Review of Maternity Services

Health and Social Security Scrutiny Panel

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CONTENTS PAGE

1. Executive Summary

The Panel's review sought to access the current maternity services and whether they could be improved to help better support and assist women and their families through such a momentous stage in their lives. A vast number of individuals chose to engage with the Panel's review, which spoke volumes about the desire and need for women to share their experiences. The Panel found that, in the past, there has been a lack of real engagement with those who use such services and little opportunity provided to women to have their voices heard. The establishment of the Maternity Services Partnership (MVP) is a very welcomed development and will be an excellent vehicle for enhanced communication between maternity services and women. The Minister for Health and Social Services (the Minister) should therefore ensure that the MVP reports to the maternity services leadership team on an annual basis to provide feedback from women and their families as to their experiences of the service. The Panel's own survey demonstrated that women wish to have their say on their experiences of maternity care. An annual service user survey and maternity staff survey would be fundamental in shaping a new maternity strategy and setting a bar for acceptable standards of care. In line with recommendations that were made in the UK as a result of the 2020 Ockenden Review, we have proposed that an independent senior advocate role is created within maternity services to represent women and their families to ensure their voices are heard and any concerns considered and addressed.

During our review we found that whilst an overarching strategy for maternity services was due to be developed by Health and Community Services (HCS), there was currently no system-wide agreement to a single maternity strategy which describes agreed outcome and performance goals for maternity services. Such a strategy is vital to establishing a modern maternity service that meets the need of our population. We therefore recommend that a system-wide strategy is developed without delay which includes cultural values, the proposed model of care (including choices of maternity care and continuity of carer), the maternity care pathway, expected service outcomes and a performance measurement framework. In the meantime, establishing a dedicated Maternity Services project team to drive forward the necessary transformation in maternity services is recommended.

Evidence we received throughout our review overwhelmingly supported the need for an upgrade to the current maternity unit, with a large majority of service users and maternity staff recognising that the current facilities within the General Hospital are inadequate and highly unacceptable. The Panel is therefore extremely pleased that a commitment has been made to upgrade the facilities imminently, which will significantly improve the physical environment, and that it has been backed by substantial funding. Unfortunately, however, it became apparent that there has been little consultation with women who are recent or future users of the service, or with midwives providing the services, when developing the refurbishment plans. We therefore

recommend that all maternity staff are given the opportunity to be involved at some point during the design stages of the refurbishment. We also believe that is vital that the MVP are engaged with to ensure that service user's views are taken into consideration as the project progresses. The upgrade is planned to take place in phases over a two-year period, whilst the Maternity Unit remains fully operational. We are extremely concerned that this timescale is too long and will lead to unnecessary disruption for women, their babies and for staff seeking to provide high quality care. For this reason, the Minister should engage an independent estates expert to assess the options for the upgrade work to the Maternity Unit and provide a more rapid response.

As recognised by our advisers, when assessing the quality of a service it is important to consider not only whether it is 'safe' but also whether it is effective, caring, responsive and well led. Furthermore, international policy is increasingly affirming that physical safety on its own is not enough and that services need to ensure that women are also emotionally safe. Whilst Jersey's maternity services appear to be 'safe' when considered through the lends of major empirical measures (such as perinatal mortality or major physical trauma), they seem to be lacking the emotional component of quality. Our evidence suggests that a lack of emotional safety in the delivery of care is leaving women feeling unsafe, unsupported and with negative opinions of the service. We found that a women's emotional safety can be largely impacted by the continuity of care/carer and the level of compassion and kindness provided when receiving maternity care. Whilst many women undoubtedly have a positive experience, we received shocking testimonies from women who have had confusing and inconsistent advice, not had their wishes respected and have not been treated with compassion and respect.

Whilst we found that there is a clear intent within the maternity team to provide continuity of care, it is evident that there is still room for significant improvement. To help address this matter, we have proposed that a midwife-led model of care is defined, which incorporates, at a minimum, continuity of care in the antenatal and postnatal period, with the ambition of extending this to the intrapartum period. The main objective of this model should be to ensure that care is delivered as close to home as possible, to reduce inconsistency of advice throughout a women's pregnancy and to increase women's satisfaction with the service.

We found that positive and progressive steps were currently being taken by the maternity services leadership team to address cultural and communication issues within the maternity team and to help ensure that all women receiving care feel listened to, supported and respected. A Local Committee has been established with the objective of developing the basis of a culture and behaviour strategy, which will include organisational values. Furthermore, we were advised that the strategy would provide a framework that supports and promotes regular appraisals, improving communication and enhancing interpersonal relationships within maternity services. Without such a framework we believe it is very difficult to challenge behavioural problems and underpin poor culture and therefore agree it is vital to improving the confidence of women and

their families in the care provided. We have recommended that the Local Committee includes multi professional and across sector representation and that the Culture and Behaviour Strategy is published as an integrated part of the Maternity Services Strategy. In addition, the culture strategy should be a statement of the overarching values of the service and the behaviours that will underpin those values.

Our review identified the need for a coherent Workforce Strategy to underpin the current maternity service and to support the new Maternity Strategy. Such a strategy would be vital for assessing whether the midwifery workforce is adequate to support a new model of midwifery-led care. We also found that the current leadership structure is not appropriate for providing leadership to the work required and for ensuring both a consistent clinical model and robust system of governance in maternity services. Furthermore, under the current leadership model, the voice of midwives is not heard in the right fora. In light of these findings, we have made two recommendations. Firstly, that a Maternity Workforce Strategy is developed which considers future workforce requirements, assesses different roles to support all aspects of maternity care, and explores options for staff rotations with partner organisations. Secondly, that an appropriate leadership team for maternity services is created, including the appointment of a Director of Midwifery and an Associate Medical Director, who is also Lead Obstetrician.

Whilst the majority of women that engaged with our review felt involved in the decisions about their care, some reported feeling unsupported with their choices or coerced into agreeing to the type of care received. A particular area of concern which was raised by women was in respect to infant feeding. A significant number of women reported receiving either inadequate breastfeeding support or a lack of compassion and respect about how they wished to feed their baby. We found that it is vital that the promotion of breastfeeding is underpinned by women having ready access to well trained professionals, in both the hospital and home, who provide consistent support and advice. The achievement of Stage One accreditation of the UNICEF Baby Friendly Initiative Programme amongst Health Visitors and, most recently, Maternity Services, is commendable and the identification of five breastfeeding ‘champions’ within both services is a positive step. However, recent staff and resource constraints have meant that breastfeeding champions have been unable to be released to work towards the Baby Friendly Initiative. As a result, it is unclear when Maternity Services will be ready to progress to Stage 2 of the accreditation. We have therefore recommended that breastfeeding champions are given protected time to undertake the work and training necessary to fulfil their role. We also recommend that that the whole maternity system (Midwives, GPs, Health Visitors) demonstrate a commitment to achieving full accreditation (all 3 stages) by Spring 2023.

It is widely recognised that mental health problems are often associated with times of stress or change in an individual’s life and that pregnancy and the first year after birth is a time where health professionals play a significant role in promoting mental health. Despite being advised that women were routinely asked about their emotional well-being and mental health at their

first contact with primary care or their booking visit with the midwife, 21% of respondents to our survey reported that neither their GP or midwife had enquired about their mood or feelings during pregnancy. Therefore, the Panel has recommended that every expectant mother is routinely asked about her feelings and mood at every antenatal appointment to ensure that any issues are recognised and acted upon as early as possible. There are undoubtedly positive developments being made in the field of perinatal mental health within maternity services. During our review we learnt of the approval of a business case for a new perinatal mental health pathway which is intended to improve the referral route for new parents, making it clearer and more consistent. However, progress needs to be made quickly and the impact of the investment needs to be monitored. To ensure that the Panel is kept abreast of progress and the outcome of the new pathway, we have asked to be provided with quarterly updates from HCS for assurance that maternity and mental health are working collaboratively and delivering consistent care to women and their partners.

2. Chair's Forward – Deputy Mary Le Hegarat

The Panel undertook this review on the back of feedback from individuals highlighting concerns about their experiences of maternity services in Jersey. We also wanted to establish how these services operated and what could be done in order to improve them. The Panel is pleased to highlight that this piece of work attracted a significant response from the public through the survey, written submissions and focus groups and as such we would draw attention to the strength of evidence behind the Panel's findings and recommendations.

It is clear that, whilst there is work ongoing to improve maternity services in Jersey, significant work is needed in a number of areas to ensure this is undertaken effectively. We have noted key themes arising from the review including:

1. Despite numerous reviews highlighting the current state of maternity facilities as inadequate, little progress has been made in upgrading the facilities.
2. The Panel has found that there is an inconsistency in the continuity of care for women within the current maternity services. It was also found that compassion is not always at the centre of the culture surrounding the service. Whilst steps are being taken, there is much more progress to be made.
3. The Panel has found that significant improvements are required in relation to the leadership and governance of maternity services. Due to a lack of clear goals and indicators for the service, as well as concerns around the current leadership model (which does not create the right fora for the voice of midwives to be heard), a single overarching strategy must be developed.
4. The Panel has found that there is an inconsistency in how women and their partners are involved in discussions about what care is received during pregnancy and after giving birth. Whilst the majority did feel involved in care decisions, concerns exist that these processes are not being delivered uniformly.
5. There is evidence to suggest that the current information, support and advice in relation to breastfeeding is inconsistent and, in some cases, women have reported a lack of compassion or respect for the manner in which they wish to feed their child. Clarity is required in relation to how and when this information, support and advice is delivered to expecting mothers.
6. The Panel has found that, whilst improvements are being made, significant work is still required to increase and improve mental health support for women and their families during their engagement with maternity services.
7. There is substantial evidence that women and families should be given the opportunity to have their voice heard in relation to maternity services. The Panel found that whilst work is being done to address this through the MVP , further work is required in order to improve this for women and their families.

The Panel has made a number of recommendations in relation to these areas which it hopes will provide a constructive input to assist Maternity Services in its ongoing improvement.

I am grateful to my fellow Panel Members for their input to this review and also Deputy Louise Doublet for joining the Panel in this review. Finally, I would like to thank all those who contributed to the Panel's review and for sharing their experiences, sometimes of a particularly distressing nature.

3. Key Findings and Recommendations

FINDINGS

FINDING 1: It has been recognised by the majority of service-users and maternity staff that the current maternity facilities within the General Hospital are inadequate and highly unacceptable. The Panel is therefore pleased that a commitment has been made to upgrade the facilities imminently. **[page 23]**

FINDING 2: Evidence suggests that there has been little active involvement in the refurbishment plans of the current maternity unit with women who are recent or future users or with the midwives providing services. **[page 25]**

FINDING 3: Without a clear strategy for the maternity services, the planned upgrade works appear to have been led by the need for improved estates rather than a chance to improve the model of care. **[page 27]**

FINDING 4: Standalone midwife led maternity units are a safe and cost-effective choice for women experiencing a 'normal' pregnancy and upgrading two rooms within the current maternity unit does not necessarily equate to a midwife led facility. **[page 27]**

FINDING 5: The Panel has concerns regarding the plan to refurbish the current Maternity Unit in phases over a two year period, whilst remaining fully operational, and the potential disruption this may cause to the service provided to women and their families and to the staff working in the Unit. **[page 27]**

OVERARCHING FINDING: The Panel has found that, despite numerous reviews highlighting the state of the current maternity facilities as inadequate, little progress has been made in upgrading maternity facilities in Jersey.

FINDING 6: Whilst maternity services appear to be 'safe' when considered through the lens of major empirical measures such as perinatal mortality or major physical trauma, it is the emotional component of quality that appears to be lacking at times. A lack of emotional safety in the delivery of care is leaving women feeling unsafe, unsupported and with negative opinions of the service. **[page 30]**

FINDING 7: Continuity of care contributes to improving quality and safety of maternity care. High quality evidence indicates that women who receive care in these models are more likely to have effective care, a better experience and improved clinical outcomes. **[page 30]**

FINDING 8: 58 per cent of women who gave birth in the last five years did not see or speak to the same midwife every time at their antenatal check-ups and 55 per cent did not see or speak to the same midwife when receiving postnatal care. **[page 32]**

FINDING 9: Differing advice provided to women by maternity staff, usually following the birth of their baby, has led to confusion and increased levels of anxiety. **[page 33]**

FINDING 10: Continuity of care in the antenatal, intrapartum and postnatal periods of pregnancy would improve women's trust in their caregivers and help them to build and maintain relationships and rapport. Furthermore, evidence suggests that continuity of care would also improve women's emotional wellbeing and mental health during and after pregnancy. **[page 33]**

FINDING 11: Whilst there is a clear intent within the maternity team to provide greater continuity of care, it is evident from the concerns received that there is much more progress to be made. **[page 35]**

FINDING 12: The development of a women centred midwife led model of care would enable women to receive the majority of care in community settings with a focus on normality, the family and a positive transition to becoming a mother. **[page 35]**

FINDING 13: Kindness and compassionate care is something that every woman, baby and family deserve and should expect from all midwives, doctors and members of the maternity team. **[page 37]**

FINDING 14: Whilst the majority of women who engaged with the review felt listened to, supported and respected throughout the three stages of pregnancy, a significant percentage did not receive the level of compassion and kindness that you would want, or indeed expect, when receiving maternity care. **[page 41]**

FINDING 15: Steps are currently being taken by Maternity Services to address communication issues, to bring compassion back into the heart of the service and to embed a more cohesive culture. **[page 41]**

OVERARCHING FINDING: The Panel has found that there is an inconsistency in the continuity of care for women within the current maternity services. It was also found that compassion is not always at the centre of the culture surrounding the service. Whilst steps are being taken, there is much more progress to be made.

FINDING 16: Currently, there is no system-wide agreement to a single maternity strategy which describes agreed outcomes and performance goals for maternity services. **[page 42]**

FINDING 17: Whilst a maternity strategy is being developed, a Task and Finish Group should be established to drive forward the necessary transformation to maternity services. **[page 43]**

FINDING 18: Critical indicators need to be identified and agreed to allow the maternity team to determine whether the service is of high quality. **[page 44]**

FINDING 19: Currently, there does not appear to be coherent workforce strategy which underpins maternity services or that could be used to support a new maternity strategy. Such a strategy is vital for assessing whether the midwifery workforce is adequate for a new model of midwife led care. **[page 47]**

FINDING 20: Insufficient staffing resources may be compromising the effectiveness of the care provided to mothers, babies and their families. **[page 48]**

FINDING 21: The inclusion of midwives who provide specialist services, such as perinatal mental health, safeguarding and practice development is essential to providing high quality care. **[page 50]**

FINDING 22: The current leadership structure is not appropriate for providing leadership to the work required (particularly developing a maternity strategy) and for ensuring a consistent clinical model and a robust system of clinical governance in the maternity service. Furthermore, under the current leadership model, the voice of the midwives is not heard in the right fora and both the midwifery and the medical leadership must be for the entire maternity pathway not focused on the hospital component. **[page 51]**

FINDING 23: Maternity Services policies are open to interpretation and can be applied differently according to the specific member of staff, leading to a "*discordance in care*". **[page 52]**

FINDING 24: There is an opportunity to improve the governance process of ratifying policies and standard procedures, as well as ensuring these are shared across the entire system (for example, to new midwives, junior doctors, GPs, Health Visitors, Perinatal Mental Health specialists etc.) **[page 53]**

FINDING 25: In concurrence with a previous review undertaken by the Royal College of Obstetrics and Gynaecology, it was found that more rapid progress needs to be made with ratifying policies as well as communicating and monitoring adherence. **[page 53]**

OVERARCHING FINDING: The Panel has found that significant improvements are required in relation to the leadership and governance of maternity services. Due to a current lack of clear goals and indicators for the service, as well as concerns around the current leadership model (which does not create the right fora for the voice of midwives to be heard), a single overarching strategy must be developed.

FINDING 26: There is currently no clear culture to uniformly encourage informed choice by the service, rather it appears to be largely driven by women themselves. **[page 54]**

FINDING 27: Once the refurbishment of the maternity unit is complete, women will have a choice of home birth care, traditional maternity care or birthing on the new midwife-led birth units. **[page 55]**

FINDING 28: Whilst the majority of women feel involved in the decisions about their care, some reported feeling unsupported with their choices or coerced into agreeing to the type of care received. **[page 57]**

FINDING 29: Women and their partners are not always given the opportunity to discuss or understand their options of care and are not routinely given access to evidence and guidelines to help them make informed decisions. **[page 57]**

OVERARCHING FINDING: The Panel has found that there is an inconsistency in how women and their partners are involved in discussions about what care is received during pregnancy and after giving birth. Whilst the majority did feel involved in care decisions, concerns exist that these processes are not being delivered uniformly.

FINDING 30: Maternity Services and the Health Visiting services have both achieved Stage one accreditation of the UNICEF Baby Friendly Initiative programme. **[page 58]**

FINDING 31: A significant number of women reported receiving either inadequate breastfeeding support, or a lack of compassion and respect about how they wished to feed their baby. The promotion of breastfeeding has to be underpinned by women having ready access to highly trained professionals, in the hospital, the community and at home, who provide easily accessible and consistent support and advice. **[page 61]**

FINDING 32: In some cases a lack of breastfeeding support from maternity staff and health visitors post birth and a lack of respect for women's choices as to how they wished to feed their baby had consequences for the mum's emotional well-being and mental health. **[page 62]**

FINDING 33: Staff and resource constraints have led to breastfeeding 'champions' being unable to be released for work towards the Baby Friendly Initiative. As a result, it is unclear when the Maternity Unit may be ready to progress to Stage 2 accreditation. **[page 64]**

FINDING 34: The Health and Community Services' intention is to recruit a breastfeeding midwife specialist who would help lead and drive training beyond the Baby Friendly Initiative. **[page 65]**

FINDING 35: UNICEF Baby Friendly Initiative strongly supports the view that pregnancy is the right time for midwives to discuss infant feeding and that it should be on a one to one basis around 34 weeks of pregnancy. Despite this, 29% of respondents to the Panel's survey were not provided with relevant information about feeding their baby during pregnancy. **[page 66]**

OVERARCHING FINDING: There is evidence to suggest that although there are examples of best practice within the service, overall the current information, support and advice in relation to breastfeeding is inconsistent and, in some cases, women have reported a lack of compassion or respect for the manner in which they wish to feed their child, particularly on the maternity ward. Clarity is required in relation to how and when this information, support and advice is delivered to expectant mothers.

FINDING 36: Despite relevant information being available online, we found that the majority of women that engaged with the Panel were not made aware of the maternity page on the Gov.je website during their pregnancy and did not know it existed. **[page 68]**

FINDING 37: Despite being advised that women were routinely asked about their emotional well-being and mental health at their first contact with primary care or their booking visit with the midwife, 21 percent of respondents to our survey reported that neither their GP or midwife had enquired about their mood or feelings during pregnancy. **[page 72]**

FINDING 38: A new pathway for perinatal mental health has been developed with the intention of making the referral route clearer and more consistent for expectant and new parents. The highest priority within the pathway is an emphasis on the identification of needs at the earliest point and early intervention. **[page 76]**

FINDING 39: The Panel was pleased to learn that the Health and Community Services Department has committed to recruiting a Perinatal Mental Health Midwife to better support staff providing and women receiving mental health support. **[page 78]**

FINDING 40: A lack of continuity in care during and after pregnancy could impact on the ability of a women to form trusting relationships with their midwives, leaving them feeling uneasy about discussing personal matters, such as their emotional wellbeing. **[page 79]**

FINDING 41: One in ten fathers/partners experience mental health issues during pregnancy and a year after birth. Despite this, the majority of women (314) who responded to the Panel's survey out of 656 said that the baby's father/their partner was not asked about their emotional wellbeing following the birth of their baby. **[page 79]**

FINDING 42: The quality of bereavement care can have a considerable effect on the wellbeing of parents and their families in the time immediately following the loss of a baby, as well as in the longer term. **[page 82]**

FINDING 43: Whilst midwives and neonatal are offered training in respect of baby loss, it is unclear as to whether there are currently any requirements for members of staff to receive such training on a regular basis. **[page 82]**

FINDING 44: Delays in the delivery of de-brief sessions following traumatic births can negatively impact parents' mental health. However, we found that, in the majority of cases, women and their partners are not offered the opportunity to ask questions about their labour. **[page 83]**

FINDING 45: There are undoubtedly positive developments being made in the field of perinatal mental health within maternity services. However, progress needs to be made quickly and the impact of the investment needs to be monitored. **[page 84]**

OVERARCHING FINDING: The Panel has found that, whilst improvements are being made, significant work is still required to increase and improve mental health support for women and their families during their engagement with maternity services.

FINDING 46: The establishment of the Maternity Services Partnership is a very welcomed development and is an excellent vehicle for enhanced communication between maternity services and women and to ensure continuous involvement of, and feedback from, women and their families. **[page 86]**

FINDING 47: The Panel's own survey, with a high level of respondents, demonstrated that women wish to have their say on their experiences of maternity care. The development of a maternity survey that collected the views of the women on a regular basis would be extremely beneficial for collating and assessing service users' experiences. **[page 87]**

FINDING 48: One of the immediate actions that was recommended following the 2020 Ockenden Review in the UK was that all Trusts must create an independent senior advocate role to ensure that women and their families are listened to and their voices heard. **[page 88]**

OVERARCHING FINDING: There is substantial evidence that women and families should be given the opportunity to have their voice heard in relation to maternity services. The Panel found that whilst work is being done to address this through the Maternity Voices Partnership, further work is required in order to improve this for women and their families.

