department at the moment. We also need to make sure that we tie this in

very closely with revalidation for professionals as well. I may invite Dana just to come in and just update on some of the work that she is doing at the moment.

Head of Midwifery and Associate Chief Nurse for Health:

We are developing a culture summit and we are working with an external agency with several members of staff. We know for some the culture has not been great and we want to sort of change that and move to more person-centred but also bring compassion back into the heart of the service across the whole of our service. We have identified several members of staff who we think would contribute well to our culture summit. We have improved our communication across our processes of what we are doing, where we are going. We look at complaints, we look at comments and feedbacks and compliments and we share that with the staff quite regularly. We meet with different staff groups regularly and give them updates about where we are going and where we are heading. If it is an individual, with every complaint that we would get we invite the individual in to read the complaint, to hear the woman's story or the family's story about the impacts, how they felt and what we feel we need to do differently subsequently. As Rose has previously said, we would start to link that to revalidation and process and, if need be, do some restorative supervision across the board.

Deputy M.R. Le Hegarat:

I am just going to ask a couple of questions. We are sort of rejigging a little bit because we noticed the time and we have got a significant amount of questions, so no doubt if there is anything that we need to mop up afterwards we will write to the Minister with some written questions. The question I would like to ask is: is it your intention going forward to introduce annual surveys for women parents to share their experiences of maternity services?

The Minister for Health and Social Services:

I believe and I am sure, Deputy, we will be regularly seeking to have input from those we care for. The Maternity Voices Partnership is a key part of that. We will certainly look at having formal surveys. I do not know if that has been part of any of the team's thinking at any stage. But we will want to use all the best methods of hearing from the voice of those we look after.

Deputy M.R. Le Hegarat:

Okay, thank you. Moving forward, the next person is Deputy Doublet.

Deputy L.M.C. Doublet:

We have touched on continuity of care a little bit but I wanted to ask in more detail about this area because a significant number of submissions have raised concerns about inconsistency of healthcare professionals that they have seen during pregnancy and after birth. Indeed some women have told us that they never saw the same midwife twice and they saw different middle-grade doctors

at every antenatal visit at the hospital and that the feelings that are coming out of that is this quite overwhelming feeling of not being supported from some women and also a touch of a lack of confidence in the delivery of care. I just wanted the Minister to respond to those concerns and then perhaps he could ask one of the officers to speak about what is being done to improve that piece.

The Minister for Health and Social Services:

Yes, I acknowledge how that can give rise to concerns and we would not want mothers to be anxious about that. We would want to try and improve the service to diminish those concerns. We have got some thoughts around how to do that. I would like to pass over to the chief nurse to discuss that.

Chief Nurse:

You are right to raise the issue around continuity of care for a small number of women who shared their experiences. This is something that we are looking to address at the moment within our staffing model for midwives. I mentioned that we had had a Birthrate Plus review last August and we are also looking to bring in some new roles, which is the public health midwife. All of that information is work that Dana is working on at the moment in relation to how we can provide the service differently moving forward in order that we can support women. I will have to caveat it a little bit in terms of 2020 being an extraordinary year for us, which did mean that staff could not necessarily move across departments either. That would have had a more severe impact on our ability to provide continuity than perhaps normally. But I do accept that some of the experiences that women have shared go beyond 2020, they go further back than that. If I could just invite Dana just to comment on the continuity of care model that she is currently looking at, that would be helpful.

Head of Midwifery and Associate Chief Nurse for Health:

So the continuity of care when we looked at Birthrate Plus, we did have sort of for low-risk women excellent continuity and I think the disruption in the continuity, certainly seeing the doctors, we are seeing much better continuity with the new medical model that has been in since February and obviously that is in its infancy at the moment. But early indications are saying for medical continuity that has improved. I think we have had some significant challenges with COVID and postnatally, reducing the amount of contact that we had. As that is starting to lift, I would hope that would revert back to its previous. I think we have also been challenged by recruitment and vacancies, making some of the continuity pathways quite difficult. Some of the recruitment processes have been quite slow, so that has been a bit difficult in terms of getting the right people in post to provide the continuity. But the new model moving forward, sort of more Parish-based care and we will have a higher level of continuity, rotating midwives from the hospital out into the community and a development with the public health midwife team will provide better continuity for women who need additional supports.