Recommendations

RECOMMENDATION 1 The Minister for Health and Social Services must ensure that all Maternity Staff are given the opportunity to be involved at some point during the design stages of the Maternity Unit refurbishment. The Minister must also engage with the Maternity Voices Partnership, and the public in general (including fathers/partners), to ensure that recent and future users of the service are able to share their views. **[page 25]**

RECOMMENDATION 2: The Minister for Health and Social Services should engage an independent estates expert to assess the options for the upgrade work, including a standalone midwifery-led unit, to the Maternity Unit and provide a more rapid response. **[page 28]**

RECOMMENDATION 3: The Minister for Health and Social Services must ensure that a midwife-led model of care is defined which incorporates, at a minimum, continuity of care in the antenatal and postnatal period, with the ambition of extending this to the intrapartum period. The main objective of the model should be to ensure that care is delivered in the home, or as close to home as possible, to reduce inconsistency of advice in both the antenatal and postanal periods, and to increase women's satisfaction with the service. **[page 35]**

RECOMMENDATION 4: The Minister for Health and Social Services must ensure that the Local Committee, developed following the initial Culture Summit, includes multi professional and across sector representation and that the Culture Strategy is published as an integrated part of the Maternity Services Strategy. Furthermore, the Culture Strategy should be a statement of the overarching values of the maternity service and the behaviours that will underpin those values. **[page 41]**

RECOMMENDATION 5: The Minister for Health and Social Services must ensure that a system-wide maternity strategy is developed without delay which includes cultural values, the proposed model of care (including choices of maternity care and continuity of carer), the maternity care pathway (community/parish led maternity service), expected outcomes, performance measurement framework with KPIs/benchmarks and approach to oversee policy development. **[page 42]**

RECOMMENDATION 6: The Minister for Health and Social Services must establish a system wide Maternity Task and Finish Group that is accountable to the Independent Jersey Care Model (JCM) Board. This should include a dedicated project manager. The remit of the Group should be to drive forward the development of the Maternity Strategy and to undertake the recommendations identified in the Panel's report. **[page 43]**

RECOMMENDATION 7: The Minister for Health and Social Services must establish a comprehensive system of performance management, including an annual service user survey and staff survey, to enable benchmarking against other appropriate maternity services. **[page 44]**

RECOMMENDATION 8: The Minister for Health and Social Services should establish a dashboard similar to the new National Maternity Dashboard to enable easy comparisons, such as Clinical Quality Improvement Metrics, with other maternity providers. The dashboard should be made publicly available. **[page 44]**

RECOMMENDATION 9: The Minister for Health and Social Services should engage the Jersey Care Commission to support the maternity system to establish a robust and measurable quality framework, with suitable resources allocated. **[page 45]**

RECOMMENDATION 10: The Minister for Health and Social Services must develop a maternity workforce strategy to consider future workforce requirements, assess different roles to support all aspects of maternity care and explore options for staff rotations with partner organisations. **[page 47]**

RECOMMENDATION 11: The Minister for Health and Social Services should develop an appropriate leadership team for maternity services, including the appointment of a Director of Midwifery and an Associate Medical Director, who is also Lead Obstetrician. **[page 51]**

RECOMMENDATION 12: The Minister for Health and Social Services must endeavour to complete all actions from the Royal College of Obstetrics and Gynaecology reviews of maternity services and have a complete set of key organisational policies in place by the end of 2021 **[page 53]**

RECOMMENDATION 13: All birthing women and their partners should routinely be provided with evidence and information concerning their options in respect of pain relief and birth choices, highlighting benefits and risks, and given the opportunity to discuss and understand these prior to labour. All information should be delivered clearly and in a non-judgemental way. **[page 57]**

RECOMMENDATION 14: The Minister for Health and Social Services should consider opportunities to better link breastfeeding and perinatal mental health support services together and train volunteers locally to provide peer support services. **[page 62]**

RECOMMENDATION 15: The Minister for Health and Social Services must ensure that breastfeeding champions are given protected time to undertake the work and training necessary to fulfil their role. **[page 64]**

RECOMMENDATION 16: The Minister for Health and Social Services must ensure that the whole maternity system, including GPs, Midwifery, Neonatal and Health Visiting services, demonstrates a commitment to achieving Baby Friendly status and that the plan to achieve BFI full accreditation by Spring 2023 is owned by every service, adequately resourced and closely monitored. **[page 64]**

RECOMMENDATION 17: The Minister for Health and Social Services must ensure that the utmost priority is given to appointing a specialist breastfeeding support midwife by the end of Q1 2022 to champion the UNICEF standards and mentor/upskill staff whose breastfeeding support skills require refinement. **[page 65]**

RECOMMENDATION 18: The Minister for Health and Social Services should ensure that relevant information about infancy feeding and, specifically, how to deal with breastfeeding issues, is provided to women and their families routinely during their antenatal appointments. **[page 65]**

RECOMMENDATION 19: The Minister for Health and Social Services should ensure that the "Pregnancy and birth' page on the Gov.je website is regularly updated and that women are made aware of the website during the very early stages of pregnancy. **[page 68]**

RECOMMENDATION 20: The Minister for Health and Social Services must ensure that every expectant mother is routinely asked about her feelings and mood at every antenatal appointment to ensure that any issues are recognised and acted upon as early as possible. **[page 72]**

RECOMMENDATION 21: The Minister for Health and Social Services must appoint a specialist perinatal mental health midwife by the end of Q1 2022. **[page 78]**

RECOMMENDATION 22: The Minister for Health and Social Services must ensure that, when recruited, the Perinatal Mental Health Midwife organises and encourages education and training of all midwives in perinatal mental health and the delivery of care to make sure there is a consistent assessment and referral across all services. **[page 78]**

RECOMMENDATION 23: The Minister for Health and Social Services must introduce guidance which ensures that all fathers/partners are routinely asked about their mental health (either directly or through the mother) during pregnancy and following the birth of the baby. The Minister should ensure that as part of the pathway, access to mental health support for fathers/partners should be expedited. **[page 79]**

RECOMMENDATION 24: The Minister for Health and Social Services should consider the recruitment of a bereavement midwife, or the training of a current midwife into this position, in order to better support families going through baby loss. **[page 82]**

RECOMMENDATION 25: The Minister for Health and Social Services should ensure that the de-brief service following birth is universally offered to women and adequately resourced. Women and their families should be made aware of the service postnatally whilst both in hospital (if the women had a hospital birth) and at home. The Minister should ensure that adequate

mental health support is available to diagnose and treat women with birth-trauma-related Post Traumatic Stress Disorder (PTSD) symptoms. **[page 83]**

RECOMMENDATION 26: The Minister for Health and Social Services should provide quarterly updates to the Panel in respect of the new perinatal mental health pathway for assurance that maternity and mental health staff are working collaboratively and delivering consistent care to women and their partners. **[page 84]**

RECOMMENDATION 27: The Minister for Health and Social Services must ensure that the Maternity Voices Partnership reports to the maternity services leadership team on an annual basis to provide feedback from women and their families as to their experiences of the service

RECOMMENDATION 28: The Minister for Health and Social Services should request feedback of families on their experiences of maternity care. This could be an annual or a bi-annual survey and/or during the six-week and two-year checks. **[page 86]**

RECOMMENDATION 29: The Minister for Health and Social Services should create an independent senior advocate role within maternity services which reports to the Health and Community Services Executive Team. **[page 88]**

4. Introduction

Background and Context

It has been widely recognised by the Health and Community Services Department, maternity staff and services users that the current maternity unit within the hospital is inadequate to provide acceptable care to women, their partners and babies. The Health and Community Services Department has recently lodged an application to upgrade the unit and whilst it is significantly overdue, any improvements to the current facilities are extremely welcomed.

Whilst the Panel itself had not received any direct concerns from members of the public regarding maternity services before launching this review, a number of concerns had been brought to the attention of another States Member. Primarily, concerns had been raised and complaints made regarding maternal mental health and the support available. The Panel was advised that some members of the public had mentioned an absence of leadership and direction in this area and the lack of expertise/training of staff. Another issue that was brought to our attention was the impact of fathers/partners being unable to stay with the mum and baby for a prolonged period following birth.

Maternity services in the UK have recently been the focus of scrutiny following the publication of the Ockenden Report in 2020. In the report, Donna Ockenden inferred that maternity services risked becoming organisations that lacked memory. The Ockenden Report was the fourth Public inquiry into Maternity Services in England and sadly the themes and concerns raised were the same themes that ran through the three previous reviews into Northwick Park 2008, Morecambe Bay 2015 and Saving Babies Lives 2019. Whilst the investigation that led to the Ockenden Report focused on the deaths of babies at two hospitals (Shrewsbury and Telford NHS), the report made system-wide suggestions and recommendations for action to improve maternity care throughout England. The 7 immediate and essential actions were:

- Enhanced Safety
- Listening to Women and Their Families
- Staff Training and Working Together
- Managing Complex Pregnancy
- Risk Assessment Throughout Pregnancy
- Monitoring Foetal Wellbeing
- Informed Consent

Key Statistics

In 2020, there were a total of 866 births in Jersey, which was a slight decrease from 2019 where there were a total of 882 births on the Island.

37% of all deliveries in both **2020** and **2019** were **via C-section**

19% of all deliveries in **2020** were **unscheduled C-section**

19% of all deliveries in **2019** were **unscheduled C-section**

21% of all deliveries in **2020** were **scheduled C-Section**

18% of all deliveries in **2019** were **scheduled C-Section**

2% of all deliveries in **2020** were **home births**. As of the end of February 2021 **8%** of all deliveries had been home births.

3% of all deliveries in **2019** were **home births.**

26% of all women who gave birth in **2020** were induced.

24% of all women who gave birth in **2019** were induced.

The Panel's Review

The Panel wished to undertake a review of Maternity Services in Jersey in order to gain an understanding of what was available for our public and whether it was adequate. More specifically, we wanted to determine whether the current provision for parental mental health care was sufficient, whether the care provided during the antenatal, intrapartum and postnatal stages of pregnancy was safe and effective and whether the current policies relating to maternity services and their application were appropriate. Inviting members of the public to share their

views and experiences with the Panel on maternity services was also paramount to our review. The submissions from the public and the survey that we undertook allowed us to better understand the services provided to parents and how these could be improved going forward. We are therefore extremely grateful to those who chose to engage with the Panel.

To assist with its review of Maternity Services, the Panel engaged an adviser to provide technical and specialist expertise. Following a tendering process, Attain were appointed as the Panel's advisor. The Adviser was asked to produce their own report on Maternity Services which would contain their own findings and recommendations. Attain's report can be found appended to the Panel's report in Appendix 2.

Methodology

Since the Panel began its review in February of this year, we have undertaken the following:

- Launched the review on the States Assembly website and on social media outlets
- Conducted a general public call for evidence via social media
- Sent letters to targeted stakeholders asking for their feedback on maternity services
- Engaged 4insight to undertake focus groups with members of the public to hear their views. The groups were separated as follows:
  - Mums with children aged between 0-6 months
  - Mums with children aged between 6 months and 3 years
  - Expecting mums
  - Fathers/partners
  - Health Care Professionals
- Created a targeted survey for mums who had given birth in the last 5 years which sought their views on the current maternity services. The survey went live on 18th March 2021 and ended on 5th April 2021. In total 655 people responded to the Panel's survey. The results of the survey will be referenced throughout our report, but a summary of the results can be found here.
- Held a Public Hearing with the Minister for Health and Social Services and his Officers on 13th April 2021.

Report Structure

It should be noted that the Panel's report does not attempt to address all areas of maternity services in Jersey. Rather, we have focused on, what we believe to be, the key areas of interest and the main areas of concern as a result of the consultation we have carried out with the public, key stakeholders and our own examination of the information provided to us.

5. The Current Maternity Facilities and Planned Upgrade

In 2015, the previous Health and Community Services Minister claimed that the safety of Jersey's maternity theatre was "borderline unsafe". Following these comments, the Director of the Hospital, at the time, admitted that Jersey's maternity unit needed major investment to bring the unit up to acceptable standards. It was further suggested that the Department would be unable to continue performing in its current state until a new hospital was built (which at the time was anticipated for 2023).

The Hospital Director identified the following amongst the highest priorities:

- Inadequate toilet facilities, particularly for female patients but also for male visitors.
- The lack of baths, which prevents this type of pain relief being given to women.
- The lack of a plumbed-in birthing pool.
- The lack of temperature control which can lead to uncomfortably high temperatures in the summer for both patients and staff.

In September 2020, the Health and Community Services Department lodged an application to upgrade the maternity unit, for the first time in 25 years and partly in response to the Covid-19 pandemic. According to the application, the unit needs expanding, and several areas require updating in line with modern practices (despite the development of the new hospital).

In a letter from the Women's, Children's & Family Care Group Senior Leadership Team in March 2021, we were advised that:

> *"The staff feel the Maternity Unit in its current state is not conductive to a comfortable and a positive experience for women, their families and their babies. Nor is it a conductive working environment for staff.*[1]

Current Facilities

The current maternity provision includes a seventeen bedded antenatal and postnatal ward and six birthing rooms, one of which can accommodate a birthing pool. The maternity unit provides 24 hour obstetric and anaesthetic cover and access to a designated Obstetric Theatre. In

[1] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021

addition, there is currently an eight bedded Special Care Baby Unit (SCBU) and a bereavement suite.

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

We have been told that a number of environmental issues within the Maternity Department have been identified that need to be addressed in advance of the new 'Our Hospital' project and therefore the rational for the recently proposed upgrade. These include:

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

In addition, the current environment does not provide visitor or partner toilets on the inpatient ward. According to the Midwifery Team, this impacts on the experience of visitors as they have to leave the Unit to access facilities and then may be left waiting to gain access on their return.

In respect of the current facilities the NSPCC commented:

> *"It is our view that the current maternity facilities are not fit for purpose and are outdated. We feel that the facilities have an impact on service users' dignity and ability to have a positive experience during their pregnancies. We welcome the proposed plan to upgrade the maternity facilities. We would hope that these would happen with minimal delays[2].*

The Panel received a substantial number of written submissions which supported NSPCC's statement and perpetuated the Panel's concerns regarding the standard of the current facility within the General Hospital. Some examples of the comments made have been provided below.

[2] Written Submission, NSPCC, 15th February 2021

> *The fact that the labour rooms don't have en-suite facilities is astonishing and as I felt I needed the loo every five minutes that walk down the corridor was awful!! I was worried I wouldn't get to the loo in time and hung on to the wall for dear life when I felt a contraction…not to mention passing other labour rooms and listening to other women some of which were louder than others.. to which can put the fear of god in you.*[3]

> *The shower room provided is on an open corridor with only a little screen covering the door. Is this for safety reasons? There has to be a better solution so patients can shower with more privacy? The shower room itself could do with an overhaul it's too small. Air-Conditioning is desperately needed. I prepared by bringing in my own fan as I was made aware of the lack of fans available*[4]

> *I had a private room and there was an ant infestation which wasn't sorted despite reporting. The bed linen was not changed once since I was there 3 night and very much needed too. The floors were also not mopped. They needed to be more clean.*[5]

> *The staff were amazing but the unit itself was tired, badly ventilated, incredibly clinical for those of us choosing a natural birth, and just isn't quite the birthing centre atmosphere that you'd hope for in 2021.*[6]

> *The shower was in a well used corridor with a screen used instead of the door 'because it gets too hot', I could see people walking past, and hear them talking, and I was always concerned that anyone could easily look in. The toilet was down a corridor and shared with other mothers. Partners could not use the toilet and had to find a toilet elsewhere in the building, leaving mum and baby and risking more touch points re covid. I walked to the toilet in my dressing gown with blood and blood clots leaving my body. Movement is not easy following birth so the walk was long and slow. The shared toilet would be covered in my blood and I always felt rushed to finish and clean up for the next person.*[7]

> *The maternity ward is very noisy and needs to be more soundproof - midwife station and buzzers very noisy.*[8]

During our review we learnt of a staff survey that had been undertaken with community and hospital midwives regarding many of the issues that the Panel was addressing within its review. The survey was commissioned by the Interim Head of Midwifery and the responses were

[3] Written Submission, Tracey, 11th February 2021
[4] Written Submission, Gemma, 11th February 2021
[5] Written Submission, Anonymous 3, 9th February 2021
[6] Written Submission, Jess, 9th February 2021
[7] Written Submission, Anonymous 1, 9th February 2021
[8] Written Submission, Anonymous 3, 9th February 2021

provided on an anonymous basis to the Panel by the Interim Head of Midwifery. In respect of the adequacy of the current maternity unit, all of the midwives (17) who responded to the survey shared similar concerns to those that have been expressed by service users. In addition, respondents commented on the impact of the state of the facilities on staff morale and discussed the inability to support women to the best of their ability within such an environment.

FINDING 1: It has been recognised by the majority of service-users and maternity staff that the current maternity facilities within the General Hospital are inadequate and highly unacceptable. The Panel is therefore pleased that a commitment has been made to upgrade the facilities imminently.

Proposed upgrade

The detailed plans of the refurbishment can be found here. In summary here, the planned works will provide:

- A new Bereavement Room
- A new SCBU area
- Six new birthing rooms with en-suite facilities (two of which will be midwifery led)
- Four new private rooms
- Collas ward 1 & 2 will each have 1 new bathroom/wet room facility per four beds
- Collas ward 3 will have one new wet room for three beds
- "Hot patient" areas for patients with Covid-19 or with a higher risk of infection.

The current Maternity Unit does not have a plumped-in pool for birth so in addition to the above we are aware that Midwives have worked with the Estates Management Department to ensure that provision for water birth is available.

We were advised that a number of steps have also been taken to comply with current infection control standards. For instance, in order to ensure Infection Prevention and Control measures are maintained to minimise risk to women, babies and families, measures are being undertaken including; cleaning rotas, hand hygiene audits, personal and protective equipment audits and touch point cleaning. The bed capacity was also reduced from 20 to 17 beds in 2020 to comply with Infection Prevention and Control measures which has increased the space between each bed.[9]

One of the main concerns raised by members of the public in respect of the current maternity unit is the lack of facilities for fathers/partners to stay with the mother and the baby following the birth. For instance, some families wrote to us about the effects of not letting fathers/partners

[9] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021

stay in the hospital, with some being told to leave very soon after a difficult labour resulting in the mother feeling unsupported and, on occasions, causing further emotional trauma. There were also concerns regarding the inconsistently in the message conveyed to families about the father/partner permitted to stay following the birth of their baby. It appears that some fathers (usually those whose partners and babies are in private rooms) are being permitted to stay for longer periods of time. Due to the cost of staying in private rooms, this may be leading to inequalities in the care and options available to parents. The Panel believes that this is something that needs to be addressed by Health and Community Services and the Minister going forward.

We queried this with the Minister for Health and Social Services at our Public Hearing in April and were advised that more will be done going forward to support partners and, whilst consideration will have to be given to safeguarding when designing facilities to accommodate partners, they will be incorporated in all of the plans.[10]

The Panel was really keen to establish how much discussion had been undertaken with midwives about a change in policy to allow partners to stay and when that policy would be in place. For instance, when would a community midwife be in a position to say to women and their partners: "You will be able to stay if you want"? The Interim Head of Midwifery informed the Panel that currently, as a result of the pandemic, private room facilities were being utilised to safeguard those needing isolation. However, we were also told that the matter would be revisited once the measures on visitors had been lifted and Jersey was completely out of the pandemic.[11] With regards to this matter, our advisers noted:

> *"Whilst we have been advised that one aim is to develop more midwife led care and that there is a desire to enable partners to be as involved as they wish, including staying overnight, not only have we not seen policies related to these desires, we have very limited assurance that the planned refurbishment will address these.[12]*

Regarding consultation in general, we wanted to understand who had been involved in, and contributed to, the development of the refurbishment plans. A letter to the Panel from the Women's, Children and Family Care Group Senior Leadership Team in March advised, that in 2016, midwifery staff engaged with service users via the Maternity Liaison Committee to gather the views of service users regarding the current Maternity Unit and proposed Unit within the new Hospital. We were also told that staff opinions had contributed to the planned refurbishment through midwifery representation on the refurbishment group.[13] One of the questions that was asked in the staff survey, that the maternity leadership team undertook with Midwives, was

[10] Public Hearing, Minister for Health and Social Services, 13th April 2021
[11] Public Hearing, Minister for Health and Social Services, 13th April 2021
[12] Attain Report, May 2021
[13] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021

whether they were aware of the refurbishment plans that were due to begin in June this year. Whilst the majority of the respondents said that they knew about the plans, a number of midwives revealed that they had not been consulted on the plans or, when they had been consulted, their thoughts and opinions had not been taken on board. For example, one member of staff commented:

> *I feel disappointed that midwives have not been consulted on the design and development of the refurbishment – I feel our thoughts and opinion would have been hugely insightful and valuable.*[14]

In addition, a number of staff members were sceptical about whether the refurbishment would take place all together, after years of repeated promises of improvements and nothing being done.

FINDING 2: Evidence suggests that there has been little active involvement in the refurbishment plans of the current maternity unit with women who are recent or future users or with the midwives providing services.

RECOMMENDATION 1: The Minister for Health and Social Services must ensure that all Maternity Staff are given the opportunity to be involved at some point during the design stages of the Maternity Unit refurbishment. The Minister must also engage with the Maternity Voices Partnership, and the public in general (including fathers/partners), to ensure that recent and future users of the service are able to share their views.

Timeline and funding

We are aware that the anticipated commencement date for the refurbishment is June 2021 and is due to be completed in 2023. The main components of the scheme include the refurbishment of the existing birthing rooms to provide en-suite facilities, as well as providing a new large SCBU. In order to increase the size of the SCBU, a single storey extension will have to be constructed within the existing first floor courtyard. It is proposed that the works would be undertaken in a phased manner whilst the existing unit is maintained as fully operational. According to the Minister for Health and Social Services, the intended phased approach is the reason why the upgrade will take two years to complete:

> *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.*[15]

[14] Maternity Staff Survey, Health and Community Services April 2021
[15] Public Hearing, Minister for Health and Social Services, 13th April 2021, p4

The intention to undertake building work on the maternity unit whilst remaining fully operational concerned the Panel in respect of the level of disruption that the works could cause to both service users and staff over a prolonged period of time. When we raised our concerns with the Minister, we were reassured that the upgrade has been "*very well planned to avoid any disruption"*[16]*.* However, a midwife raised a similar concern in response to an internal survey stating:

> *I understand it will take over 2 years to complete and it's a staged process. It will be noisy, messy and provide a very poor environment for the women and babies to labour, deliver and recover in.*[17]

The Panel queried the anticipated cost of the refurbishment of the maternity unit during the hearing with the Minister. We were encouraged to learn that a figure of £6 million had been set aside from the capital programme to invest in the upgrade of the facility.[18]

Modernising the service in addition to the physical environment

In the Public Hearing in April we questioned the Minister as to the possibility of modernising the maternity service itself at the same time as upgrading the physical environment. We were advised that a lot of work was currently being undertaken by the leadership team within Women's and Children's Services to modernise midwifery care and the medical model of provision. We were also assured that it was possible to continue to improve the service whilst the upgrade was being completed. When we pressed the Minister and his Officers on the nature of the service-led improvements that had recently been made to the service, or were looking to be made, and what this would look like to service users, we were told of the following:

- The medical model has been streamlined; maternity services is now aligned to consultants, high-risk clinics and medical morbidity clinics in order to increase the level of continuity of care that women are receiving.
- Maternity is growing and developing its home birth services for women and therefore providing greater choice.
- Consideration is being given to a new midwifery-led workforce model and the aim is to transition into a more midwifery led care in the community.
- Focusing efforts on building up better continuity of care for high-risk women.[19]

In respect of mid-midwifery led care and the ambition for a new midwifery-led workforce model, we queried whether there was an intention to create a midwifery-led unit within the newly

[16] Public Hearing, Minister for Health and Social Services, 13th April 2021, p4
[17] Maternity Staff Survey, Health and Community Services April 2021
[18] Public Hearing, Minister for Health and Social Services, 13th April 2021
[19] Public Hearing, Minister for Health and Social Services, 13th April 2021

refurbished maternity unit. It was confirmed that there would be a midwife-led area, including 2 midwife-led birthing rooms. Whilst there will be a separate area for that within the unit, it will remain within the footprint itself. Therefore, once the refurbishment had been completed women will have a choice of traditional care, home birth care or birthing on the midwife-led birth units.[20]

During our review there have been several suggestions of constructing a standalone midwife led unit instead of simply updating the current unit in the hospital to include two midwife led rooms. In their report, our advisers affirmed that standalone maternity units are a safe and cost effective choice for women experiencing a 'normal' pregnancy and that upgrading two rooms within the current maternity unit did not necessarily equate to a midwife led facility. When we queried whether this option had been given considered by the Department we were told that whilst the construction of a modular unit, outside of the maternity unit connected to the delivery suite, was considered in relation to a midwifery led unit (MLU), it was felt that the most financially and operationally viable approach was to have the MLU co-located within the maternity unit.[21]

In respect of the proposed refurbishment to the currently maternity unit and in light of the above, our advisers summarise as follows:

> *"The budget for the refurbishment is considerable (£6 million), which is a testament to the paucity of the current facility and also the commitment from the Government to address these issues. Without a clear strategy for the maternity services the planned upgrade works appear to have been led by the need for improved estates rather than a chance to improve the model of care. This seems to be a missed opportunity. Ideally the options appraisal/business case should be revisited to include this, and the options appraisal published especially as there is no clear timetable as to the new hospital build but on the other hand there is a strong case to be made for getting on with the upgrade over as short a period as possible."* [22]

FINDING 3: Without a clear strategy for the maternity services, the planned upgrade works appear to have been led by the need for improved estates rather than a chance to improve the model of care.

FINDING 4: Standalone midwife led maternity units are a safe and cost-effective choice for women experiencing a 'normal' pregnancy and upgrading two rooms within the current maternity unit does not necessarily equate to a midwife led facility.

FINDING 5: The Panel has concerns regarding the plan to refurbish the current Maternity Unit in phases over a two year period, whilst remaining fully operational, and the potential disruption

[20] Public Hearing, Minister for Health and Social Services, 13th April 2021
[21] Letter, Minister for Health and Social Services, 29th April 2021
[22] Attain Report, May 2021

this may cause to the service provided to women and their families and to the staff working in the Unit.

RECOMMENDATION 2: The Minister for Health and Social Services should engage an independent estates expert to assess the options for the upgrade work, including a standalone midwifery-led unit, to the Maternity Unit and provide a more rapid response.

OVERARCHING FINDING: The Panel has found that, despite numerous reviews highlighting the state of the current maternity facilities as inadequate, little progress has been made in upgrading maternity facilities in Jersey.

6. Safety and Effectiveness of Maternity Care

In Jersey, the provision of care along the maternity pathway is given by a range of professionals in a range of care settings. According to our advisers, there is inconsistency in the implementation of the pathway which means that there is an unacceptable variation in the service experienced by individual women.[23] However, generally, in Jersey, the majority of women see a GP at the very beginning of their pregnancy and go on to receive the majority of their antenatal care from midwives and GPs. If a pregnancy is high risk, women tend to receive care from hospital-based midwives and obstetricians. The majority of deliveries are supported by midwives and medical professions in the hospital setting, although, as we will discuss later in our report, an increasing number of women are now accessing home birthing care which is extremely positive. Not only does this suggest that women feel more able to make choices that are right for themselves and their babies, but it has been found that low risk women who have homebirths are less likely to get an infection, have a better chance of a vaginal birth after a caesarean and their baby has less chance of being admitted to a neonatal department.[24] Following birth and once out of hospital, both community midwives and health visitors, who are employed by Family Nursing and Home Care, provide postnatal support to parents.

For many people, safe maternity services mean an outcome of a physically healthy mother and baby. However, numerous studies have found that safety is not just about whether a baby lives or dies. Safety for childbearing women and their partners and families also means emotional, psychological and social safety. For instance, emotional safety could include women being treated respectfully, involved in decisions about their care and feeling listened to, as well as having their emotional and mental health needs met. According to our advisers, international policy is increasingly affirming that physical safety on its own is not enough and that services need to ensure that women are also emotionally safe.

In addition, we note that the term ‘safe’ is only one component of a high-quality service. For instance, the CQC (Care Quality Commission) Framework outlines the following as components of a high-quality service – safe, effective, caring, responsive and well led.

Our advisers found that, when considered through the lens of major empirical measures such as perinatal mortality or major physical trauma to mother and baby, Jersey’s maternity services do appear to be ‘safe’. However, what did concern the advisers and Panel alike was the lack of emotional safety in some cases which left women feeling unsafe, unsupported and with negative opinions of the service due to their treatment.[25] It is the emotional component of quality that

[23] Attain Report, May 2021
[24] www.nct.org.uk
[25] Attain Report, May 2021

ensures women and their families embark positively on their parenting journey and it is therefore imperative that this is considered equally alongside physical safety.

FINDING 6: Whilst maternity services appear to be 'safe' when considered through the lens of major empirical measures such as perinatal mortality or major physical trauma, it is the emotional component of quality that appears to be lacking at times. A lack of emotional safety in the delivery of care is leaving women feeling unsafe, unsupported and with negative opinions of the service.

Continuity of Care and Support

Continuity of care has been defined as having three major types – ***management, informational and relationship.***

Management *continuity involves the communication of both facts and judgements across team, institutional and professional boundaries, and between professionals and patients.* ***Informational*** *continuity concerns the timely availability of relevant information. Both are important to managers and health care users.* ***Relationship*** *continuity means a therapeutic relationship of the service user with one or more health professionals over time.*[26]

According to the Royal College of Midwives, *"Continuity of care contributes to improving quality and safety of maternity care. High quality evidence indicates that women who receive care in these models are more likely to have effective care, a better experience and improved clinical outcomes."* This finding is supported by many different studies undertaken by professionals within the field of maternity care. In light of this, we wished to explore the subject of continuity of care within our own review.

FINDING 7: Continuity of care contributes to improving quality and safety of maternity care. High quality evidence indicates that women who receive care in these models are more likely to have effective care, a better experience and improved clinical outcomes.

In a letter from the Women's, Children's & Family Care Group Senior Leadership Team that we received in March this year we were told how crucial continuity of care was in building a rapport with women and enabling them to make informed choices about their care. Whilst the team recognised that the ability to offer continuity of care was affected due to the Covid-19 pandemic, we were told that it is improving now midwives were back working in GP surgeries.[27]

[26] The Contribution of continuity of midwifery care to high quality maternity care, Professor Jane Sandall CBE, Royal College of Midwives
[27] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021

As acknowledged by the maternity team, the rapport between the primary midwife and the woman encourages autonomy, choice and birth preference. In their view, women with low risk pregnancies in Jersey develop good relationships with their midwife and receive "*excellent continuity of care*". Rather, it is the women with high risk pregnancies who are assessed as requiring Consultant led care who they feel have not previously had the same level of continuity from midwives and doctors. We were advised that efforts are being made to address this with a newly implemented Medical Model. The model has been in place since February this year and means that Consultants are now aligned to clinics and women will be booked into clinics depending upon their specific needs, such as perinatal mental health clinics, foetal medicine clinics and high-risk clinics. Whilst the model is still in its infancy, we were told by the Interim Head of Midwifery that early indications are showing that medical continuity has improved. In respect of further planned improvements, it was advised that work was underway to align midwifery staff to clinics and promote continuity and advocacy for safe birth and to support women in their decision making.[28]

An overall lack of continuity of care during and after pregnancy was one of the main areas of concern raised in the written submissions that we received from members of the public and a main theme identified by 4inight in the focus groups/interviews that they conducted. Those who raised this as a concern reported feeling unsupported, lacking confidence in the delivery of care and unable to build rapport with health professionals:

> *I had a different midwife at every visit to my doctor's surgery- where possible, I think that mothers should have one designated community midwife to build up a rapport with. My surgery is indigo medical.*[29]

> *I also wish to mention that throughout my pregnancy and after birth I never saw the same midwife twice. This inconsistency of care was not good and did not fill me with confidence.*[30]

> *Secondly, it's disappointing how many different people you see in relation to your pregnancy. I have seen a number of sonographer and midwives. You should be dedicated members of staff and stay with them throughout. Having to explain time and time again your circumstances, wishes, feelings, experience etc to each person would not be necessary if you saw the same person and built a rapport. I was very disappointed from the beginning to learn having the same person would not be the case.*[31]

> *Antenatal Care- throughout my 2nd pregnancy which was May 2020, I was placed under consultation care due to my 1st pregnancy complications. In that time I saw approximately 10 different doctors/consultants. For me there was no consistency of care, each*

[28] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021
[29] Written Submission, Anonymous 3, 9th February 2021
[30] Written Submission, Anonymous, 11th February 2021
[31] Written Submission, Anonymous 2, 10th February 2021

appointment started with me having to provide a back story to my last pregnancy, and each and every consultant/doctor had a very different opinion. If you are allocated under a specific consultant it should be that consultant you see throughout.[32]

> *There is no consistency in staffing. I didn't see the same healthcare professional more than once during each pregnancy. This resulted in a very serious, life affecting misdiagnosis in my first pregnancy and no available psychiatrist in my second. I felt completely alone because I was alone.*[33]

Comparably, in the survey we undertook with women who had given birth in the last 5 years we found that 58% (378) of women did not see or speak to the same midwife at their antenatal check-ups every time. Of those who didn't see the same midwife every time, 77% saw between two and five midwives, 13% saw a different midwife every time, 8% saw between six and eight midwives and 1% saw more than eight. Similarly, 55% (354) reported having not seen or spoken to the same community midwife post birth and 24% (154) said they saw or spoke to a different health visitor.

FINDING 8: 58 per cent of women who have birth in the last five years did not see or speak to the same midwife every time at their antenatal check-ups and 55 per cent did not see or speak to the same midwife when receiving postnatal care.

When we queried these results with the Minister and his Officers at the Hearing, we were advised that the Covid-19 pandemic had posed some significant challenges by reducing the amount of contact maternity staff had had with women postnatally. In addition, we were advised that, due to Covid-19, there was an increased sickness and absence rate amongst staff which would have impacted on the amount of continuity the team were able to provide.[34] However, our survey results indicated that whilst continuity in care worsened during the pandemic period, it was certainly an issue that was in existence before the pandemic. For instance, 54.7% of those who answered "no" when asked whether they saw or spoke to the same midwife at every antenatal check-up had given birth two or more years ago. When we raised this finding with the Interim Head of Midwifery at the Public Hearing and asked for an explanation, she advised that this would partly be due to the staffing model – staff would naturally be pulled into supporting the labour ward and the postnatal service. We were also informed that the maternity service had been running with vacancies but that this situation had improved and, where there was previously gaps in the service, they were now in a much better position vacancy and recruitment wise.[35]

[32] Written Submission, Helen, 9th February 2021
[33] Written Submission, Felicity, 8th February 2021
[34] Public Hearing, Minister for Health and Social Services, 13th April 2021
[35] Public Hearing, Minister for Health and Social Services, 13th April 2021

During our review it became evident that concerns surrounding continuity of care weren't only in regard to the number of staff seen or spoken to but also in respect of the consistency of advice and information provided to women and their families by staff members. For instance, we were told on a number of occasions that the differing advice provided by maternity staff, usually following the birth of their baby, led to confusion and increased levels of anxiety. For instance, we heard:

> *Lots of staff keep telling you different stuff. Getting you stressed as a first-time mum.*[36]

> *The midwives offered a lot of differing advice and I found my mental health declined quickly as a new mum.*[37]

> *Midwives frequently gave greatly differing advice/information and then were annoyed if you were doing something the way a different midwife had told you and not their way. I was told I could not go with my baby to SCUBU even though it was clear that I was very distressed that she would have to go without me.*[38]

> *Reading the stories above has made me realise I'm not alone, so thank you.....and it's also made me angry that I just accepted everything that happened to me as "bad luck" and almost my fault. The maternity unit needs a serious overhaul, both in the facilities AND the level of care. Some of the staff are excellent, and I will be forever thankful to them, but they were certainly not the norm and the lack of a consistent approach or any communication between staff is a serious failing with extremely negative consequences for the women in their care.*[39]

FINDING 9: Differing advice provided to women by maternity staff, usually following the birth of their baby, has led to confusion and increased levels of anxiety.

From those we heard from, a great deal of issues arose in respect of breastfeeding and, often, advice provided by one midwife would conflict with the advice provided by another health professional. On some occasions the lack of consistent advice led to the women experiencing emotional well-being and mental health issues. This matter, and breastfeeding in general, is addressed later on in our report in Chapter 8.

FINDING 10: Continuity of care in the antenatal, intrapartum and postnatal periods of pregnancy would improve women's trust in their caregivers and help them to build and maintain relationships and rapport. Furthermore, evidence suggests that continuity of care would also improve women's emotional wellbeing and mental health during and after pregnancy.

[36] Survey Respondent, March 2021
[37] Written Submission, Bella, 10th February 2021
[38] Survey Respondent, March 2021
[39] Social Media, 10th February 2021

One of the findings from our survey which really stood out to us was that 87% of respondents reported not having previously met any of the midwives they had throughout labour, during the antenatal period. This finding very much supports the call from service users to have the same midwife, where possible, through pregnancy, delivery and postnatally. The Maternity Voices Partnership also reported that they would prefer care delivered in small teams of 3-4 midwives and would relish the idea of having the same team throughout the antenatal, intrapartum and postnatal periods.[40]

Model of care

According to our advisers, verbal and written evidence provided to the review suggests that the current model of care needs to change to be less hospital centric, less medically led and less paternalistic with more integration across the length of the maternity pathway and the promotion of greater continuity of care for women.[41] This is supported by the maternity staff survey with a number of respondents referring to a current system which is hierarchical and patriarchal and too medical centric, resulting in individual requirements and needs being ignored.

In the Public Hearing with the Minister for Health and Social Services, the Interim Head of Midwifery referred to "*a new model of care moving forward*" which would provide more parish-based care and would involve midwives being rotated from the hospital into the community. It was anticipated that the new model would provide a higher level of continuity of care.[42] Whilst we were made aware of the intent to provide a service model based on greater continuity of care, we have not had sight of any written support for this strategy.

As mentioned earlier in our report, we are aware of the intention to establish a midwifery-led model of care for maternity services. The Panel's advisers support this proposed approach and suggest that women experiencing low risk/uncomplicated pregnancy and labour do not require the involvement of obstetricians in their care. With regard to this new model of care, our advisers also commented:

> *"The development of a women centred midwife led model of care enables women to receive the majority of care in the community settings with a focus on normality, the family and a positive transition of becoming a mother.*

Unique to Jersey is the role played by GPs in the provision of maternity care, with the majority of women seeing a GP at the very beginning of their pregnancy. For example, 90% (587) of respondents to our survey saw a GP before any other health professional when they discovered

[40] Written Question to the Minister for Health and Social Services, 2nd November 2020
[41] Attain Report, May 2021
[42] Public Hearing, Minister for Health and Social Services, 13th April 2021

they were pregnant. This differs considerably to the UK where GPs play a minimal role in providing maternity care and where midwives are the first point of contact for expectant parents. In Jersey, six-week check-ups after labour are also provided by GPs. When asked in the survey whether women are content that these appointments are provided by GPs, 34% (221) said that they would rather that they saw their midwife for the 6-week check-ups.

Our advisers suggest that if Jersey wishes to move to a midwifery-led model of care then consideration should be given to the role currently played by GPs. However, they also suggest that there is no reason why GPs cannot be part of a system that helps to ensure women centred continuity of care, as long as they are prepared to retain an expertise in care of low risk pregnant women and be part of multi-disciplinary training and education. Furthermore, as proposed in the adviser's report, if a midwifery-led model of care is to be developed to encourage more care in the community, several aspects will need consideration before this can be achieved. For instance:

- The number of deliveries that are likely to take place per parish and the necessary workforce to manage these births.
- Whether a combined urban and rural model of care, akin to that adopted by the Health Visiting service, is most appropriate
- Whether midwives provide full continuity of care (covering community and labour care) and the potential need for innovative employment contracts to enable this.

With regard to the general issue of continuity of carer, our advisers have recommended that a midwife-led model of care is defined which incorporates, at a minimum, continuity of care in the antenatal and postnatal period, with the ambition of extending this to the intrapartum period. They suggest that the aim of this model of care should be to "*ensure care is delivered as close to home as possible, and to reduce inconsistency of advice in both the antenatal and postnatal periods as well as increasing women's satisfaction with the service.*"[43]

FINDING 11: Whilst there is a clear intent within the maternity team to provide greater continuity of care, it is evident from the concerns received that there is much more progress to be made.

FINDING 12: The development of a women centred midwife led model of care would enable women to receive the majority of care in community settings with a focus on normality, the family and a positive transition to becoming a mother.

RECOMMENDATION 3: The Minister for Health and Social Services must ensure that a midwife-led model of care is defined which incorporates, at a minimum, continuity of care in the antenatal and postnatal period, with the ambition of extending this to the intrapartum period.

[43] Attain Report, May 2021

The main objective of the model should be to ensure that care is delivered in the home, or as close to home as possible, to reduce inconsistency of advice in both the antenatal and postanal periods, and to increase women's satisfaction with the service.

Culture and Communication

As highlighted in our adviser's report, culture and communication between different professional groups has been raised as an issue through interviews with key stakeholders, surveys and in the Public Hearing with the Minister for Health and Social Services. It is noted that there are several aspects where culture can be addressed, such as:

- Intra-hospital relationships
- Clinician to clinician
- Clinician to patient

Intra-hospital and clinician to clinician relationships

In a written submission received from the Royal College of Midwives (RCM), they spoke about concerns they had in relation to the multidisciplinary team which exists within the maternity service and how it has been functioning. It was advised that RCM members had reported a lack of effective communication between the medical and midwifery workforce which could have a direct impact on the maternity care provided to the women and their families.[44] This finding was also evident in the recent staff survey, with some respondents referencing poor communication between midwives and doctors and occasional disagreement as to the most appropriate care for the patient. Our advisers found that whilst relationships between midwives and doctors are generally good, they are often based on an old-fashioned concept of the Obstetrician being in charge and 'owning' the woman and therefore being accountable for her care. Furthermore, they found that there were examples where the respective roles and responsibilities of professionals have not been clear enough to ensure that the midwife takes accountability for the care of low risk woman or to ensure the midwife's voice is heard in multi-discipline team working. This has resulted in conflicts between doctors and midwives in their approach to the care provided.[45]

Similarly, we are aware of instances where conflicts between staff of the same profession have occurred. A number of members of the public who engaged with the Panel's review reported staff providing opposing advice which left women feeling confused and unsupported. Some of these findings were evidenced earlier in our report when considering continuity of care.