Deputy L.M.C. Doublet:

Can I just thank you both for your answers? I just wanted to pick up on the COVID issue. So looking at our survey results, which we have not fully released those results yet, but one of the indicators was around women who stated they did not see the same midwife at all their antenatal appointments and 55 per cent of women, who stated that, were women who had given birth before COVID. It is clear that even before COVID, while it has got worse because of COVID, it was still a problem. I just wanted to get an understanding of why that is a problem? If someone could please answer why was that an issue, the continuity of care?

Head of Midwifery and Associate Chief Nurse for Health:

I think it is part of the staffing model that resources would be pulled into supporting it naturally on the labour ward and postnatally in the acute area. We have run with vacancies. We are in a much better position vacancy wise and recruitment wise now, whereas previously we did have some gaps in the service, which would have impacted on that.

Deputy L.M.C. Doublet:

Okay. I am just trying to get an understanding of the service. The Minister has stated or the officers have stated - I cannot remember who - that we have a low birth rate. But we do, of course, have a fully equipped maternity service, given the fact that we are an isolated jurisdiction, so to me that would mean there would be excess staff time. You are saying because there are not enough staff fulfilling those roles, it is because of the vacancies mainly.

Head of Midwifery and Associate Chief Nurse for Health:

It was part due to vacancies and part due to some long-term sickness. We have had sickness absence rates which was majorly impacted through COVID but prior to COVID, which would have impacted on the amount of continuity we were able to provide.

Deputy L.M.C. Doublet:

The vacancies: what are the reasons for those vacancies, in your mind?

Head of Midwifery and Associate Chief Nurse for Health:

Difficult to say really because some of those vacancies were there before.

Deputy L.M.C. Doublet:

That might be one for Rose or for the Minister then.

Head of Midwifery and Associate Chief Nurse for Health:

Yes, I think Rose might be able to answer that better than myself.

Chief Nurse:

In relation to our vacancy turnover rate, it has been fairly consistent, I think, over the last 5 years. Some of this is natural sort of turnover because of the age of our workforce. Some of it has been because people have decided they have wanted to seek employment elsewhere. I think we saw an increased turnover during 2020 as a direct impact of COVID and that was not just within maternity services but that was in some of our other areas, where staff recognised that their family was in the U.K. and they were struggling because they were not able to see them. I think last year was an extraordinary year, again, in relation to turnover from our point of view. But generally in the maternity unit our turnover is fairly consistent and, as I say, it is usually for other reasons.

Deputy L.M.C. Doublet:

Thank you for the answer. In terms of recruitment and retention, what was being done before COVID to improve that and, in particular, were you doing exit interviews for every staff member that left?

Chief Nurse:

Yes, we do do exit interviews, well we offer exit interviews. They are not mandatory, so it is only if the member of staff wants to go through an exit interview that they are undertaken. But in relation to recruitment, we have done quite a lot of work over the last couple of years within the Government of Jersey to try and improve our recruitment processes. How we support people when they come to the Island has been a particular driver for us. Information that is available for potential candidates is better available now about working in Jersey, cost of living, what it is like to relocate to schools and all of those things that was not particularly accessible and available for candidates, so the work is being done on that. We have also put additional resource in in relation to a relocation service for new staff. There are organisations that work with the Government of Jersey who support individuals when they get a job here to source schools, housing, all of the things that are quite difficult, particularly if you have never been to the Island before. Those things we have had some really good feedback from staff in relation to the relocation service and it has made their move here really smooth. We have also managed to secure some additional housing of a better quality for our staff through the work that we have done with Andium Homes as well, so that has given us a bit more availability should staff want to go into staff accommodation for a period of time.