[44] Written Submission, Royal College of Midwives, 25th March 2021
[45] Attain Report, May 2021

According to our advisers, such conflicts have resulted from a lack of standard policy, which has meant that individuals have developed their own approach based on their own experience.[46]

Clinician to patient - Compassion, kindness, and respect

One of the "*most disappointing and deeply worrying*" themes that emerged from the 2020 Ockenden Review was the reported lack of kindness and compassion from some members of the maternity team at the Shrewsbury and Telford NHS Trust. Whilst we acknowledge that the Ockenden Review was undertaken as a result of a number of alleged avoidable neonatal and maternal deaths and that in these instances kindness and compassion is even more essential, we believe that all women and their partners who are receiving care throughout a pregnancy should be treated with kindness, listened to and supported. As stated in the Ockenden Report *"kindness and compassionate care is something that every woman, baby and family deserve and should expect from all midwives, doctors and members of the maternity team."*[47]

FINDING 13: Kindness and compassionate care is something that every woman, baby and family deserve and should expect from all midwives, doctors and members of the maternity team.

The attitude and kindness of staff and those providing care was also an emerging theme from the written submissions we received, the survey results and from the focus groups that were conducted by 4insight. Whilst we received a lot of positive feedback about the maternity team, both within the community and the hospital, we were also told of some negative experiences. Reassuringly, the results of our survey indicated that the majority of women felt listened to, supported and respected throughout the three stages of pregnancy: antenatal, intrapartum and postnatal. This was reflected in the fact that 75% (493) of women said that they were always treated with respect and dignity throughout their labour and 69% (448) said that they had absolute confidence and trust in the staff caring for them throughout their labour. Furthermore, 53% (338) of respondents to the survey said that they were always treated with kindness and understanding whilst on the maternity ward, following the birth of their baby. Examples of some of the positive feedback we received from members of the public are as follows:

> *The many staff that dealt with my birth and aftercare were great and I could not fault them.*[48]

> *With regards to the services provided by the Antenatal team, midwives, doctors and nurses – not complaints, extremely well looked after.*[49]

[46] Attain Report, May 2021
[47] Ockenden Report, 10th December 2020, p12
[48] Written Submission, Anonymous 1, 11th February 2021
[49] Written Submission, Gemma, 11th February 2021

Couldn't fault the service and care received. In both cases care was exemplary.[50]

> *Outstanding level of care and staff are truly amazing individuals.*[51]

> *Whilst upgrading seems sensible, the staff are second to none. They do an incredible job with the resources they have. The care and attention was wonderful.*[52]

Unfortunately, this level of kindness and compassion did not appear to be experienced by every individual using maternity services. Whilst we acknowledge that this finding is probably true of most services provided, not just within health but the wider community, the care received by expectant and new mums and their families is particularly important. The care they are given at this time can impact on their emotional well-being, the connection with their baby and future decisions about extending their family. According to the NHS, "*compassion is fundamental to patient care and the need for compassion is as strong as it has ever been*."[53] One study around dignity and compassion in maternity services found that compassionate midwifery had the potential to reduce birth trauma and associated PTSD and that "compassionate" components of midwifery care are fundamental to safe care.[54] Some examples of the concerns we received in respect of this matter are provided below:

> *Come to 9pm on that day, I had a new midwife, this one unfortunately was unkind and judgmental. I shared with her that I was scared and she said 'i would just go home if I was you'. This was against all the other medical advice I had received, so I ignored her.*[55]

> *The staff were rude and not compassionate in the slightest.*[56]

> *I gave birth to my daughter in 2015 I was 15 days overdue by the time she arrived! I had been induced for 2/3 days my midwife was the most awful woman I have ever met! She kept telling me YOU'RE WASTING TAXPAYERS MONEY! Because the pessary they had put in me to induce labour kept falling out (I was a 22-year-old taxpayer at the time) I was treated like I was a child who was in trouble!*[57]

We had an experience in April, which was quite frankly abhorrent. My partner was treated by staff like dirt for wanting to come home after a traumatic birth with one midwife saying "I want to go home too"[58]

[50] Written Submission, Sally, 12th February 2021
[51] Written Submission, Kate, 13th February 2021
[52] Social Media Submission, 10th February 2021
[53] cip-one-year-on.pdf (england.nhs.uk)
[54] Jenny Patterson and Diane Menage, The Practising Midwife, Volume 23, Issue 8, September 2020
[55] Written Submission, Leila, 10th February 2021
[56] Survey Respondent, March 2021
[57] Written Submission, Nadia, 10th February 2021
[58] Social Media Submission, 10th February 2021

> *There was no consistency with the standard of care and courteousness, only polar extremes.*[59]

> *Some of the midwives were quite rude and often very forthcoming with their opinions, which isn't always very helpful or supportive to a new mum.*[60]

> *I was judged and ignored whenever I asked for help. I was ignored and pushed to the side by questioning about breastfeeding, sterilising equipment etc and my labour.*[61]

> *Some staff were incredible, and others were openly condescending and judgemental.*[62]

> *Throughout my whole stay in the hospital, I mostly felt like I was not of importance, that my baby was the only patient and I was only there for her milk. My needs were constantly ignored, so much that I struggled to understand that I do in fact matter and when [my baby] was 6 weeks old, my family had to call a dr home as I was suicidal.*[63]

In addition to these submissions, we found that 28% (116) of those who raised a concern during labour and birth did not feel that the concern was taken seriously.

At the Public Hearing with the Minister for Health and Social Services, our advisers raised the issue of person-centred care and how all maternity services should be striving to provide this to all women. In particular, the Minister and his Officers were asked what work was being undertaken to improve culture in order to deliver a truly person-centred approach for all women, where they felt listened to, involved and taken seriously. The Chief Nurse informed the Panel that whilst the maternity team strives to deliver personalised care to all, in light of the feedback from service users, it is clear that a *"small few"* have not had that experience.[64] We were also told that, as well as a wider piece of work that was being undertaken to address culture across the Government with Team Jersey, specific work was also being carried out within maternity services itself. The Interim Head of Midwifery explained:

> *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*

[59] Survey Respondent, March 2021
[60] Survey Respondent, March 2021
[61] Survey Respondent, March 2021
[62] Survey Respondent, March 2021
[63] Written Submission, Leila, 10th February 2021
[64] Public Hearing, Minister for Health and Social Services, 13th April 2021, p28

> *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 [the Chief Nurse] has previously said, we would start to link that to revalidation and process and, if need be, do some restorative supervision across the board.*[65]

According to our advisers, all of the cultural issues that have been addressed above could be minimised if everyone worked to agreed guidelines and policies and if there was an overarching statement of values and behaviours that could be upheld across the service. Without an agreed, overarching framework it is difficult to challenge the behavioural problems that underpin poor culture. It is suggested that questions, such as those below, need to be considered when establishing overarching values for the maternity service:

- ***'what kind of service will be delivered?'***,
- ***'what are the expectations of professional input?***'
- ***'what will the user experience be as a result?'***

In response to further questions we asked regarding the culture summit, we were told that the first one concluded on 14th April of this year, in which a Local Committee had been developed, and that a second summit was due to take place in May 2021. The Committee is expected to come together to develop the basis of the culture and behaviour strategy which will include the organisational values. We were also advised that the strategy would provide a framework that supports and promotes regular appraisals, one to ones, improving communication and enhancing interpersonal relationships within maternity services.[66] We concur with our advisers that these are positive and progressive steps and should be the start of an on-going process to embed a more cohesive culture that has the involvement of participants from across maternity services. With regard to the Local Committee and culture strategy referred to by the Department, our advisers recommended:

> *"The Local Committee should include multi professional and across sector representation and the culture strategy be published as an integrated part of the maternity services strategy. This culture strategy should be a statement of the overarching values of the maternity service and the behaviours that will underpin those values. Such a statement should be referenced during all appraisals.*

[65] Public Hearing, Minister for Health and Social Services, 13th April 2021, p29
[66] Letter, Minister for Health and Social Services, 29th April 2021

FINDING 14: Whilst the majority of women who engaged with the review felt listened to, supported and respected throughout the three stages of pregnancy, a significant percentage did not receive the level of compassion and kindness that you would want, or indeed expect, when receiving maternity care.

FINDING 15: Steps are currently being taken by Maternity Services to address communication issues, to bring compassion back into the heart of the service and to embed a more cohesive culture.

RECOMMENDATION 4: The Minister for Health and Social Services must ensure that the Local Committee, developed following the initial Culture Summit, includes multi professional and across sector representation and that the Culture Strategy is published as an integrated part of the Maternity Services Strategy. Furthermore, the Culture Strategy should be a statement of the overarching values of the maternity service and the behaviours that will underpin those values.

OVERARCHING FINDING: The Panel has found that there is an inconsistency in the continuity of care for women within the current maternity services. It was also found that compassion is not always at the centre of the culture surrounding the service. Whilst steps are being taken, there is much more progress to be made.

Strategy for Maternity Services and Performance Framework

In order to be able to assess the quality of maternity care provided to women and their families it is important that there are appropriate tools in place to measure performance, along with a strategy that sets objectives and goals for the service to aspire to.

The Panel and its advisers were keen to establish whether there was a written strategy in place for maternity services which described the framework for the current maternity services, and which outlined the objectives for the future. When we asked questions at the Public Hearing in April, we were advised by the Chief Nurse that this was something that was currently being developed by the Women's and Children's Care Group leadership team and that it would take into account the new hospital build and the Jersey Care Model. We were also told that external organisations, as well as the Maternity Voices Partnership, would feed into that piece of work. HCS anticipate that this work will start this year "in earnest" and that a strategy will be in place early next year.

Our advisers expressed their concern regarding the current absence of a system wide agreement to a single maternity strategy which describes agreed outcomes and performance goals for maternity services within their own report:

> *This is a serious deficit as there is currently no apparent way that all parties involved in the delivery of maternity service can adequately assess how well the services are performing.*[67]

They went on to argue that the maternity strategy will be vital to establishing a modern maternity service that meets the need of the population, outlining the strategies intentions (based on evidence, such as preventative public health) and defining implementation targets against which process can be monitored. It is also suggested that a system wide collaborative approach needs to be taken when developing the strategy, involving all parties, to move away from a hospital centric model of care.

FINDING 16: Currently, there is no system-wide agreement to a single maternity strategy which describes agreed outcomes and performance goals for maternity services.

RECOMMENDATION 5: The Minister for Health and Social Services must ensure that a system-wide maternity strategy is developed without delay which includes cultural values, the proposed model of care (including choices of maternity care and continuity of carer), the maternity care pathway (community/parish led maternity service), expected outcomes, performance measurement framework with KPIs/benchmarks and approach to oversee policy development.

Recognising that it could take some while to develop a system-wide maternity strategy, in the short-term we propose that a Maternity Services Task and Finish Group is established to drive forward the necessary transformation in maternity services. Our advisers proposed that the Group would be a project team made up of lead professionals (e.g. midwives, medics GPs, health visitors, Public Health) and lay members (e.g. recent parents) with the objective of providing sufficient momentum and capacity to develop the maternity strategy and deliver the wider recommendations of our review, and others commissioned by HCS, by the end of 2021. In respect of the Group's defined remit, our advisers stated:

> *This Task and Finish Group should be responsible for the project plan that outlines the: what, who, how and by when, the key tasks in transforming the maternity services highlighted in this review. A dedicated project manager should be assigned to this Task and Finish Group, that is only in place to deliver this work, to ensure that there is appropriate resource to complete all tasks.*

[67] Attain Report, May 2021

We also propose that, when established, the group reports to the Independent Jersey Care Model (JCM) Board in order to demonstrate how the maternity service transformation could be undertaken to achieve the objectives of JCM outlined to the States Assembly in November 2020.

FINDING 17: Whilst a maternity strategy is being developed, a Task and Finish Group should be established to drive forward the necessary transformation to maternity services.

RECOMMENDATION 6: The Minister for Health and Social Services must establish a system wide Maternity Task and Finish Group that is accountable to the Independent JCM Board. This should include a dedicated project manager. The remit of the Group should be to drive forward the development of the Maternity Strategy and to undertake the recommendations identified in the Panel's report.

With regard to quality measurement and how the service is currently assessed, we were advised by the Chief Nurse that the maternity team are presently working on how they can benchmark themselves across other comparable organisations and national standards. Furthermore, we were told that the team is currently developing a comprehensive list of over 240 standards and considering how to prioritise that information going forward.[68]

Within their report, our advisers suggest that a list of 240 standards is far too many. It is critical to maintain a coherent high-level small number of indicators in each of the categories identified by the Care Quality Commission (CQC)[69]. The indicators should be available to everyone, including the Independent JCM Board (which the Panel proposed in its review of the JCM), and should sit alongside a dynamic overall risk register of service. As a priority, the critical indicators need to be identified and agreed to allow the maternity team to determine whether the service is of high quality. The advisers also argue that it is critical that the indicators are monitored regularly and that statistical analysis charts are used, which show trends that might indicate problems early on so they can be rectified at the earliest possible opportunity. The indicators must also include the views of service users and staff, which could be provided through annual surveys. It is suggested that such indicators should pick up on areas that require improvement, such as breastfeeding targets for the number of women breastfeeding on discharge from hospital, but also at two weeks and six months post birth. Continuity of care is also something that could be assessed through the indicators.

In order for the indicators to be useful, it is essential that they are benchmarked against peer norms or international comparators. Regarding the matter of benchmarking, our advisers commented:

[68] Public Hearing, Minister for Health and Social Services, 13th April 2021 – P.16
[69] The CQC framework outlines the components of a high-quality service as safe, effective, caring, responsive and well led.

> *It is recognised that direct comparators are a challenge in a small island-based service but many maternity outcomes, are related to the characteristics of populations not to size and geography. For inputs the Jersey service could access three sources: the Royal College of Midwives (RCM) blue top guidance programme "RCM standards for midwifery services in the UK", Royal College of Obstetricians and Gynaecologists (RCOG) guidance and NICE guidance. All three have regular update reviews to incorporate new trials and studies so are kept up to date, and all three have key specific measurement criteria. Every service can point to unique elements of a given service and it will be helpful to have comparators with services with comparable numbers of births per year, and relative isolation. If possible, it would be constructive to identify some overarching metrics that will indicate relative investment levels (e.g. workforce) so that expectations against similarly high investment services can be used for comparison.*[70]

To address issues relating to performance framework, our advisers have recommended that a comprehensive system of performance management is established including a regular user survey and staff survey, which enables benchmarking against other appropriate maternity services.

Interestingly, during our review we came across the National Maternity Dashboard that is used in the UK and which lists key measures and metrics for maternity care. The dashboard presents an easy way to view historical changes and compare Clinical Quality Improvement Metrics and other measures with comparable maternity providers. A similar dashboard could be adopted in Jersey, which would allow comparisons with other jurisdictions and which would also allow those accessing maternity services to see how Jersey measures against other jurisdictions.

FINDING 18: Critical indicators need to be identified and agreed to allow the maternity team to determine whether the service is of high quality.

RECOMMENDATION 7: The Minister for Health and Social Services must establish a comprehensive system of performance management, including an annual service user survey and staff survey, to enable benchmarking against other appropriate maternity services.

RECOMMENDATION 8: The Minister for Health and Social Services should establish a dashboard similar to the new National Maternity Dashboard to enable easy comparisons, such as Clinical Quality Improvement Metrics, with other maternity providers. The dashboard should be made publicly available.

We note that, in addition to a system of robust performance, it is essential that the audit programme, which is just starting, is developed further. According to our advisers, an audit

[70] Attain Report, May 2021

programme should be linked to a system of continuous improvement and should be focused on key clinical guidelines and standards (for example, waiting times for pain relief, decision to caesarean timing, record keeping assessments to check informed choice and regular assessment of need).

In a letter from the Women's, Children's and Family Care Group Leadership Team, we were advised that in September 2020 the Care Group was placed on a Task and Finish Programme in order to assure the Executive team of the progress the care group was making regarding implementation of the local improvement plan. The Care Group initially met weekly with the Executive Team to provide updates but from January 2020 the meetings take place monthly.[71] Whilst our advisers note the importance of the Plan and agree that it should be completed without delay, they suggest that it should only be seen as one aspect of a more comprehensive quality improvement framework. It is therefore recommended that the Jersey Care Commission are engaged to support the maternity system to establish a robust and measurable quality framework.[72]

RECOMMENDATION 9: The Minister for Health and Social Services should engage the Jersey Care Commission to support the maternity system to establish a robust and measurable quality framework, with suitable resources allocated.

[71] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021
[72] Attain Report, May 2021

7. Staffing, Governance and Policies

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

In order to gain an understanding of the staffing levels within maternity services and whether they are sufficient to deliver the best care to women and their families, we asked Health and Community Services for the number of staff members currently working within the Maternity Unit and Antenatal Clinic within the General Hospital and Midwives within the community. We were provided with the following data:

Staff Position	No. of Staff
Consultant, Obstetrics and Gynaecology	6
Foundation year 2 doctors, Obstetrics and Gynaecology	2
Head of Midwifery	1
General Manager - Women and Children	1
GP Trainee/Speciality Trainee doctor (ST2) /Clinical Fellow	4
Healthcare Assistant – Maternity	9
Lead Midwife	1
Locum Staff Grade Obsterics and Gynaecology	2
Maternity Senior Secretary	1
Maternity Unit Receptionist	1
Midwives	50
Governance and Risk Manager	1
Senior HCA - General Midwifery	1
Sonographer	1*
Staff Grade Obstetrics and Gynaecology	4
Ward Clerk – Maternity	2

- 2 midwives have been trained and can do a limited range of scans
- 1 midwife just commenced in role can do the full range of scans

As shown in the table above, there are currently 52 midwives employed in Jersey, including the Interim Head of Midwifery and Lead Midwife. We were advised that this equated to 47.21 full time equivalents (FTE).[73] In addition, we were told by Family, Nursing and Home Care that, in full establishment, they employ 14.8 FTE health visitors. However, currently they are 2.6 FTEs down and are looking to recruit.

Recruitment and Retention of staff

Internationally the healthcare workforce is a significant challenge for all care systems, and this is witnessed in Jersey too. According to our advisers, the maternity service has a good ratio of midwives employed compared to the number of births in Jersey (47 FTE for on average 984

[73] Letter, Women, Children and Family Care Group, 2nd March 2021

births over the last 5 year) and they note that there is on-going work to refine the shift patterns to support capacity across all shifts.[74] In addition, there has been recent work done in relation to the medical workforce with an increase in the numbers of Obstetric consultants and changing in their shift patterns to ensure a greater consultant presence and more support for junior doctors. We have been told that the new medical workforce staffing model has, to date, been well received and is making a positive contribution to the wellbeing of mothers and babies.[75]

With regard to the retention of staff, we were advised by the Chief Nurse that the vacancy turnover rate within maternity services has been fairly consistent over the last 5 years. However, as a direct impact of the Covid-19 pandemic, there was an increased turnover rate during 2020, not just within the maternity services but in some other areas of Health and Community Services.[76] In light of the retention figures that we were provided, our advisers found that whilst there has been a low churn of midwives and consultants in the Obstetrics and Gynaecology team, there has been a double digit turnover in the medical team over the last 5 years (excluding junior doctors who you would expect to rotate).

The Panel and its advisers recognise that, currently, there does not appear to be a coherent workforce strategy which underpins maternity services or that could be used to support a new maternity strategy. Such a strategy is vital for assessing whether the midwifery workforce is adequate for a new model of midwife led care. In addition, the service is currently reliant on locum staff (largely responsible for the staff turnover) and 45% of midwives are due to retire within the next ten years.

In their report, our advisers acknowledge the challenges that Jersey face in terms of maintaining competency amongst Obstetric junior doctors with small caseloads. As a possible solution to this they encourage further development of off-island rotations with a bigger UK hospital(s) "*to enable more structured integration of medics to retain clinical development and ensure service continuity for the Jersey maternity service.*"[77]

During the Hearing in April with the Minister for Health and Social Services, we were advised of the partnership Jersey currently has with the University of Chester in order to develop our own midwives and to add to the Island's workforce.[78] This is considered a very positive development as it will support the expansion of a more sustainable on-island workforce.

FINDING 19: Currently, there does not appear to be coherent workforce strategy which underpins maternity services or that could be used to support a new maternity strategy. Such a strategy is vital for assessing whether the midwifery workforce is adequate for a new model of midwife led care.

[74] Attain Report, May 2021
[75] Letter, Minister for Health and Social Services, 29th April 2021
[76] Public Hearing, Minister for Health and Social Services, 13th April 2021, p29
[77] Attain Report, May 2021
[78] Public Hearing, Minister for Health and Social Services, 13th April 2021

RECOMMENDATION 10: The Minister for Health and Social Services must develop a maternity workforce strategy to consider future workforce requirements, assess different roles to support all aspects of maternity care and explore options for staff rotations with partner organisations.

Impact of staffing levels on delivery of care

Despite a consistency in the vacancy turnover rate, the majority of midwives who responded to the staff survey felt that current staffing levels were inadequate and that they needed to be reviewed. A number of respondents reported recent high turnovers of staff and high sickness rates as reasons for this deficit. The impact of insufficient staffing levels on the ability to provide adequate care to women and their babies was also referenced, with a number of midwives referring specifically to the home birthing service. In the Hearing with the Minister we were advised of the ambition to develop the home birthing service on the Island. However, it seems that this ambition may be hard to achieve without firstly assessing resourcing and staffing issues. We note that community midwives have been providing a home birth service with a 6-7% homebirth rate for the past 3 months. We also note that midwives in the community are running on a 30% vacancy which has meant that vital work of running antenatal clinics, postnatal clinics, breastfeeding clinics and providing home birth services currently gets by on a "*wing and a prayer and the good will of staff*".[79]

The apparent staffing issues within maternity services raises the question as to whether or not they impact on the safety and effectiveness of care delivered to women, their babies and families during each of the stages of pregnancy. We have already considered the matter of continuity of carer and the many benefits this can have for women accessing maternity services. However, staff themselves have raised concerns about whether this is achievable in light of the current staffing levels without impacting on the health and well-being of staff members. Whilst we have no evidence to suggest that the safety of the women and their babies is comprised by the staffing shortage, we have received some evidence to suggest that the effectiveness of care might have been impacted. For instance, one member of staff said that whilst midwives in the hospital were striving to do their best, the lack of midwives meant at times the care that was being provided was safe enough but not effective. Similarly, another commented that staff shortages meant that it was sometimes difficult to provide a gold standard of care.[80]

FINDING 20: Insufficient staffing resources may be compromising the effectiveness of the care provided to mothers, babies and their families their families.

[79] Maternity Staff Survey, Health and Community Services April 2021
[80] Maternity Staff Survey, Health and Community Services, April 2021

Planned additional staff

In response to the Panel's review, we were advised by HCS of a number of specialist positions which they hoped to recruit to. In addition to an Infant Feeding Specialist and Perinatal Mental Health Midwife, which we discuss in greater detail later on in our report, they are hoping to build capacity for a Practice Development Midwife, Public Health Midwife and a Safeguarding Midwife. According to HCS, in order to develop services that are responsive to women and their families, they need additional capacity in the workforce to drive Public Health and Safeguarding agendas forward, improving expertise, experience and engagement whilst increasing efficiencies and effectiveness and therefore providing a seamless pathway for women and their families.[81]

A Practice Development Midwife would lead on responsive and experiential learning from service user feedback and evidenced based practice. We were told that every incident that occurs within the maternity unit is investigated with care by senior clinical and operational staff and whilst an immediate review is undertaken of all cases, in depth and robust reviews are often delayed in their completion. HCS believe that this delay is due to competing demands and a lack of administrative resources and it is hoped that the role of Practice Development Midwife, along with further administration support will prevent this delay. According to the Royal College of Midwives, "*the addition of a practice development midwife will enable staff to keep up to date and provide evidence based high quality care."*[82]

We discussed in an earlier chapter that the absence of public health support and information in maternity services has been recognised by the Minister and maternity staff. We note that, going forward, women will be invited to appointments during their antenatal period to discuss and receive information regarding protection, prevention, and promotion. When asked how the current provision of maternity services could be improved to better meet the needs of mothers, fathers/partners and their babies, one response that was given by the Women's, Children's and Family Care Group Senior Leadership Team was the development of a Public Health Midwifery Team. The team would work with and across all local health economies and specialities and would include midwives with roles in smoking, cessation, reducing drug and alcohol intake, perinatal mental health and an increase in hours for the safeguarding midwife. The intention is to recruit a Public Health Midwife to lead on this work and head up the team.

In addition to building capacity for these specialist roles, the senior leadership team has recognised that the pathway from best, better to brilliant is not only dependant on midwives, doctors and relationships with women but is also dependant on the operational and core business partners who support the smooth and effective delivery of care at the point of need.

[81] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021
[82] Written Submission, Royal College of Midwives, 25th March 2021

HCS is therefore looking to develop their midwifery support staff (care assistants) and to train them to midwifery training entry level.

FINDING 21: The inclusion of midwives who provide specialist services, such as perinatal mental health, safeguarding and practice development is essential to providing high quality care.

Governance and Leadership

In September 2020 a review of maternity services was undertaken by the Royal College of Obstetrics and Gynaecology (RCOG). The review was prompted by the recommendation from an external review of a serious incident that a larger assessment of quality and safety of the Obstetrics and Gynaecology service was performed. The review highlighted a number of concerns in regard to leadership within maternity services. Specifically, it found, among other things, a lack of direct, high-level leadership which engaged the views of many and delivered visible outcomes. When conducting their own review, our advisers also found the leadership structure of maternity services to be less than ideal. The evidence gathered from their interviews with key stakeholders indicated that the leadership structure was not appropriate for providing leadership to the work required (particularly developing a maternity strategy) and for ensuring a consistent clinical model and a robust system of clinical governance in the maternity service. The advisers found that having an Associate Medical Director as effectively the lead of the Care Group model, despite being part of a triumvirate model, did not appear to be the best option if the current challenges are to be addressed. On this point, the advisers further commented:

> *The feedback from engagement is that the voice of the midwives is not heard in the right fora. It is important that both the midwifery leadership and the medical leadership must be for the entire maternity pathway not focused on just the hospital component. What needs to be achieved in a time when major change is required is a leadership structure which ensures that the two most significant professional groups delivering maternity services, i.e. midwives and obstetricians, are at all key strategic and operational meetings and that the voices of these clinical experts along with those of women are heard at every forum about maternity services.*[83]

In view of the above, our advisers have suggested that a Director of Midwifery and an Associate Medical Director, who is also lead Obstetrician, is appointed as the triumvirate leadership of maternity services.

FINDING 22: The current leadership structure is not appropriate for providing leadership to the work required (particularly developing a maternity strategy) and for ensuring a consistent clinical

[83] Attain Report, May 2021

model and a robust system of clinical governance in the maternity service. Furthermore, under the current leadership model, the voice of the midwives is not heard in the right fora and both the midwifery and the medical leadership must be for the entire maternity pathway not focused on the hospital component.

RECOMMENDATION 11: The Minister for Health and Social Services should develop an appropriate leadership team for maternity services, including the appointment of a Director of Midwifery and an Associate Medical Director, who is also Lead Obstetrician.

Policies

During our review we found that, specific to maternity service, there are currently:

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

We acknowledge that recently there has been a rapid development of a number of guidelines and policies and a lot of work has been put in to bringing Jersey policies up to date. This is an extremely positive step for both the staff utilising the policies and the women and babies receiving safe, evidence-based care.

The Panel was advised that, in recent years, guidelines have been allocated to Midwifery and Obstetric team members to write or update and that completed guidelines are circulated to all Maternity staff, discussed at teaching sessions and at the Professional Midwifery Advocate meetings for comments. Every Monday a Maternity Risk meeting is held for case presentation where learning is shared, and matters reported on Datix are reviewed. We are told that this is one forum where guidelines that are deemed ready for ratification are brought and discussed. Once the guidelines have been ratified, they are shared on the Maternity Unit via handover and all staff are emailed to ensure they are aware that a new guideline has been uploaded to the intranet for easy access and/or for reference guide. With regard to developing guidelines, we were told that the recent allocation of a Lead Obstetric Consultant for Governance has provided 12 hours over a rolling 6-week period for Governance work, four of which are specifically for guidance development working with a small team.[84]

According to our advisers, interviews with key stakeholders have suggested that there is an opportunity to improve the governance process of ratifying policies and standard procedures, as well as ensuring these are shared across the entire system (for example, to new midwives, junior doctors, GPs, Health Visitors, Perinatal Mental Health specialists etc.) It is believed that

[84] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021

this could improve consistency of practice, encourage evidence-based practice and patient safety and risk.

Many of the policies/guidelines used by maternity services in Jersey are based on the Royal Colleges within the UK and also the NICE (National Institute for Health Care Excellence) guidelines. However, our advisers found that there was no automatic process to adopt these guidelines for Jersey. It is recognised that the translation of UK policies into Jersey policies can be time consuming, and therefore it could be suggested that, for the majority of policies, a simple process is established allowing quick endorsement of a wider policy, with only a few policies requiring substantive change.

This finding is consistent with evidence the Panel received from the maternity staff survey, which suggests that policies are often open to interpretation and applied differently according to the specific member of staff, leading to a "*discordance in care*". It was also found that staff are presented with differing guidelines from different sources – RCOG, NICE and Jersey's own guidance – that sometimes conflict with one another causing confusion and an inconsistently in the approach taken. According to our advisers, it is unclear how often modification of policies/guidelines is necessary for Jersey specific issues and what this means in terms of safety of care. They therefore suggest that it may be most prudent to propose that all NICE guidelines are adopted unless there is an exception.[85]

FINDING 23: Maternity Services policies are open to interpretation and can be applied differently according to the specific member of staff, leading to a "*discordance in care*".

What was also evident from the staff survey was that policies and guidelines are often difficult to find on the States Intranet due to the way that they are listed. It is imperative that staff can access and refer to guidelines when necessary and it is therefore important that steps are taken to ensure that they are made more easily accessible.

The review undertaken by RCOG in 2020 also highlighted the need for a governance structure which encouraged a more devolved, collective ratification and approval process. These findings are supported by our advisers who encourage more rapid progress to be made, not just with ratifying policies, but also with communicating and monitoring adherence. Our advisers also make the important point that many of the organisational policies and standards are established for hospital-based services and therefore may need revisiting and adapted in line with any proposed midwifery-led community service model.

[85] Attain Report, May 2021

In light of the above, the advisers recommended for all actions from the RCOG reviews of maternity services elsewhere to be completed and for a complete set of key organisational policies to be in place by the end of 2021.

FINDING 24: There is an opportunity to improve the governance process of ratifying policies and standard procedures, as well as ensuring these are shared across the entire system (for example, to new midwives, junior doctors, GPs, Health Visitors, Perinatal Mental Health specialists etc.)

FINDING 25: In concurrence with a previous review undertaken by the Royal College of Obstetrics and Gynaecology, it was found that more rapid progress needs to be made with ratifying policies as well as communicating and monitoring adherence.

RECOMMENDATION 12: The Minister for Health and Social Services must endeavour to complete all actions from the Royal College of Obstetrics and Gynaecology reviews of maternity services and have a complete set of key organisational policies in place by the end of 2021.

OVERARCHING FINDING: The Panel has found that significant improvements are required in relation to the leadership and governance of maternity services. Due to a current lack of clear goals and indicators for the service, as well as concerns around the current leadership model (which does not create the right fora for the voice of midwives to be heard), a single overarching strategy must be developed.

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

The question of whether women are able to make safe and appropriate choices of maternity care has raised many different views and opinions amongst parents, key stakeholders and maternity staff. The matter of 'choice' doesn't just refer to where women are able to give birth to their baby but rather whether they receive sufficient support, and are provided with the right information, to be able to make the best decisions for themselves and their babies throughout their entire pregnancy and beyond. As noted by our advisers in their own report, evidence that the Panel received during its review indicated that whether or not women can make informed choices is "*inconsistent at best and random at worst".* They also found that there is currently no clear culture to uniformly encourage informed choice by the service, instead it appears to be largely driven by women themselves.

FINDING 26: There is currently no clear culture to uniformly encourage informed choice by the service, rather it appears to be largely driven by women themselves.

Inconsistency in advice

Earlier on in our report we have discussed the common concern regarding a lack of continuity of care provided to women and their partners antenatally and postnatally. Whilst we don't wish to repeat the points already made, we do wish to touch on the subject again specifically in relation to how inconsistency in carers and the advice given can impact upon a women's ability to make the right decision for themselves and their babies. One of the key themes that came from the staff survey that was undertaken by Government, was that the inconsistent messages and decisions from medical staff can make it difficult for the staff themselves to provide women with appropriate advice – which in itself can cause strain on working relationships. It is also reported that inconsistency in advice and mixed messages from staff, at such a vulnerable time, can leave women feeling confused and makes it impossible for them to make their own decisions based on fact.

In addition, we are aware that whilst many midwives feel able to advocate for women's choices, some feel somewhat oppressed by a hierarchal culture within maternity services. This means that, in some cases, the level in which midwives feel able to advocate the women's choices is dependent on the senior staff who are involved in the care of the women.

Choice of birthplace

Currently Jersey can offer hospital and home birth as birthplace choices. However, as discussed earlier, Health and Community Services aim to provide a midwife led unit within the hospital

when the planned refurbishment is completed. This will of course be dependent on risk assessment at the booking appointment with the women's midwife and during pregnancy. For 'low risk' pregnancies, as a result of this upgrade, women will have a choice of home birth care, traditional maternity care or -midwifery-led care in the new birthing units.

FINDING 27: Once the refurbishment of the maternity unit is complete, women will have a choice of home birth care, traditional maternity care or birthing on the new midwife-led birth units.

In March of this year, in a letter to the Panel, we were advised that a routine questionnaire is completed at the women's booking appointment with the midwife regarding birth place preference and is continually assessed during pregnancy, with an in-depth birth discussion held at 36/40 weeks of pregnancy. We were also told that women can discuss their choice of birthplace with the community midwife providing care throughout the pregnancy.[86]

Contrary to this understanding, 27% (179) of women who completed our survey said that no discussion of options as to where to birth their baby took place. Of those who said that no discussion took place, 64% (115) gave birth two or more years ago, confirming that the pandemic was not the sole reason for this result. When we queried this with the Minister and his Officers, the Interim Head of Midwifery told the Panel:

> *This would not be our intention not to ask those sorts of questions and this 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 that 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.*[87]

We were advised by the Women's, Children's and Family Care Group Senior Leadership Team that the Community midwifery team was working hard to advocate for women and support women's choice regarding place of birth. In respect of the home birth service, which is provided by the Community midwifery staff, we were told that the home birth rate had significantly increased in the last few months. As we highlighted in our introduction, 8% of all deliveries at the end of February this year were home births compared to 2% of all deliveries in 2020. The Panel are pleased to see that this option has been available to women to allow them to make the choice they felt was right for them during the height of the pandemic.

[86] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021
[87] Public Hearing, Minister for Health and Social Services, 13th April 2021, p33

Involvement in decisions about care

A number of questions within the Panel's survey attempted to gage whether women felt that they had enough involvement in the decisions about their care antenatally, during labour and postnatally. Encouragingly, our results show that when women were asked whether they were involved in decisions about their antenatal care, 60% (390) said they always were. This is compared to 30% (194) who said 'yes, sometimes' and 7% (46) who said 'no'. When asked a similar question about their involvement in decisions about the care they received during labour and birth the results were similar. 61% (397) said 'yes always', 28% (184) said 'yes, sometimes' and 8% (53) answered 'no'. In addition to these results, another positive finding was that the majority of respondents (85% - 557) felt that their partner was as involved in the whole birthing experience as much as they had wanted them to be.

Whilst we acknowledge that most women who engaged with the Panel felt involved in decisions about their care, we cannot ignore the significant minority who felt that their choices were not always respected or enacted by health professionals. In the majority of cases, concerns about decision making fell into two different categories – feeding (their babies) and pain relief during labour. We will address feeding later on in the chapter. In respect of decisions around pain relief, below are some examples of the submissions that we received:

> *My main midwife who I had for the majority of the time, I found to be a little cold and abrupt if I'm honest. After several hours the sickness and the pain became too much for me and I said I wanted an epidural. I felt like the midwife was trying to put me off having it. She listed all the cons and said it would slow my labour down. She also kept on saying how well I was coping despite me telling her I was in a huge amount of pain! When she brought an information sheet about the epidural, she gave it to my husband and not to me. I feel very strongly that the decision to have pain relief should be mine and mine alone and that my husband should not have been involved and I would have appreciated it if the midwife had supported me in my choice more.*[88]

> *On the 3rd day I was given the option of either have a c section or trying a catheter balloon. I was excused I hadn't slept for 3 days and I just wanted my child to be born. I felt forced by the midwife to have the balloon rather than a section.*[89]

> *Was forced into having an epidural as the midwife clearly couldn't be bothered. This can be backed up by 3 other witnesses. I then had an epidural 4 times in my back due to the*

[88] Written Submission, Ellen, 11th February 2021
[89] Written Submission, Courtney, 11th February 2021

lady not concentrating. When I told the midwife it wasn't working and I needed gas and air she told me I was stupid.[90]

We also received a submission from a woman who had felt pressurised to be induced:

> *In the week before I gave birth, I felt under a lot of pressure to be induced. Something I really really did not want and had to fight for second scans and second opinions to have my voice heard. I do worry that women who aren't as comfortable with confrontation or standing their ground would be medically coerced to make decisions they don't want to. I felt patronised, and that my wishes were tantamount to causing a still birth. It was only because I had ante natal Hypnobirthing classes that I felt empowered to make my own, informed choices and baby arrived when he was ready.*[91]

Worryingly, similar concerns of coercion were also addressed by midwives in their staff survey. A number of midwives reported witnessing women being coerced, forced and belittled into agreeing with their care provider as to the care they should receive. It was also explained that, in such occasions, women are not given the opportunity to discuss or understand their options and are not routinely given access to evidence and guidelines to help them make an informed decision. In order to provide truly balanced choices, all women should be provided with all the facts without any bias to allow them to take ownership of their own decisions, supported by evidence. One mum commented on this very point during a focus group session:

> *I wasn't given many options, when I was like 'I'm not sure' they put me under so much pressure. I just said, 'okay let's do the induction'. I know they're professionals, but they could have given me more information on the options.*[92]

FINDING 28: Whilst the majority of women feel involved in the decisions about their care, some reported feeling unsupported with their choices or coerced into agreeing to the type of care received.

FINDING 29: Women and their partners are not always given the opportunity to discuss or understand their options of care and are not routinely given access to evidence and guidelines to help them make informed decisions.

RECOMMENDATION 13: All birthing women and their partners should routinely be provided with evidence and information concerning their options in respect of pain relief and birth choices, highlighting benefits and risks, and given the opportunity to discuss and understand these prior to labour. All information should be delivered clearly and in a non-judgemental way.

[90] Survey Respondent, March 2021
[91] Written Submission, Jessy, 10th February 2021
[92] 4insight Report, Maternity Services, April 2021

OVERARCHING FINDING: The Panel has found that there is an inconsistency in how women and their partners are involved in discussions about what care is received during pregnancy and after giving birth. Whilst the majority did feel involved in care decisions, concerns exist that these processes are not being delivered uniformly.

Feeding choices and decisions

The most recent official figures published in the 2019 Births and Breastfeeding profile show the percentage of babies being breastfed on discharge from Jersey's Maternity Unit was 75 per cent.[93] From our survey with women who had given birth in the last 5 years, we found that 55% (356) of respondents exclusively breastfed their baby for at least the first few days after birth.

In a press release on 18th February 2021, it was advised that Jersey's Maternity and Special Care Baby Unit (SCBU) had achieved Stage One of the UNICEF Baby Friendly Initiative, an internationally recognised award for quality care. The UNICEF Baby Friendly Initiative (BFI) aims to support breastfeeding and good infant nutrition, which helps parents to develop close and loving relationships with their babies. This programme is a commitment in the Government's Food and Nutrition Strategy and features in the Children's Plan, as breastfeeding is a key indicator of success in the Future Jersey priorities. BFI is a tiered programme with three stages: Stage Three being achievement of full Baby Friendly Accreditation. To reach Stage One, breastfeeding champions have developed evidence-based guidelines, new processes, and have attended specific training on the benefits of breastfeeding and how to support mothers to get breastfeeding off to a good start. Back in Autumn 2018, the Health Visiting service at Family Nursing and Home Care made a commitment to work towards BFI accreditation and in October 2019 the service gained Stage One accreditation.

Maternity staff worked closely with Sarah Keating, project lead for the Baby Friendly Initiative at Family Nursing and Home Care, to achieve the accreditation. According to Health and Community Services, the fact that the Maternity Unit has now joined the Family Nursing and Home Care's Health Visiting Team in this accomplishment will help to ensure that families in Jersey receive a consistent message of support across all services. We were advised that, as of February 2021, 91% of Maternity staff had received training in line with the UNICEF BFI standards. [94]

FINDING 30: Maternity Services and the Health Visiting services have both achieved Stage one accreditation of the UNICEF Baby Friendly Initiative programme.

[93] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021
[94] News Release, Government of Jersey, 18th February 2021

We also note that an 'Infant Feeding Guideline' was published by Health and Community Services in November 2020. The purpose of the guideline is to "*ensure that all staff understand their role and responsibilities in supporting expectant and new mothers and their partners to feed and care for their baby in ways which support optimum and well-being."* The objectives of the policy are:

- *"An increase in breastfeeding initiation rates*
- *Amongst mothers who choose to formula feed, an increase in those doing so as safely as possible, in line with nationally agreed guidance*
- *Improvements in parents' experiences of care*
- *A reduction in the number of re-admissions for feeding problems"*

In a letter from the Women's, Children's & Family Care Group Senior Leadership Team in March, we were told that these guidelines were a good example of when service user opinion is taken into consideration. We were also informed that the guidelines ensure consistency of advice given to new mothers regarding infant feeding advice across both the midwifery and Health Visiting Service.[95]

Whilst the achievement of Stage 1 of the UNICEF BFI amongst the majority of maternity staff and the Health Visiting service is commendable and the development of the Infant Feeding guideline is certainly a step in the right direction, both are in their infancy and we are unable at this stage to draw conclusions as to the impact they will have on mums and their babies. For now, we are only able to report on the evidence we have available to us in respect of women's experiences of feeding support.