[12:15]

Deputy L.M.C. Doublet:

Very, very briefly, I am aware of time, in terms of retention, what is the culture and the ethos like, if you can make that a short answer? I am just trying to get an understanding of retention and why somebody would stay or go.

Chief Nurse:

I think in relation to why somebody would stay or go, I think it is quite a complex question with probably many layers in relation to an answer. But we did have a particularly older workforce in maternity for a period of time, which is absolutely valuable. Their experience is invaluable to the service but we had a cohort of midwives who were all in the same age group. Some of those midwives have now retired and we have managed to recruit into those posts. We also grow our own midwives through the University of Chester Partnership. We have a pre-registration programme for midwifery as well, which is small numbers but also adds to our sustainability in terms of adding into our workforce. I think in terms of retention, I think the feedback from the team in maternity is that the culture is good within that department, that people feel that they are involved, they are engaged. They have regular one-to-ones with their senior leaders, who are very visible and on the shop floor; they feel supported. I think it is very difficult to give an answer to that but a lot of the measures that are in place have given some really positive feedback from the staff team down there.

Deputy L.M.C. Doublet:

Thank you. I am going to pass it to Deputy Alves now. Thank you for your answer.

Deputy C.S. Alves:

My question is around the questionnaire that we have put out. In a letter to us in March you advised that a questionnaire was completed with women at their first antenatal appointment about their birth choices and is continually assessed during pregnancy with an in-depth birth discussion held at 36 to 40 weeks. However, in our survey 27 per cent of women advised that they were never asked about their preference as to where to have their baby. How do you respond to that, please?

Chief Nurse:

Dana, could you respond to this one, please?

Head of Midwifery and Associate Chief Nurse for Health:

That would not be our intention not to ask those sort of questions and that is usually part of our routine process. I would not be able to answer and say why 27 per cent of women would say that has not happened, when that is usually part of our core business of what we would do. I am not sure whether COVID would have impacted on that if that was around at that time or whether it was before or after then. I am afraid I could not answer that question.

Deputy C.S. Alves:

I see that the Minister has come on camera but I cannot hear him.

The Minister for Health and Social Services:

I do not think we have seen the results of your survey, Deputy, so I wonder if we could see the data you have collected and the questions. Then please question us on what you have and we will try and provide you with clear answers on that. I think it is difficult to respond without seeing exactly what you have collected.

Deputy C.S. Alves:

I believe those results will be shared with you, Minister; they are just currently being analysed. Once that is completed we will be sharing that with you. I think the next question I am going to be handing back to Deputy Doublet.

Deputy L.M.C. Doublet:

Apologies, I am just trying to look at the last few questions; I am aware we have only got 10 minutes. Yes, I did have a series of questions on feeding support but I think if the chair is agreeable I might ask for those to be answered as a written question after the hearing. Can I just get confirmation from the chair about that?

Deputy M.R. Le Hegarat:

Yes, I think that might be of benefit because I noticed, as you rightly say, we are sort of running fairly short of time, so we can ask for that, if the Minister is in agreement, to be able to ask all of those by way of a written submission.

The Minister for Health and Social Services:

Yes, we would be happy to do that.

Deputy L.M.C. Doublet:

Thank you. Would you like to go to 28, Mary, which I think was yours?

Deputy M.R. Le Hegarat:

Yes, that will be fine. Thank you, Louise. Are there any plans to establish a robust system of audit of adherence to policies and guidelines or a robust system of record-keeping, so as to why policies and guidelines are not adhered to?

The Minister for Health and Social Services:

From my point of view we are in a system where we do monitor these through governance arrangements. We have an escalation plan that reviews take place within care groups and are then reviewed by the quality and the risk committees and, ultimately, can come up to H.C.S. Board. We have that rigour but I will pass over to the chief nurse to talk about further detail.

Chief Nurse:

All care groups have developed audit plans, which include audits against policies and guidelines, as well as other aspects of care provision. Those mechanisms are already in place. We would expect the care groups through their own governance arrangements, as the speciality experts, to hold the governance arrangements in relation to that. As the Minister has advised, from an executive point of view we review that on a regular basis. At least monthly through the care group performance review of women and children and then through the various quality assurance committees, which then report into the H.C.S. Board.