Encouragingly, 69% (448) of respondents to our survey felt that both midwives and health visitors provided active support and encouragement about feeding their baby (11% (69) did not feel they were supported by either). However, despite this, one area which women have expressed particular concern about during our review is that of infant feeding. One of the consistent themes that emerged from the focus groups, that were commissioned by 4insight, was the need for better and more consistent breast-feeding support.[96] Additionally, a significant number of written submissions we received from women expressed a general concern regarding the lack of support available to them on breastfeeding. For instance:

> *"The advice in relation to breastfeeding was wholly inadequate. There was no clear demonstration given by any midwife and I was left to figure it out by myself. I was told it was natural and the baby would know what to do. This wasn't the case.*[97]

[95] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021
[96] 4insight Report, Maternity Services, April 2021
[97] Written Submission, Private, 6th April

> *The staff for the most part are very helpful however there is a serious lack of education around breastfeeding and especially the identification of tongue and lip ties which cause serious issues to a babies breastfeeding ability.*[98]

Other women spoke of poor communication skills amongst staff, forceful behaviour by staff, and a lack of compassion and respect for a mum's choice about how they wish to feed their baby:

> *The midwives were incredibly biased towards 'breast is best' and honestly, originally, I had been too. However, all the pain, discomfort and the fragile state of my mind, I pleaded with the midwifes for formula for my baby, but I would always be guilt tripped into trying the breast 'one more time'.*[99]

> *Without my permission, and very roughly, she stuck her hand down my top, pulled out my breast and squeezed me hard enough to hurt me, but to also draw out some colostrum and told me 'see; now feed your baby' of which I tried, but [my baby] was too small to know how to feed.*

> *The midwives came to show me the basics, including assistance with breast-feeding. I cannot remember the midwife's name; however, she forced my baby onto my breast, and I had trouble getting my son to latch onto my breast, but the midwife kept forcing. Since that first feed whenever I tried to breast-feed our son I was in agony. I asked the midwife if I could try using formula in a bottle for the baby and she glared at me and said I should keep trying to breast feed.*[100]

Whilst the Panel recognises and strongly supports the promotion and encouragement of breastfeeding amongst expectant and new mums, we also acknowledge the need for a balance of the advice provided – i.e. encouragement that does not leave women feeling pressurised. The objective of UNICEF's Baby Friendly Initiative is to "*create a supportive, enabling environment for women who want to breastfeed*" and affirms that breastfeeding requires support, encouragement and guidance. In our view, women need to be informed of the benefits of breastfeeding but respected if they then decide not to. A representative from Jersey's National Childcare Trust (NCT) confirmed in their submission to the Panel that feedback from service users suggests that advice has not always been provided consistently and without judgement. It was advised:

> *One point that is often raised however is the huge range of different and inconsistent advice offered which can leave new parents somewhat bewildered, and the often perceived over enthusiastic promotion of breast feeding. Working in line with*

[98] Written Submission, Anonymous, 10th February 2021
[99] Written Submission, Leila, 10th February 2021
[100] Written Submission, Anonymous, 14th February 2021

> *UNICEF recommendations on breast feeding is acknowledged, but there is regular feedback of feeling pressured and judged if breastfeeding is not the chosen path.*[101]

The promotion of breastfeeding has to be underpinned by women having ready access to well trained professionals, in both the hospital and at home, who provide consistent support and advice. Disappointingly, thirty-five per cent (230) of respondents to our survey said that the advice they had received from different midwives/health professionals about feeding their baby was inconsistent.

FINDING 31: A significant number of women reported receiving either inadequate breastfeeding support, or a lack of compassion and respect about how they wished to feed their baby. The promotion of breastfeeding has to be underpinned by women having ready access to highly trained professionals, in the hospital, the community and at home, who provide easily accessible and consistent support and advice.

Sadly, we found that in some cases a lack of breastfeeding support from maternity staff and health visitors post birth and a lack of respect for women's choices as to how they wished to feed their baby had consequences for the women's emotional well-being and mental health. One woman who suffered from post-natal depression due to a lack of support when breastfeeding her tongue and lip tied children felt that the service was failing all mothers and babies on the Island by not providing completely adequate care. Another woman believed that greater emotional support was needed for those suffering as a result of the pressure put on mums to breastfeed:

> *There needs to be much better support for women whose mental health is suffering, under the monumental societal pressure to breastfeed. The pendulum has swung way too far in the other direction. The mantra 'breast is best' completely disregards what might be best for a mother's mental health and as a consequence, her bond with her baby. I do think health visitors need to recognise when a woman wants support to continue her breastfeeding journey and when she needs to stop for her own emotional well-being and that of her child.*[102]

In 2017, the Royal College of Obstetricians & Gynaecologists (RCO&G) wrote a report - 'Maternal Mental Health – Women's Voices' – based on the survey of over 2300 women on their experiences of care in relation to their mental health during pregnancy and in the postnatal period. In respect of breastfeeding and mental health the College found that, overall, respondents felt the pressure to breastfeed was sometimes overwhelming and the judgement and stigma that came along with not breastfeeding their babies was hard to cope with. This was

[101] Written Submission, NCT, 10th March 2021
[102] Written Submission, Jess, 9th March 2021

especially true of women who had planned to breastfeed but were unable to because something had gone wrong. Rather than receiving support, many felt that they were being blamed and it became hard to hope with this alongside their own feelings of failure. This is despite NICE clinical guidelines that state that each woman should be supported in her choice of the feeding method that suits her and her family. In light of the responses in the survey on breastfeeding and mental health, RCO&G made the following recommendation:

> *Difficulties in breastfeeding can impact on a mother's mental health. Commissioners should examine opportunities for more breastfeeding support in communities. They should also consider opportunities to better link breastfeeding and perinatal mental health support services together; for instance, breastfeeding drop-ins and groups could provide opportunities to discuss and raise awareness for perinatal mental health services.*[103]

FINDING 32: In some cases a lack of breastfeeding support from maternity staff and health visitors post birth and a lack of respect for women's choices as to how they wished to feed their baby had consequences for the mum's emotional well-being and mental health.

RECOMMENDATION 14: The Minister for Health and Social Services should consider opportunities to better link breastfeeding and perinatal mental health support services together and train volunteers locally to provide peer support services.

The evidence we have gathered throughout our review suggests that many of the issues faced by woman in regard to breastfeeding their baby have resulted from either the absence of adequate support from health professionals, and often failure to communicate the ambition of the UNICEF policy appropriately, or lack of information provided to parents antenatally and postnatally. We will address each of these points in turn.

Training and specialist support for breastfeeding

A number of submissions the Panel received from members of the public called for more training amongst maternity staff on breastfeeding and for additional specialist support. For example, two individuals commented:

> *"More support with breastfeeding and a breastfeeding specialist [needed] - sort of left to your own devices and get told conflicting advice by midwives.*[104]

[103] Maternal Mental Health – Women's Voices, Royal College of Obstetricians & Gynaecologists, February 2017, p31
[104] Written Submission, Anonymous 3, 9th March 2021

> *Dedicated, paid, trained breastfeeding support, the current provision is hit or miss and not consistent enough.*[105]

In respect of the BFI training, we note that all maternity staff, including health care assistants and nursery nurses, had received 2 full days of breastfeeding training which would equate to 15 hours. We were told that part of the transition to achieve Stage 2 (which relates to the education and skill level of the workforce) is that all staff undergo the same amount of training. The Maternity staff have a two-year window to progress to Stage 2 of the BFI but the ambition is for all staff to achieve that within the next 12 months.[106] Following receipt of further information provided to the Panel in April, we are aware that the maternity services' objective is to achieve Stage 3 BFI accreditation by Spring 2023.

We note that the Health Visiting service is on track for applying for Stage 2 accreditation by September 2021. Recent staff audits, which took place throughout the pandemic, have shown an ongoing improvement in staff knowledge of breastfeeding support mapped against the UNICEF BFI standards. Once applied for, UNICEF will complete staff interviews to see if the standards are met and, upon successful completion, Stage 2 will be awarded. UNICEF then allow a further 12 months for completion of Stage 3 assessment, at which point the Baby Friendly service is awarded. We were advised that the Health Visiting Service will know that they are ready for Stage 3 assessment when parental audits indicate that the standards are embedded in practice with parents receiving information in line with the same.

We note that both the Maternity Service and the Heath Visiting Service have five identified 'champions', each who received five days of training directly from UNICEF BFI team, which covered all of the standards, train the trainer, and audit. The champion role is to support the best practice, support the BFI lead with training delivery, assessment of staff practical skills and audit, and to contribute to the BFI Operational Group. Furthermore, the champions should be a resource for staff prior to referring on to the BFI lead for more complex cases.

According to the Baby Friendly Project Lead, engagement with champions has been a challenge due to staff resource and subsequent inability to allow the champion's time to take this role forward. This has had an impact upon the progress made towards achieving Baby Friendly as a baseline staff knowledge. We are told that a baseline audit undertaken in Autumn 2020 showed that, at the time, staff knowledge within the Maternity services did not meet the UNICEF standards. It was suggested that this could be the result of the pandemic and a reduced opportunity for staff to practice these skills at a time when services were largely restricted. Furthermore, no further staff interviews were completed in Q1 to allow the BFI lead to audit

[105] Written Submission, Leila, 9th March 2021
[106] Public Hearing, Minister for Health and Social Services, 13th April 2021

these against the standards. Therefore, despite HCS's ambition to achieve Stage 2 accreditation within the next 12 months, the BFI Lead advised us:

> *There is at this time insufficient data to suggest when the Maternity Unit, including SCBU, may be ready for stage 2 assessment. UNICEF guidance required that stage 2 is completed by January 2023, with stage 3 taking place by January 2024.*[107]

It is the view of our advisers that the whole maternity system, including GPs, midwifery, neonatal and Health Visiting services demonstrate a commitment to achieving Baby Friendly status and that the plan to achieve BFI full accreditation by Spring 2023 should be owned by every service, adequality resourced and closely monitored.[108]

FINDING 33: Staff and resource constraints have led to breastfeeding 'champions' being unable to be released for work towards the Baby Friendly Initiative. As a result, it is unclear when the Maternity Unit may be ready to progress to Stage 2 accreditation.

RECOMMENDATION 15: The Minister for Health and Social Services must ensure that breastfeeding champions are given protected time to undertake the work and training necessary to fulfil their role.

RECOMMENDATION 16: The Minister for Health and Social Services must ensure that the whole maternity system, including GPs, Midwifery, Neonatal and Health Visiting services, demonstrates a commitment to achieving Baby Friendly status and that the plan to achieve BFI full accreditation by Spring 2023 is owned by every service, adequately resourced and closely monitored.

In addition to breastfeeding champions, we were informed at the Public Hearing with the Minister for Health and Social Services that the intention was to recruit a breastfeeding midwife specialist who would help lead and drive training beyond the BFI. The specialist would also be in a position to ascertain whether further support was needed, such as a lactation consultant.[109]

According to the BFI lead, the frequent change in Heads of Midwifery has also slowed progress towards the BFI standards, with the most recent Interim Head of Midwifery being the first to prioritise champion release to complete work required on the Maternity Unit for Stage 1 accreditation. It was also suggested that staff sickness has impacted upon this ongoing release of staff to continue to progress towards Stage two. It was advised that, for this reason, the BFI lead would support the needs for a staff member on maternity and SCBU who was responsible for championing the UNICEF standards and mentoring/upskilling staff whose breastfeeding

[107] Written Submission, Family Nursing and Home Care (Breastfeeding), 12th May 2021
[108] Attain Report, May 2021
[109] Public Hearing, Minister for Health and Social Services, 13th April 2021

support skills needed to be refined. They believe that this could either be in the form of a specialist post or within a current role, with protected time and a contingency for sickness or absence cover.[110]

FINDING 34: The Health and Community Services' intention is to recruit a breastfeeding midwife specialist who would help lead and drive training beyond the Baby Friendly Initiative.

RECOMMENDATION 17: The Minister for Health and Social Services must ensure that the utmost priority is given to appointing a specialist breastfeeding support midwife by the end of Q1 2022 to champion the UNICEF standards and mentor/upskill staff whose breastfeeding support skills require refinement.

The Panel learnt during its review that FNHC was committed to the commencement of a complex breastfeeding clinic in Autumn 2020 as part of specialist support requirement within the UNICEF BFI standards. The clinic is run by the BFI lead and, although FNHC anticipated that midwifery colleagues may also be involved in the clinic, it has not been possible due to resource/staffing issues. We were told that the BFI lead was currently in the process of developing a business case for a member of the Health Visiting team to undertake additional breastfeeding training, and to take on within the current role, support of the specialists Breastfeeding support service.[111]

The Panel strongly supports the additional support of a complex breastfeeding clinic and believes it will benefit a significant number of women who need additional help and advice in breastfeeding their baby. We would hope, going forward, that maternity staff are encouraged and supported, when time allows, to be involved in the clinic, alongside the Health Visiting team, in order to learn and develop their skills.

Feeding information provided during pregnancy and postnatally

In light of the concerns raised in respect of breastfeeding, the Panel believes it is imperative that all women whilst pregnant, as well as postnatally, are provided with sufficient information in respect of breastfeeding. This information should not only highlight the many benefits of breastfeeding for the mum and child but also advice on how to address any issues that may arise. It should also emphasise that successful breastfeeding is not the sole responsibility of the mother, and that the father/partner has a key role to play by taking ownership of tasks such as nappy changing, bathing the baby, washing clothes, cooking, etc, so that the mother is free to focus on establishing breastfeeding, especially in the first few weeks after birth.

[110] Written Submission, Family Nursing and Home Care (Breastfeeding), 12th May 2021
[111] Written Submission, Family Nursing and Home Care (Breastfeeding), 12th May 2021

The recent Infant Feeding Guidelines, that were published in November 2020, include a section on pregnancy and the dissemination of information to parents about feeding during the antenatal period. The policy recognises that the UNICEF BFI strongly supports the view that pregnancy is the right time for midwives to discuss infant feeding and that it should be on a one to one basis around 34 weeks of pregnancy. The guidelines therefore set out that all pregnant women will have the opportunity to discuss feeding and caring for their baby with a midwife (or a suitably trained designated person) and that the conversation will be documented on page 27 of the green pregnancy Notes.

As part of the 'feeding your baby' section of our survey, we asked whether women were provided with relevant information about feeding their baby during their pregnancy. Of those who responded, 29% (188) answered 'no'. This is compared with 36% (234) who said 'yes, to some extent', 31% (206) who said 'yes, definitely' and 4% (27) who couldn't remember. In their written submission, one member of the public wrote:

> *"The midwife appointments only focussed on the pregnancy. They didn't discuss anything about postpartum. What would have been particularly helpful would be the opportunity to discuss breastfeeding, how to deal with any breastfeeding issues (clogged ducts, shallow latch, soreness, milk supply etc.)*

FINDING 35: UNICEF Baby Friendly Initiative strongly supports the view that pregnancy is the right time for midwives to discuss infant feeding and that it should be on a one to one basis around 34 weeks of pregnancy. Despite this, 29% of respondents to the Panel's survey were not provided with relevant information about feeding their baby during pregnancy.

RECOMMENDATION 18: The Minister for Health and Social Services should ensure that relevant information about infancy feeding and, specifically, how to deal with breastfeeding issues, is provided to women and their families routinely during their antenatal appointments.

OVERARCHING FINDING: There is evidence to suggest that although there are examples of best practice within the service, overall the current information, support and advice in relation to breastfeeding is inconsistent and, in some cases, women have reported a lack of compassion or respect for the manner in which they wish to feed their child, particularly on the maternity ward. Clarity is required in relation to how and when this information, support and advice is delivered to expectant mothers.

Antenatal Educational Courses

Whilst much of the Panel's review has focused on maternity services provided in the hospital and GP surgeries, we recognise that maternity care is also provided in the community by external providers and charities. Antenatal classes can help parents prepare for the birth of their baby and provide tips on how to look after their new-born. Furthermore, and perhaps most importantly, antenatal education can enable women and partners to make informed choices about their care during their pregnancy, labour and post birth.

There are a number of options in Jersey in respect of antenatal classes depending on the type of information the women are seeking. Baby Steps, for example, is a free and structured antenatal and early postnatal programme for expectant parents and their babies. The programme is provided by Family Nursing and Home Care and delivered by experienced Health Visitors, Midwives and skilled facilitators. Other examples are Positive Birth Jersey Hypnobirthing course and the National Childcare Trust (NCT) Antenatal Course, which are both fee paying.

In order for these classes to be beneficial to families, it is imperative that women and their partners are provided with all the choices available to them as early on in their pregnancy as possible so they are able to make information decisions. A written submission from a representative of NCT spoke about this point as well as the importance of antenatal courses:

> *"There is felt to be a good range of antenatal education choices, although unfortunately these are not always fully explained. Possibly midwives are not aware of all the options, and that is a shame. The take up of antenatal education and attendance of appointments and clinics are crucial in enabling women and partners to make informed choices about their care and is felt to be very important amongst my clients. (NCT, 10th March)*

Similarly, 4insight found that Baby Steps was perceived positively overall as it gave expectant parents a chance to engage with other expectant parents and talk through birthing options. However, some mothers-to-be that engaged in the focus groups had not been told about Baby Steps and would have preferred to have been involved.[112]

The Panel would suggest that information regarding antennal courses and the choices available in Jersey should routinely be provided to women at their booking appointment with their community midwife.

[112] 4insight Report, Maternity Services, April 2021

Information provided during and after pregnancy

In general, the Panel's survey results suggest that women are satisfied with the level of information they are provided during and after pregnancy. However, on occasions some respondents to our review reported feeling overwhelmed with the amount of information that was provided and with the way in which it was provided. This was also recognised by maternity staff who at times felt women were provided with too many leaflets and written material.

We were advised by the maternity team that Wellbeing Wallets from Mama Academy, are given to expectant mothers. The wallets are plastic pouches which allow mums to keep their handheld records in and are colourfully printed with important messages and advice regarding mum's and baby's health. Leaflets with relevant information on are provided to women at their antenatal appointments, at hospital after the birth of their baby and by midwives and health visitors at postnatal check-ups.[113]

In 2019, the Government of Jersey published a maternity website to make information more accessible to those who were thinking about having a baby, those who were already pregnant and those who had recently given birth. Before the new website was published the information available to new mums online was minimal and most of the information needed was provided in paper handouts.[114] Despite information being available online, we found that the majority of women that engaged with the Panel were not made aware of the website during their pregnancy and did not know it existed. For instance, 60% (236) of women who had given birth after the summer of 2019 did not know about the website.

In order for parents to make informed decisions about the care they receive during and after pregnancy it is vital that they are made aware of all of the information that is available to them and that they are able to easily access this information. It is also extremely helpful if all the information on maternity services in Jersey is stored in one place where expectant parents can access sections of it if and when they need it. One respondent of the maternity staff survey felt that communication with the public about maternity services could be improved by modernising the website and updating and modernising the leaflets. Another believed that it would be beneficial for the maternity service to have more of a social media presence to tap into modern day communication; including information about the staff, virtual tours of the maternity unit and information about the services provided in the community.[115]

[113] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021
[114] Written Submission, Charlene, 10th February 2021
[115] Maternity Staff Survey, Health and Community Services April 2021

We were advised in April that the Maternity Unit would be updating and refreshing the Maternity website for service users to access links and be sign-posted to all appropriately affiliated organisations to enable women to gain access to all the necessary information on one site.[116]

FINDING 36: Despite relevant information being available online, we found that the majority of women that engaged with the Panel were not made aware of the maternity page on the Gov.je website during their pregnancy and did not know it existed.

RECOMMENDATION 19: The Minister for Health and Social Services should ensure that the "Pregnancy and birth' page on the Gov.je website is regularly updated and that women are made aware of the website during the very early stages of pregnancy.

In a written submission from Family Nursing and Home Care, we were advised that they were contributing to a new multiagency meeting with a Public Health focus in which the aim is to establish evidence-based information that can be given to parents consistently. The meeting is chaired by the Interim Head of Midwifery and attended by all agencies who meet parents in the prenatal, antenatal and postanal periods. We were told that the intention was to broaden the attendance to include the Community and Voluntary Sector. The subjects that are currently being prioritised are: smoking, alcohol, mental health, nutrition and C-sections and, to-date, there had been one meeting.[117]

[116] Letter, Minister for Health and Social Services, 29th April 2021
[117] Written Submission, Family Nursing and Home Care, 24th February 2021

9. Availability and Quality of Perinatal Mental Health Care and Emotional Wellbeing Support

Perinatal Mental Health refers to a woman's mental health during pregnancy and the first two years after birth. This includes mental illness existing before pregnancy, as well as illnesses that develop for the first time, or are greatly exacerbated in the perinatal period. Examples of perinatal mental illness include antenatal depression, postnatal depression, anxiety, perinatal obsessive-compulsive disorder, postpartum psychosis and post-traumatic stress disorder (PTSD). These illnesses can be mild, moderate or severe, requiring different kinds of care or treatment.[1]

It is widely recognised that mental health problems are often associated with times of stress or change in an individual's life and that pregnancy and the first year after birth is a time where health professionals play a significant role in promoting mental health. It is also acknowledged among professionals and the general public that the period directly after birth and the parent infant relationship is crucial for the health and wellbeing of the infant, both in the present and long term.

The impact of perinatal mental health problems can and often do extend beyond the mother's physical and mental wellbeing, having consequences for their partner, family and child(ren). NICE guidelines[118] state that opportunities for service development should be identified. It highlights that services need to recognise the importance of the mother-baby relationship and relationships with partners and the wider family, looking at the whole family picture.

Estimated Prevalence

Research from the Royal College of Obstetricians & Gynaecologists indicates that, across the UK, up to 1 in 5 women develop some form of mental health problem during their pregnancy or in the year after birth[119]. In fact, an NCT survey, undertaken in 2017, of 1,000 women who had recently had a baby found that half of women who had recently had a baby had had a mental health or emotional problem postnatally or during pregnancy. If this were also to be true in Jersey, around 450 mothers a year would experience mental health or emotional issues, based on an average of 984 births in the last 5 years.[120] Furthermore, according to the NSPCC, in just the first to the third week of lockdown in the UK in 2020, the number of adults that contacted the NSPCC Helpline about parental mental health increased by just over a quarter (28%).