Deputy M.R. Le Hegarat:

I do not know if there is anything else that the advisers want to ask in relation to that particular part of the questioning.

Panel Adviser (1):

Mary, I had one very specific question, if I could come in with that.

Deputy M.R. Le Hegarat:

Yes, certainly.

Panel Adviser (1):

There was a question came in about this policy around anti-D and so I looked into it and I understand that on Jersey anti-D is not given routinely in the antenatal period to all rhesus-negative women, which is the guidelines that are advised by N.I.C.E. (National Institute for Health and Care Excellence) and the R.C.O.G. I just wondered if this was a clinical decision or a financial decision. But I could not really understand why that policy would not be adhered to.

Medical Director, Health and Community Services:

I am aware of this discussion. It is not a financial, it is a clinical decision. I am aware that there are discussions taking place within the consultant obstetricians and with our haematologists and other areas looking at whether we should be moving towards the N.I.C.E. guidance that you have just described but that is ongoing discussion.

Panel Adviser (1):

Do you know when that will be concluded, Patrick?

Medical Director, Health and Community Services:

Not exactly but soon because this hub has been going on for some time. As is often the case, I am sure you are aware that doctors have varying views on this particular subject. But, yes, soon but I could not give an exact date.

Panel Adviser (1):
Yes, I did appreciate that quite some time ago there were differing views but I did think a consensus had been reached. But of course it is a question of how things do get applied locally, is it not? Thank you for that.

Deputy M.R. Le Hegarat:
I believe there may be one or 2 questions that Struan was asking, if you could ask Cathy in relation to questions 30 and 31 and then we will move …

Panel Adviser (1):
Yes, thank you, I have just seen the email. My other question really, I think Patrick has already or somebody has already talked about the changing patterns of consultants, so that is fine. But the question I had was around the head of midwifery job description. I really hoped that you might have had some applicants to that, I do not know. But when I read the job description it did not seem to me to be sort of lined up with everything else I have heard in terms of the value that is placed on the head of midwifery in terms of strategic thinking. Indeed, it did not seem to pick up the real opportunity to develop a different model of care on Jersey. I felt it kind of fell back into a rather traditional model of a head of midwifery and I thought it was an opportunity lost. I just wondered if someone could comment on that.

Chief Nurse:
Cathy, I am happy to take that question, thank you. As I explained when we met in our interview that when we restructured as a whole government department we were issued clear guidance in relation to job descriptions that had to be generic. The job description that you saw most recently is the original job description. We have been out to adverts, we have been unsuccessful in attracting any candidates. That gives us now an opportunity to rewrite the job description and I have been working with colleagues from my maternity team to do that. I agree, it is an exciting opportunity for us to look at this and consider this in light of all the exciting changes that are happening in Jersey. It is a real opportunity for the head of midwifery and the leader of that profession to take a significant leadership role in maternity provision moving forward. But I think it is fair to say that we needed to test the market against our existing job description first.

Deputy L.M.C. Doublet:

I will just come in with a couple of feeding questions, seeing as we have got through some of the other questions. Minister, we note from some of the submissions that women are suggesting that they are being strongly encouraged to breastfeed their baby but they are not being given adequate support to successfully do so and is sometimes leading to mental health issues as a result of the lack of support. Minister, I just wanted to get your response to those concerns, please.

The Minister for Health and Social Services:
Yes, Deputy. Do you mean support prenatally or while in the wards or after upon discharge?

Deputy L.M.C. Doublet:
All of those have been raised but I think mainly it is after the birth of the baby.

The Minister for Health and Social Services:
Yes, that would be support that is presently delivered through the health visitors, I guess, which is a service commissioned by C.Y.P.E.S.

Deputy L.M.C. Doublet:
No, it is the ward as well.

The Minister for Health and Social Services:
It is the ward as well, therefore, can I pass over to the chief nurse to talk about the breastfeeding champions we have and how they ...