[118] https://www.nice.org.uk/guidance/cg192
[119] maternalmental-healthwomens-voices.pdf (rcog.org.uk)
[120] Hidden Half Shortform report.pdf (nct.org.uk)

Prevalence in Jersey

The Panel was keen to learn how many women in Jersey develop a mental illness during pregnancy or within the first year of having a baby and how these figures compare to other jurisdictions when benchmarked against them. In a letter from the Minister in April, we were advised that this data was not currently collected by the Health and Community Services Department but that an audit was currently in progress within the Community Midwifery Services to ascertain the number of women experiencing, or who are at risk of, developing mental health concerns. Furthermore, we were told that the audit is being undertaken to help plan for future service provision.

Whilst we are pleased that work is currently being undertaken to ascertain this information, we are surprised that this data has not previously been collected, especially given the increased spotlight on mental health in Jersey over the last few years.

Current Mental Health pathway and support

Whilst there are numerous services available for women to access in respect of perinatal mental health, evidence suggests that, to date, the issue has been a lack of consistency in the way women are assessed antenatally and postnatally. It is also apparent that current services are not adequately resourced, impacting on the education and training of midwives and GPs and the provision of specialist care.

During our review we learnt that considerable focus and energy had recently been given to developing the mental health offer to pregnant and new mums, which is applaudable and very much welcomed by the Panel. We were advised by the Health and Community Services Department that, for the last two years, the Midwifery staff have been part of a multidisciplinary team, involving Adult Mental Health Services (AMHS), Health Visitors, Midwifery, NSPCC, Baby Steps and Child and Adolescent Mental Health Service (CAMHS) to develop a Perinatal Mental Health Pathway.[121]

The current pathway for severe mental health concerns in pregnant women is via Adult Mental Health Services (AMHS). We are told that women are screened as part of the pregnancy booking appointment and signposted, where it is indicated, to AMHS for acute/chronic mental health needs and priority care. At a woman's first contact with primary care, or her booking visit with the midwife, a general discussion takes place about a woman's emotional well-being and mental health and specific questions are asked to identify women at risk of developing depression. The women will also have access to a Consultant Obstetrician and ongoing Midwifery/Health Visiting/GP support. We are advised that once referred to AMHS, the

[121] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021

assessment usually takes place within 2 weeks and is undertaken by a psychiatry consultant or a mental health nurse.

During our review we also discovered that as of 1st February 2021, a Consultant led Perinatal Mental Health Clinic has been launched in the Antenatal Clinic and that this is held every 6 weeks. The clinic was developed to ensure that there is a multidisciplinary team approach taken to care, with guidelines that underpin the operational care delivery. As well as this Consultant clinic, there is provision for women to be seen by a mental health nurse/health visitor counsellor in the Antenatal Clinic.[122]

In the Panel's survey we asked respondents a number of questions in respect of emotional well-being and mental health and whether these were matters that they were asked about and addressed by health professionals throughout their pregnancy. One of the questions on our survey asked mothers whether a GP or midwife had asked about their 'mood' or 'feelings' in respect of their emotional wellbeing during antenatal check-ups. Encouragingly, the majority of respondents (47% - 306) said that both their midwife and GP had asked about their emotional wellbeing whilst pregnant. However, despite the response from the Department, and our understanding that such questions were routinely asked, 21% (135) said that neither their midwife or their GP had asked about their mood or feelings during antenatal check-ups.

When we asked a similar question about post-birth, reassuringly 85% (559) of respondents said that they were asked by either a GP, midwife or health visitor about their emotional well-being, compared to 9% (56) who weren't asked and 6% (40) who couldn't remember. Given this result we were quite surprised to then learn that 27% (175) were not given information about possible changes to mood/feelings/thoughts after having their baby (compared with 60% - 292 who were).

FINDING 37: Despite being advised that women were routinely asked about their emotional well-being and mental health at their first contact with primary care or their booking visit with the midwife, 21% of respondents to our survey reported that neither their GP or midwife had enquired about their mood or feelings during pregnancy.

RECOMMENDATION 20: The Minister for Health and Social Services must ensure that every expectant mother is routinely asked about her feelings and mood at every antenatal appointment to ensure that any issues are recognised and acted upon as early as possible.

We received mixed responses from members of the public who wrote directly to the Panel on the current mental health services available to parents. Some of those responses have already been referred to in our earlier discussion regarding breastfeeding (Chapter 8). A number of

[122] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021

parents shared their own experiences of mental health care following the birth of their children. For example, they wrote:

> *What mental health care? They took absolutely no responsibility for mine in there after a seriously traumatic birth that I am still recovering from. Complete negligence on their part for the lack of mental health care supplied. I'm glad that people like us who've had bad experiences are speaking up!*[123]

> *Sadly, I had a pretty appalling experience with perinatal mental health care. It definitely needs improving! I'm just grateful I had an amazing community midwife and a good experience in the maternity ward.*[124]

Some parents spoke of the need for more support and guidance for mental health and post-natal depression post-birth:

> *I urge you to look into other ways you can support the mental health of new mums to include care packages. Look up letters of light, an incredible uk based charity who I'm sure would be willing to support the new unit. Peer mentoring or doulas where midwives are unable to pick up some of the needs of mums and dads because of workloads.*[125]

> *[There is the need for] a better after-care programme for new parents to include more support and guidance and services for post-natal depression.*[126]

One respondent commented on the need to further promote the great courses that currently exist for expectant parents:

> *I was fortunate enough to attend the Pregnancy in Mind course run by the NSPCC, this is a fantastic course, but personally I don't feel this course is promoted enough to expectant parents. This course would be of benefit to all parents to be, and would certainly highlight how you handle emotions, meditation & relaxation and when to know if things aren't right such as possible post-natal depression.*[127]

Proposals for new pathway and improvements

The Midwifery Team have acknowledged the current absence of a dedicated Perinatal Mental Health Service in Jersey and that this care is currently incorporated within the AMHS. They also recognise that a dedicated service is needed to fully support women. As we mentioned earlier,

[123] Social Media, 10th February 2021
[124] Social Media, 10th February 2021
[125] Written Submission, Bella, 9th February 2021
[126] Written Submission, Charlene, 10th February 2021
[127] Written Submission, Helen, 9th February 2021

a multidisciplinary team has been working on developing a Perinatal Mental Health Pathway. It is hoped that the new pathway will improve service provision and provide significant quality improvements for the mental health of women and their families. However, in order for the new pathway to be implemented additional staffing resources and funding is required.

A comprehensive business case for the perinatal mental health service has been developed and, we were advised whilst undertaking our review, that it has now been adopted in full.[128] In regard to the funding of the business case we are aware that some additional funding has already been provided to help develop the perinatal mental health service. This funding will allow the Liaison Psychiatry Consultant to be provided with some much-needed additional resource to help provide care to women in a timelier manner. Furthermore, two additional sessions of doctor time will be made available to support the development of the new pathway and we were informed that HCS have funding for an additional perinatal mental health nurse to join the service. This will be piloted in 2021 and the plan is to develop the business case, learn from the work that is currently being undertaken and look to roll out a more comprehensive service in 2022 as part of the Government Plan. The intention within the business case is also to build capacity for a Perinatal Mental Health Midwife to help support women and staff. According to the Group Managing Director of HCS:

> *We are pretty confident that it [the business case] 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.*[129]

The plan for the future is that the Perinatal Mental Health Pathway will be accessed through a single doorway with a streamlined referral process for all. In addition to this, we have been told that a Mental Health Forum has recently been created to include midwives, obstetricians, health visitors, Adult Mental Health Services (AMHS), Children and Adolescent Mental Health Services (CAMHS), perinatal psychologists, counsellors and other island wide services. The forum will meet on a regular basis to discuss individual women and adopt an appropriate and comprehensive care plan.

Commenting on the new pathway, Home Care and Family Nursery said:

> *This pathway is looking to integrate services that already exist, which will be informed by client experience. In addition, the pathway is looking to develop new ways of working for referrals, triage and service response. Where gaps in provision are being identified, it is proposed that a business case will be developed to enable the service to meet client*

[128] Public Hearing, Minister for Health and Social Services, 13th April 2021
[129] Public Hearing, Minister for Health and Social Services, 13th April 2021

> *needs and become more robust. This development will include protected time for a dedicated midwife and aligning the service to meet Safeguarding requirements. The highest priority within the pathway is an emphasis on the identification of needs at the earliest point and early intervention.*[130]

In a submission from NSPCC, they spoke about the current issues they believe exist in respect of antenatal and perinatal mental health services and of their hope that the new pathway will help to address their concerns:

> *We believe that there are suitable antenatal and perinatal mental health services; however, delivery of services is patchy and inconsistent. We also believe that there are limited resources to meet the needs at the time expectant parents needs additional support; there is a lack of preventative approach which often lead to crisis management. We also feel that there are too many doors to access mental health services; the referral route is unclear and inconsistent which leads to some expectant parents to fall through the gaps. It is our hope that the work currently being undertaken by the Government of Jersey around re-designing perinatal mental health services will address these issues.*[131]

When we raised these concerns with the Minister at our hearing in April, he recognised that the public health aspects of maternity care are vital and something that has not been emphasised or given enough resource in the past. In respect of NSPCC's comments regarding a lack of preventative care, the Minister confirmed that HCS would like to create a post for a midwife who had a specific role in preventative care and who would be responsible for highlighting the risks to expectant mums and keep them well during pregnancy.[132]

With all aspects of maternity care, the Panel is keen to understand how service improvements will impact the average woman using such services. In the Public Hearing with the Minister for Health and Social Services, we asked the Interim Head of Midwifery how the service would look different to those using it following the implementation of the new pathway. We were told that one of the major differences will be in respect of how women are screened. For instance, the new pathway will "tease out" mental health and mental illness and the screening will be done at subsequent visits from the booking appointment. The screening sessions will include screenings for postnatal depression, postnatal anxiety and PTSD related to birth trauma. We were also informed that the plan is to introduce a new public health section into the 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 Interim Head of Midwifery also confirmed that as well as antenatally, postnatally there will be more robust interviews to tease out those women who feel more vulnerable.

[130] Written Submission, Family Nursing and Home Care, 24th February 2021
[131] Written Submission, NSPCC, 15th February 2021
[132] Public Hearing, Minister for Health and Social Services, 13th April 2021

The Women's, Children's & Family Care Group Senior Leadership Team, advised the Panel that whilst maternity staff in Jersey believe that they offer a good service to women with mental health challenges, they feel that the care will be greatly enhanced once the Perinatal Mental Health Clinic is imbedded.[133]However, the staff survey that was commissioned by the maternity senior management team, raised a number of concerns regarding the current perinatal mental health care provided to women that have not yet been considered in this report. One of those is poor communication between the maternity team and the mental health team resulting in no feedback being provided to the named midwife regarding the women's mental health needs. Another concern which appeared a number of times was the lack of information and knowledge that had been given to ward-based midwives in the respect of the appropriate referral forms and how to book appointments. Both of which appeared to impact on the appropriate care provided to women when needed the most. We will discuss staff training further on in this chapter.

FINDING 38: A new pathway for perinatal mental health has been developed with the intention of making the referral route clearer and more consistent for expectant and new parents. The highest priority within the pathway is an emphasis on the identification of needs at the earliest point and early intervention.

Referrals and Waiting Times

As explained earlier by Family Nursing and Home Care, one of the highest priorities of the new pathway is an emphasis on the identification of needs at the earliest point and early intervention. Within our survey we hoped to gain an understanding of the number of women and partners who had experienced mental health issues during or after pregnancy and the care they were provided. Of those who responded to the survey, 23% (153) said that they themselves had experienced mental health issues during or after pregnancy, 4% (26) said their partners had, and in 6% (40) of occasions the mum said that both her and her partner had experienced issues. Of the mums who had experienced mental health issues, 34% were referred to a support service. However, 27% (56) of mums were never offered this option by the health professionals they saw during or after pregnancy.

The Panel was advised by HCS that the average wait for assessment for referrals to the Adult Mental Health Service, that are marked as Perinatal, was 7.6 days (Jan 2020 to date).[134] We have also been told that the Baby Steps programme and MECSH currently have no waiting lists. Whilst we acknowledge that waiting times for such services may have changed in recent years, 52% of respondents who were referred to a mental health service were not seen within a week. Of that 52%, 18% did not see the specialist that they were referred to for 4 weeks.

[133] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021
[134] Email correspondence, Health and Community Services,13th April 2021

Staffing resources and staff training in emotional wellbeing and mental health support

The recruitment of a specialist Perinatal Mental Health Midwife has been adopted widely across the UK. The Maternal Mental Health Alliance, NSPCC and the Royal College of Midwives all supported the call for a specialist mental health midwife in every maternity service in the UK to ensure that women and their families receive the specialist care and support they need during pregnancy and in the postnatal period. Additionally, the specialist role would support their maternity team colleagues to ensure that services deliver the best possible personalised care to these women and their families to optimise their mental health.[135] During our Hearing with the Minister, the Interim Head of Midwifery confirmed the intention to recruit a Perinatal Mental Health Midwife in order to support and help women with the referral and to help other midwives manage expectations and manage referrals and processes.[136] We found that Midwives appeared to support the recruitment of a specialist mental health midwife with one staff member commenting:

> *"I feel that midwives need a specialist midwife that we can discuss cases with and to help support us in making sure women and their families access the right mental health care."*[137]

Another member of staff expressed their astonishment as to why a named mental health midwife has not yet been appointed in Jersey:

> *According to the latest MBRRACE-UK report, 10% of maternal deaths relate to mental health conditions; I struggle to understand how a named mental health midwife/team is still not seen as a priority here in Jersey.*[138]

With regards to the responsibility of the specialist perinatal mental health midwife, our advisers are of the opinion that it is critical that their key role is to ensure the education and training of all midwives to make sure that there is a consistent assessment and referral across all services. The advisers are also of the opinion that direct referrals by midwives, based on criteria agreed with the perinatal mental health team, should be permitted without reference to a GP or an obstetrician (which is currently not believed to be the case).[139]

During the Public Hearing we asked the Assistant Minister for Health and Social Services whether he was confident that the new pathway would ensure that all midwives (both community and hospital), health visitors and GPs would receive the necessary training on emotional well-

[135] https://www.rcm.org.uk/media/2370/specialist-mental-health-midwives-what-they-do-and-why-they-matter.pdf
[136] Public Hearing, Minister for Health and Social Services, 13th April 2021
[137] Maternity Staff Survey, Health and Community Services April 2021
[138] Maternity Staff Survey, Health and Community Services April 2021
[139] Attain Report, May 2021

being to help better support women and their families during and after pregnancy. The Panel was assured that such training was very much part of the new model of perinatal care. In a letter from the Women's, Children's & Family Care Group Senior Leadership Team it was advised that:

> *Further training to midwives to include antenatal mental health screening, identification and knowledge of mental health conditions, treatments, pharmacology and referral processes should be integral to a midwives' continuing professional development. Ideally, specialist mental health midwives should be available to support women and staff.*[140]

FINDING 39: The Panel was pleased to learn that the Health and Community Services Department has committed to recruiting a Perinatal Mental Health Midwife to better support staff providing and women receiving mental health support.

RECOMMENDATION 21: The Minister for Health and Social Services must appoint a specialist perinatal mental health midwife by the end of Q1 2022.

RECOMMENDATION 22: The Minister for Health and Social Services must ensure that, when recruited, the Perinatal Mental Health Midwife organises and encourages education and training of all midwives in perinatal mental health and the delivery of care to make sure there is a consistent assessment and referral across all services.

Earlier in our report we discussed the issue of a continuity of care and carers during and after pregnancy. The Panel wishes to touch on this briefly again here and highlight the potential impact of a lack of consistency in health professionals on the well-being of parents. In the correspondence from the Women's, Children's and Family Group Leadership Team we were also advised that midwives were in "*an ideal position to build a trusting relationship with women due to the frequency of appointments in pregnancy*" and that midwives can monitor well-being and make sure clear care plans are in place for pregnancy, labour and the postnatal period.[141] However, the Panel is concerned that a lack of continuity of care could mean that such relationships with midwives aren't necessary being formed which could leave women feeling unable to speak out about their emotional well-being. Furthermore, fragmented care could also result in women not being appropriately monitored and, as a result, any issues with their well-being not being detected at the earliest possible opportunity.

FINDING 40: A lack of continuity in care during and after pregnancy could impact on the ability of a women to form trusting relationships with their midwives, leaving them feeling uneasy about discussing personal matters, such as their emotional wellbeing.

[140] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021, p6
[141] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021

Mental Health support for fathers/partners

Whilst we know that more mums than dads experience mental health issues in the perinatal period – during pregnancy and after birth, a significant number of dads (1 in 10) are still affected.[142] For that reason we feel it is extremely important that dads/partners are routinely asked (directly or through the mum) about their emotional well-being during the stages of pregnancy. When women were asked in our survey whether a GP, midwife or health visitor had enquired about the fathers/partner's emotional well-being following the birth of their baby a staggering 48% (314) said no. This is compared to 37% (244) who said yes and 14% (93) who couldn't remember.

We were advised by the Minister and his Officers that a partner's mental health was not routinely assessed nor was there a specific pathway for support for fathers. However, if the partner highlighted issues when attending antenatal or postnatal appointments then they are *"appropriately referred/signposted to services support as required".* [143]

KEY FINDING 41: One in ten fathers/partners experience mental health issues during pregnancy and a year after birth. Despite this, the majority of women (314) who responded to the Panel's survey said that the baby's father/their partner was not asked about their emotional wellbeing following the birth of their baby.

RECOMMENDATION 23: The Minister for Health and Social Services must introduce guidance which ensures that all fathers/partners are routinely asked about their mental health (either directly or through the mother) during pregnancy and following the birth of the baby. The Minister should ensure that as part of the pathway, access to mental health support for fathers/partners should be expedited.

Miscarriage/Baby loss

It is well known that the provision of support following a bereavement makes a significant difference to the family and how supported they feel. The quality of bereavement care can have a considerable effect on the wellbeing of parents and their families in the time immediately following the loss of a baby, as well as in the longer term.[144]

The Ockenden Report that was undertaken in 2020 recognised that midwives and obstetricians need to have an awareness of the recognition of parenthood, using sensitive and effective communication, whilst enabling informed choice in all aspects of care and decision making. Furthermore, it is imperative that they also have an awareness of the grief and trauma that families may be going through. The report comments:

[142] NSPCC, May 2020.
[143] Letter, Minister for Health and Social Services, 29th April 2021
[144] Ockenden Report, 10th December 2020, p17

> *Compassion and kindness in care and communication by midwives, obstetricians and all members of the maternity team parents may encounter is essential. Such compassion can have a positive and long-lasting influence on the experience families have at this time.*[145]

The Ockenden Review found several instances where the bereavement care was either inadequate or non-existent, which had a negative impact on the wellbeing of the parents and their overall experiences.

During our review, we enquired with HCS as to how many miscarriages and stillbirths had occurred each year since 2015 that they were aware of. We were provided with the following data[146]:

The data below in reference to 'miscarriage' refers to those women who were known to Maternity services at the time of their miscarriage. The information is only available from 2016 onwards.

Indicator	Definition	2015	2016	2017	2018	2019	2020
Miscarriage	Deliveries with an outcome of 'Spontaneous Miscarriage'	_	109	125	105	122	102
Stillbirth	Deliveries with an outcome of 'Stillbirth'	0	2	2	3	4	1

Whilst our survey with women who had given birth in the last five years didn't address baby loss, we received a number of submissions from members of the public and key stakeholders who spoke about this matter and, on a number of occasions, expressed concern as to the care and support delivered following a miscarriage or still birth. For example, we were informed by NSPCC that:

> *Expectant parents' feedback highlights at times insufficient emotional support following pregnancy loss, that information shared with expectant parents can be delivered in an abrupt manner resulting in increased stress and anxieties. Delays in delivery of debrief sessions following traumatic births has an impact on parents' mental health and potential connection to their unborn babies.*[147]

Parents themselves have echoed the views of NSPCC in their own submissions to the Panel. One mum who delivered her still born son at 24 weeks old advised us of the of the lack of support her and her husband received following the discovery at her 20-week anatomy scan that there was something wrong with their baby. The parents had been referred to Southampton's foetal medicine unit to undertake 4 weeks of tests and scans. The mum told us:

[145] Ockenden Report, 10th December 2020, p17
[146] Letter, Women, Children and Family Care Group, 2nd March 2021
[147] Written Submission, NSPCC, 15th February 2021

> *During these 4 weeks of tests, we received 4 phone calls from midwives in the antenatal department at Jersey's General hospital. Each time was a different midwife who called and each time was to arrange our flight to Southampton. There was no care or compassion in the calls, it just seemed like a formality to get the flights booked. This was by far the most scared I have ever been and I felt so alone and let down by the antenatal department at the hospital for their complete lack of support to me and my husband. I had no communication with any Jersey consultants or my community midwife (who I had seen throughout my first pregnancy and who I had seen 3 times during this pregnancy before my 20-week scan).*[148]

Similarly, mothers who opened up about their experiences regarding miscarriages in the focus groups (that were held by 4insight) reported the services as being "cold", "inhumane" and "awful". For instance, "*one mother had 3 separate miscarriages and reported feeling "like a piece of meat" due to the lack of emotional support. She had no follow up or one on one support and when asking for help she would receive a different doctor each time, having to explain her traumatic experiences multiple times to different people."*[149]

Two members of the public, who themselves had experienced baby loss, spoke of the need for further support in the way of bereavement midwives and further training for both doctors and midwives in the maternity ward in how to better communicate with parents:

> *I am so shocked and upset that Jersey doesn't have a bereavement midwife. This needs to be made a priority along with supporting families that lose babies pre and post loss. Bereavement midwives are such a valuable resource to have and prove invaluable to families going through baby loss. We were lucky enough to meet one in Southampton and she provided exceptional care in the 2 times we met her.*[150]

> *I have researched stillbirths and note that the UK have specially trained bereavement midwives for miscarriages, stillbirths, and other traumatic experiences someone may have in pregnancy. I know that Jersey may not have the same number of stillbirths as the UK, however, providing periodic training sessions to midwives and doctors in relation to this would be beneficial. This should include better training for doctors on what the forms are that they are communicating to persons and consider timing of providing information/leaflets to those dealing with loss.*[151]

When asked at the Public Hearing what particular area the maternity team would like to prioritise and address from the issues that had been raised by members of the public in their submissions to the Panel, the Chief Nurse listed bereavement support as one of the three answers she provided (continuity of care and aftercare support being the other two). In her response she also

[148] Written Submission, Anonymous, 26th March 2021
[149] 4insight Report, Maternity Services, April 2021
[150] Written Submission, Anonymous, 26th March 2021
[151] Written Submission, Anonymous, 14th February 2021

referred to the planned works to the current maternity unit and the anticipation that the improvements would go some way in providing better support to families who had lost their baby. We note that part of phase 1 of the refurbishment of the maternity unit will involve creating a new Bereavement Room.