Deputy L.M.C. Doublet:
Can I just get your view on those concerns, not from a clinical point of view but from a political point of view, given that Jersey has this goal of raising breastfeeding levels?

The Minister for Health and Social Services:
I absolutely recognise that breastfeeding gives children such an excellent start in life and can boost immune systems, can just mean that they are equipped to deal with so much more that might assail them as we move through life. Breastfeeding is what we want to allow mothers, if they make that choice, to feel free to offer it for as long as they think appropriate and to be supported in that. Anything we can do to assist is what I would back politically. But to answer specific questions, can I pass to the chief nurse?

Chief Nurse:
I think it is really important that while we encourage breastfeeding that we really make sure we focus on nutrition and good nutrition for babies. Again, in some of the feedback from women who have

used our services, we need to make sure that while breastfeeding is encouraged, women are also encouraged with other types of feeding and felt supported in that type of feeding as well. Our breastfeeding rates on discharge from the unit are really good. Of course we would like to see them higher but as they stand at the moment and with our achievements at level 1 and starting to work towards the B.F.I. (Baby Friendly Initiative) level 2, we hope to see those come up a bit more.

[12:30]

Deputy L.M.C. Doublet:
Thank you. In terms of that training and of course I am fully on board with the B.F.I. work, I wanted to just ask a question about beyond B.F.I. What level of training, Rose, do you aspire for staff to have? So what level of breastfeeding specialist training would you aspire for staff, either all the staff or specific specialist staff to have on the ward, please?

Chief Nurse:
I mean I would expect that all midwives were able to give good breastfeeding support. I would expect that all midwives were trained in breastfeeding techniques that would enable them to support any new mum on the unit.

Deputy L.M.C. Doublet:
What is that qualification called, is that universal qualification?

Chief Nurse:
I would have to defer to Dana for the name of the qualification.

Deputy L.M.C. Doublet:
Yes, happy to ask Dana that question.

Head of Midwifery and Associate Chief Nurse for Health:
We have currently got 6 breastfeeding champions who undergo the B.F.I. standards training. Our plan is to get a breastfeeding midwife specialist and once we have got that person in post and has helped leading and driving that, so when you are talking about B.F.I. and beyond, to see, I think, that 2-year window is going to give us an opportunity to see if we need a lactation consultant and properly sort of embrace that with that person in post. I think that is a wider conversation across with our health-visiting colleagues as well.

Deputy L.M.C. Doublet:

You said there were 6 champions; how many hours of training have those champions had? Also, while you are answering that question I also wanted to know: what would you say is the gold standard in terms of breastfeeding support that could be provided on the ward?

Head of Midwifery and Associate Chief Nurse for Health:
Sorry, could you repeat that?

Deputy L.M.C. Doublet:
The current training that these 6 champions have, how many hours training has that involved? Also, what is the gold standard in terms of training or qualifications? How many hours training is involved in whatever that gold standard is?

Head of Midwifery and Associate Chief Nurse for Health:
All our B.F.I. midwives have had 2 days training, so 2 full days training, so that would be about 15 hours of breastfeeding training and that work has been cascaded. Part of the transition to achieve level 2, it is all our staff will undergo the same amount of training.

Deputy L.M.C. Doublet:
The gold standard for breastfeeding support and how many hours training that would involve?

Head of Midwifery and Associate Chief Nurse for Health:
I am not sure, it escapes me at the moment but I can get back to you on that one.

Deputy L.M.C. Doublet:
Thank you for your answers.

Deputy M.R. Le Hegarat:
Just before Deputy Pamplin asks the final question, can I just ask: when do you want to have sort of achieved that gold standard in relation to your breastfeeding?

Head of Midwifery and Associate Chief Nurse for Health:
It is a work in progress at the moment. We have 2 years to do the B.F.I. but we would like to see within the next 12 months that we are at that gold standard.

Deputy M.R. Le Hegarat:
Okay, thank you. I will just ask Kevin Pamplin to ask the final question before we finish up, thank you.

Deputy K.G. Pamplin:

Yes, thank you. It has been a fascinating couple of hours and obviously my question is focused on what we have been doing with the last year and that is COVID. What lessons have you learnt from the COVID-19 situation and work that has been put in to manage the hospital and the challenges you have had?

The Minister for Health and Social Services:

I think COVID has, of course, had a huge impact on staff working in H.C.S., indeed across the healthcare sector. Measuring exactly what effect that is and what that means long term is an ongoing piece of work. But we are keen to ensure that we learn and that ways of working, which we might have developed as a result of COVID, we will take the best from them and we will bring that into our business as usual. But we also want to understand the sort of stresses staff can go through and ensure that their well-being is catered for. We have our maternity unit staff working in not ideal conditions. That creates stresses and anxieties and worries for the people they are caring for. We want to ensure that we can address that. The refurbishment of the unit is going to be a great leap forward in addressing staff issues and give staff a far better environment to work in and care for. I hope that may go some way to answering your question, Deputy.

Deputy K.G. Pamplin:

Yes, I mean of course we cannot forget that we are still going through the pandemic, even though we are the latter stages, we hope, as we go through the next few months. Obviously the big standout issue for Islanders was the unfortunate situation of not allowing partners for screening; it is a subject we have touched on during this review. But is there anything particularly, when you look back on it, how that was communicated, how that was handled? I know there were staffing issues around that and the safety of staff and everybody but is that one particular lesson you could look back on and say to us today, well, maybe we could have communicated that a little differently?

The Minister for Health and Social Services:

Yes, I will accept certainly, Deputy, one can always look back and see that we could have done things better in some of the areas; hindsight is a wonderful gift. But we must remember the pressures at the time and the immediacy of concerns being raised for infection control and the need to make the service safe. We could not put staff at risk when we were being advised that that risk existed. It was that very careful balance, we do not want to cause that concern and worry to families who are trying to bring a child into the world. But at the same time we have to maintain a safe way of working and look after our staff. That was the reason why we, not just in Jersey but even many trusts in the U.K., had to withdraw the visiting for partners for as long as it was necessary. Fortunately, it is no longer necessary and I am pleased we have been able to restore that as soon as were able.

Deputy K.G. Pamplin.:

Sure. I go back to where I first started, it is almost 35 years since the maternity service came into this building that we have been talking about: how can you reassure anybody watching this today, staff, parents, future parents, mothers who have gone through the service, that things will happen now in the interim? We cannot obviously focus on a new hospital, but we do not know the end date of that, that we will start to see the services improving and things enhanced which are working. Yes, that is a good way to end it; how can you reassure everybody today?

The Minister for Health and Social Services:

I believe, Deputy, we can demonstrate that we have very clear plans to make improvements. We have got the physical environment that is changing but also we have got our service development and we have got wonderful people in post who are looking to improve all the time, who are following an improvement plan and who are being rigorous in measuring how they are developing this service. It is the clinicians themselves that are putting this forward. It is not coming from the top down saying you shall work in this way, it is staff collaborating, learning about new ways to improve services and saying, yes, that is what we want to do for the Island. I am proud of them and they have come through difficulties in the past and they have struggled with the environment they are in. But they are so committed and dedicated to providing the very best they can for their patients.

Deputy K.G. Pamplin:

I think we would all echo that and obviously part of this review as a critical friend is to improve and enhance their working environments as well, as well as all the people who use the service. Thank you for bearing with me. I had my vaccine yesterday, so apologies if I look a little bit spaced out. I am a little bit flaky today but it was a wonderful service up there. But thank you for bearing with me and I will hand back to the chair.

Deputy M.R. Le Hegarat:

Okay. Just to say thank you very much, we have slightly run over but thank you very much to all of those that have attended this morning, both from members of the public and Ministers, alongside the panel, the advisers and obviously all those officers that have been answering the questions. If there is anything that we suddenly find that we have missed, Minister, we would be grateful if we can send you anything in writing and we look forward to speaking to you again. Thank you all very much.

[12:40]