The Panel queried what training midwives/health care professionals currently received in respect of talking to and supporting women and their families who had experienced miscarriages and baby loss. We were told that, in 2019, midwives and neonatal staff had the opportunity to attend SANDS (Stillbirth and Neonatal Death Charity) training. In addition, staff had been offered in-house training which included bereavement/pregnancy loss pathway. Whilst the fact that such training has been and is offered to staff is encouraging, we are unclear as to whether there are currently any requirements for members of staff to receive regular training on this subject.

FINDING 42: The quality of bereavement care can have a considerable effect on the wellbeing of parents and their families in the time immediately following the loss of a baby, as well as in the longer term.

FINDING 43: Whilst midwives and neonatal are offered training in respect of baby loss, it is unclear as to whether there are currently any requirements for members of staff to receive such training on a regular basis.

RECOMMENDATION 24: The Minister for Health and Social Services should consider the recruitment of a bereavement midwife, or the training of a current midwife into this position, in order to better support families going through baby loss.

Debriefs after labour

According to NSPCC, delays in delivery of debrief sessions following traumatic births has an impact on parents' mental health and potential connection to their babies.[152]

In written correspondence to the Minister we asked how many women were offered a debrief following their birth in 2019 and 2020 and how many women took up the offer. It was advised that in 2019, a total of eighty women (plus some partners/family) accessed support through a 'Maternity Listening Clinic'. Out of those, fifty-five were seen at the hospital and twenty-five in their own home. In 2020, a total of fifty-four women accessed support through the Listening Clinic. In later correspondence with the Department, we were told that the listening clinic is held by the Professional Midwifery Advocated (PMA) on a twice monthly basis. Regarding the clinic they told us:

[152] Written Submission, NSPCC, 15th February 2021

> *This is an opportunity for women and their families to raise concerns about care and treatment they received. Women and their families are not limited to one appointment when accessing this service.*[153]

The Panel are aware that the listening clinic is not offered to every new mum, or indeed everyone who has experienced a traumatic birth. We are therefore unclear as to how those, who are offered the chance of discussing their labours through the clinic, are selected. For instance, one member of the public told the Panel that despite asking three times to see her medical notes and for a review of the birth to allow her to come to terms with her traumatic experiences, neither were provided.[154] In addition, our survey showed that a significant 58% (375) of respondents were not offered a debrief about their labour from a midwife or health visitor.

In respect of the listening clinic, our advisers are of the opinion that the future offer for perinatal mental health care should include a systematic approach to who gets into the debrief system for post-natal support. They feel that whilst it is good practice that this service exists, the offer should be a universal, adequately resourced offer which women are made aware of postnatally in hospital and at home.

FINDING 44: Delays in the delivery of de-brief sessions following traumatic births can negatively impact parents' mental health. However, we found that, in the majority of cases, women and their partners are not offered the opportunity to ask questions about their labour.

RECOMMENDATION 25: The Minister for Health and Social Services should ensure that the de-brief service following birth is universally offered to women and adequately resourced. Women and their families should be made aware of the service postnatally whilst both in hospital (if the women had a hospital birth) and at home. The Minister should ensure that adequate mental health support is available to diagnose and treat women with birth-trauma-related PTSD symptoms.

Mental Health and well-being services available in Jersey

Jersey has many services that provide emotional well-being support to new parents. These include:

- Pregnancy in Mind (PIM)
- Adult Mental Health Services (AMHS)
- Health Child Program (HCP) (Health Visitor Service)
- Baby Steps – provided by Family Nursing and Home Care

[153] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021, p10
[154] Written Submission, Bella, 10th February

- Jersey Talking Therapies
- Parent and Infant Psychotherapy
- The Listening Lounge
- MESCH
- Brighter Futures

More information on these services can be found in Appendix 4.

There are other private services offered on the Island. These include:

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

Summary

As noted by our advisers, there are undoubtedly positive developments being made in the field of perinatal mental health within maternity services. However, progress needs to be made quickly and the impact of the investment needs to be monitored. Thus, our advisers encourage continued scrutiny "*to ensure collaborative working between maternity and mental health services and to ensure consistency of education and approach of all professionals.*

FINDING 45: There are undoubtedly positive developments being made in the field of perinatal mental health within maternity services. However, progress needs to be made quickly and the impact of the investment needs to be monitored.

RECOMMENDATION 26: The Minister for Health and Social Services should provide quarterly updates to the Panel in respect of the new perinatal mental health pathway for assurance that maternity and mental health staff are working collaboratively and delivering consistent care to women and their partners.

OVERARCHING FINDING: The Panel has found that, whilst improvements are being made, significant work is still required to increase and improve mental health support for women and their families during their engagement with maternity services.

10. Experiences of women and their partners and families

> "Without the voice of women, how can decisions be made?

According to our advisers, the evidence that this review has accumulated contradicts evidence from elsewhere; that women are usually broadly satisfied with the overall experience of their maternity pathway. They note that the expected bell curve of women's experiences has been replaced by a more much polarised set of responses – extremely positive or extremely negative.[155] The inconsistency in women's experiences is evidenced in the written submissions we received and in the evidence gathered from the targeted focus groups. It is extremely important that all views are heard, and that real efforts are made to address concerns so that the service can be improved for women and their families.

Our review has shown that there is real intent from the Minister and his Officers to continue to enhance maternity services for women and their families. However, whilst communication with women has started to improve, it still needs to improve further – something that is recognised by the Minister and Executive team. An extremely positive step which has been taken by Government, which we believe is vital to making continual improvements to the service, is the establishment of the Maternity Voices Partnership.

Maternity Voices Partnership

In 2015, Health and Community Services operated a scheme called 'Quality & Women & Children's Services (QWAC). In 2016, this was termed 'Maternity Liaison' and more recently it has been re-branded as Maternity Voices Partnership.

The Maternity Voices Partnership is a women and families participation forum which seeks to gather constructive patient feedback and valuable information from their experiences. The service will remunerate patients for their time taken in participating in this group.[156] MVP was started by Community midwives in early 2020. We have been told that on 19th February 2020 a Facebook post was published by Government of Jersey which received over 50 respondents. Unfortunately, due to the Covid-19 pandemic, the ongoing work on this programme was

[155] Attain Report, May 2021
[156] Letter, Women, Children and Family Care Group, 2nd March 2021

delayed. However, work recommenced in Autumn 2020 and Maternity Voices Partnership recruited the first 10 women as core members. We were advised in March that the plan was to recruit a further 5 members and following that elect a Chairperson. The Maternity Voices Partnership required funding of £10,000 per annum and these monies have been identified for 2021 from the Maternity Gift Fund. According to the Women's, Children's & Family Care Group Senior Leadership Team:

> *"The MVP group are powerful advocates for change and the initial focus group identified service changes that would enhance care for mothers and families in Jersey. The service changes are in alignment with the proposed Midwifery Model of Care the maternity team would like to introduce. This includes Midwifery Led Care, increased continuity and Parish based and not GP based midwifery care, following the Jersey Care Model.*

All women who are members of the Maternity Voices Partnership have experienced the service so are able to provide a greater insight into what they believe maternity services should look like, the structure of it, what works well and what isn't working so well. Moving forward the Partnership will work collaboratively with other service users to determine how the service can be improved and how both women and partners can be better supported.[157]

Our advisers concur with our views regarding the establishment of the Maternity Voices Partnership by commenting:

> *"The establishment of the Maternity Voices Partnership (MVP) is a very welcome development and is an excellent vehicle for enhanced communication between the department and women and to ensure continuous involvement of and feedback from users.*

FINDING 46: The establishment of the Maternity Services Partnership is a very welcomed development and is an excellent vehicle for enhanced communication between maternity services and women and to ensure continuous involvement of, and feedback from, women and their families.

RECOMMENDATION 27: The Minister for Health and Social Services must ensure that the Maternity Voices Partnership reports to the maternity services leadership team on an annual basis to provide feedback from women and their families as to their experiences of the service.

In a written response by the Minister for Health and Social Services in November 2020 to a question posed by Deputy Doublet, it was advised that one of the ways that was being considered for ensuring engagement from women who had assessed maternity services in the past was an annual or bi-annual survey (for both women and their birth partners/family to

[157] Public Hearing, Minister for Health and Social Services, 13th April 2021

complete). We understand that, now the MVP has reconvened following an easing of the pandemic restrictions, further discussion will take place regarding a maternity survey, how this will be developed and who it will target. In light of the number of respondents we had to our own survey, we would suggest that the development of a maternity survey that collected the views of the women on a regular basis would be extremely beneficial for collating and assessing service users' experiences.

As discussed earlier, annual surveys directed at both service users and maternity staff would also be extremely helpful in determining how the service is performing and for benchmarking against other appropriate maternity services.

FINDING 47: The Panel's own survey, with a high level of respondents, demonstrated that women wish to have their say on their experiences of maternity care. The development of a maternity survey that collected the views of the women on a regular basis would be extremely beneficial for collating and assessing service users' experiences.

RECOMMENDATION 28: The Minister for Health and Social Services should request feedback of families on their experiences of maternity care. This could be an annual or a bi-annual survey and/or during the six-week and two-year checks.

Complaints

We believe it is clear from this review that the Maternity team recognise that the experience of women and their partners of maternity care impacts on their well-being and their ability to positively develop loving and lasting bonds with their babies. It is therefore imperative that any complaint received by the team from a woman or their family member is thoroughly considered, discussed and learnt from, in order to identify issues and continually improve the service. In the initial stages of our review we were keen to establish how many complaints had been raised each year since 2014 in respect of the care provided whilst receiving maternity services, and the nature of these complaints. The following information was provided by HCS[158]:

Indicator	2015	2016	2017	2018	2019	2020	2021
No of Complaints	5	5	5	7	2	20	3

[158] Letter, Women, Children and Family Care Group, 2nd March 2021

Care related	17
Communication	5
Attitude & Behaviour	17
Confidentiality	1
Admissions/Appointment	3
Personal Records	1
Premises	1
Other	2

The Panel notes the significant increase in complaints in 2020. When we queried this with the Minister and his Officers, we were advised that, in 2020, the Maternity Unit received 8 formal complaints and the maternity ultrasound department received 11 formal complaints. There were two consistent themes which were care and treatment and attitude and conduct.[159]

With regards to how complaints are managed by the maternity team, we were told that user feedback was received via the Patient Advisory Liaison Services (PALS), where complaints and compliments are logged. Any service user who raises concerns whilst receiving care and treatment have their issues escalated to the senior midwife or Professional Midwifery Advocate (PMA) and/or Consultant/Clinical Lead. We were advised that all complainants are telephoned and encouraged to discuss their experience, the impact this has had on them, what resolution they are seeking and what recommendations or adjustments could be implemented to improve the experience for others. Once a complaint has been received, the staff identified from the complaint are given the opportunity to respond to the complainant and the opportunity to reflect on the experience of the service user.[160]

During our review we have received several submissions from women who had raised formal complaints with the service following their maternity experience. Whilst the Panel and our advisers are unable to provide a view on individual cases, we considered what enhancements could be made to the complaint process, in general, to ensure women and their families voices are heard.

As previously discussed, the 2020 Ockenden Review identified seven immediate and essential actions and 27 local recommendations following an initial probe into baby deaths at Shrewsbury and Telford NHS Trust. One of those seven immediate and essential actions fell under the category “listening to women and their families” and stated that every Trust must create an independent senior advocate role to represent women and families and to make sure their voices are heard. It was proposed that the role would report directly to the Trusts and the Local Maternity Services. Our advisers believe that establishing an advocate role to ensure that women and their families are listening to would be a powerful statement to complement the

[159] Letter, Women’s, Children’s & Family Care Group Senior Leadership Team, 18th March 2021
[160] Letter, Women’s, Children’s & Family Care Group Senior Leadership Team, 18th March 2021

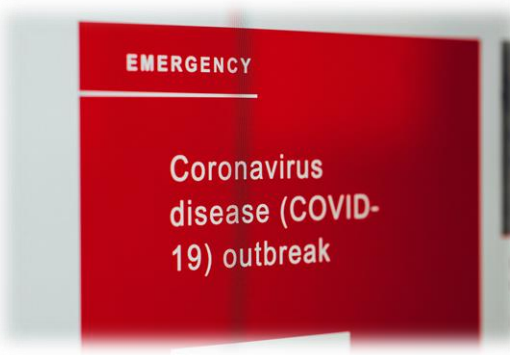
existing maternity services. They therefore recommend that an independent senior advocate role is created for maternity which reports to the HCS Executive.[161]

FINDING 48: One of the immediate actions that was recommended following the 2020 Ockenden Review in the UK was that all Trusts must create an independent senior advocate role to ensure that women and their families are listened to and their voices heard.

RECOMMENDATION 29: The Minister for Health and Social Services should create an independent senior advocate role within maternity services which reports to the Health and Community Services Executive Team.

OVERARCHING FINDING: There is substantial evidence that women and families should be given the opportunity to have their voice heard in relation to maternity services. The Panel found that whilst work is being done to address this through the Maternity Voices Partnership, further work is required in order to improve this for women and their families.

11. Impact of Covid-19 on the provision of Maternity Services



There is no doubt that the Covid-19 pandemic has had a significant impact on Health and Community Services as well as the wider Island and our community. The response from the Jersey Maternity Team must be seen in the context of the wider international problem where services had to react to a very fluid situation with very little global evidence of best practice. As highlighted by our advisers, whilst there were unwelcome restrictions and changes to normal practice, the majority of women and families that we received evidence from understood the changes imposed on them during this period.

The most difficult aspect of Covid-19 rules was the inability of partners to attend antenatal appointments in the hospital for ultrasound appointments. This decision was not popular with the public and a petition to allow companions to antenatal scans was created which, in total, gained 1,448 signatures. Despite this, the decision was taken to continue to prevent fathers/partners from attending antenatal scans until further notice. These restrictions were in place for the periods from 23rd April 2020 to 13th July 2020 and 14th December 2020 to 24th February 2021.

[161] Attain Report, May 2021

A response from the Minister for Health and Social Services on the 8th February to the petition stated (the full response can be read here):

> *The importance of the support that partners and relatives can provide to pregnant women is recognised but this needs to be balanced against the need to keep women and staff safe from Covid.*[162]

In correspondence from the Women's, Children's & Family Care Group Senior Leadership Team in March we were advised that whilst the National Health Service did support partners attending antenatal scans, it was not possible in Jersey. We were also informed that that the NHS guidance was not following the guidance from the Royal College of Obstetrics and Gynaecology and the Royal College of Midwives. The decision to prevent fathers/partners from attending scans was based on the guidance of the local Health and Safety and the Infection Prevention and Control teams. In conjunction with having only one sonographer at the time, it was considered to be a single point of failure for the whole of the maternity scanning service should the sonographer have contracted Covid-19 and been unable to work. This situation highlighted the need for greater resilience in workforce planning to cover such situations. We note that this issue was recognised early on by the hospital team and, since then, several colleagues have been trained to provide additional key skill capacity and give a more robust contingency plan.[163]

Health and Community Services advised that whilst they received a lot of negative feedback regarding the scan restrictions, particularly regarding the impact on family's mental health and wellbeing, they also received positive feedback from women about attending them alone. According to the Department:

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

They also recognised some benefits in restricting visitors in the maternity unit following the birth:

> *Restricting visitors postnatally has had a positive impact on some new parents. We understand the eagerness of families to celebrate in the first hours and days of the new arrival, but women and their partners felt the breastfeeding bonding and attachment without interruption had a positive impact.*[164]

Whilst there may have been some benefits to changes to working practices brought about as a result of the Covid-19 pandemic, evidence suggests that the postnatal care received by women and their families following discharge from hospital during this period was substandard.

[162] https://petitions.gov.je/petitions/200595
[163] Attain Report, May 2021
[164] Letter, Women's, Children's & Family Care Group Senior Leadership Team, 18th March 2021

Ordinarily, following birth, the family would receive home visits from community midwives and health visitors to check on the women and baby's health and wellbeing. However, due to the pandemic, women were required to attend the Bridge for postnatal care. Although we have been told that this change benefited the services as it was much more efficient, families as well as midwives have recognised the negative impact it had on the women's health and on continuity of care:

> *We understand that postnatal care includes one home visit and the rest of the appointments take place at the Bridge, according to need. This again is likely to impact on parents' mental health, connection to their babies and parental relationships.*[165]

> *I was discharged on Saturday 21st March and we went into full lockdown on 23rd March. The main failing was in my post-natal care. Whilst I appreciate the unprecedented nature of a global pandemic I believe the care I received post-partum was sub-standard. My physical recovery took longer than expected and I had to return to the hospital with a possible infection. When contacting the bridge I spoke to different midwives each time and I was made to feel like I was an inconvenience.*[166]

> *Lack of postnatal home visits due to staffing and Covid-19 restrictions has been saddening and resulted in extremely poor postnatal continuity of care.*[167]

[165] Written Submission, NSPCC, 15th February 2021.
[166] Written Submission, Emma, 9th February 2021
[167] Maternity Staff Survey, Health and Community Services, April 2021

Appendix 1: Panel Membership and Terms of Reference

Panel Membership

Deputy Mary Le Hegarat (Chair)

Deputy Carina Alves

Deputy Kevin Pamplin (Vice-Chair)

Deputy Louise Doublet

Deputy Doublet was co-opted onto the Panel in February 2021 to assist with its review of Maternity Services. The Panel would like to thank the Deputy for her time and hard work.

Terms of Reference

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

    - Suitability and adequacy of current maternity facilities
    - Availability and quality of antenatal and perinatal mental health care
    - Safety and effectiveness of care provided during the antenatal (before birth), intrapartum (labour) and postnatal (after the birth) stages of pregnancy
    - Appropriateness of current policies, relating to maternity services, and their application
    - Experiences of women, fathers/second partners, support partners and families.
    - Ability for women to make safe and appropriate choices of maternity care for themselves and their babies
    - Availability of sufficient manpower/resources/skills to deliver the best care.

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

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

Appendix 2: Advisers Report – Attain Health Management

Attain

Improving health and wellbeing

Maternity Service Report

Report to the States of Jersey Health and Social Services Scrutiny Panel

May 2021

States of Jersey
States Assembly

États de Jersey
Assemblée des États

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2.1	14/05/21	Attain	Final
3.0	22/06/21	Attain	Final – addressing HCS comments

CONTENTS

1. EXECUTIVE SUMMARY

In February 2021 the Health and Social Security Scrutiny Panel launched a review of maternity services in Jersey. Since this Review has been launched women have been given a voice, based on their real experience to share their positive and negative experiences. It is vital that this voice must be able to be heard and acted upon beyond the life of this single HSSS Panel review - it is fundamental to shaping the new strategy and sets a bar for acceptable standards. While Jersey is different to any other jurisdiction, expectations of high quality are not - in fact arguably in a geographically contained environment with a relatively small number of births, Jersey should aspire to an even higher level of quality of experience than is found elsewhere.

At the Ministerial Hearing the Panel was told an overarching strategy for maternity services is to be developed by the Health and Community Service (HCS). This will be vital to establishing a modern maternity service that meets the needs of the population. It should offer a vision for the future care model, that is based on best practice evidence (such as preventative public health) and detail implementation targets, against which progress can be monitored. The role of midwives working in a community/ parish based maternity service would support choice and continuity of carer as well as being in keeping with the Jersey Care Model, which promotes community-based care. In the short-term establishing a dedicated Maternity Services project team to drive forward the necessary transformation in maternity services is recommended.

There has been a considerable amount of evidence submitted to the Panel that concurs with the view of the previous Director of the Hospital in 2015, that the current maternity facilities are not fit for purpose. The work on-going is well funded and offers the opportunity for a much improved physical environment. In our view the timescale of two years for the planned refurbishment is too long and will lead to unnecessary disruption for women and their babies and for staff seeking to provide high quality care.

Progress has been made on mental health provision as part of the maternity service pathway with a business case recently approved. There is more to be done to fully integrate mental health within antenatal and perinatal care as this new model is implemented This will build on the good work underway.

The term 'safe' is only one of a number of components of a high quality service. The Care Quality Commission (CQC) framework outlines the components of a high quality service as safe, effective, caring, responsive and well led. A high quality maternity service would have all these components, therefore this review discusses them all not just safe and effective. While many women undoubtedly have a positive experience, we have seen shocking testimonies from women where they have not been treated with compassion, not had their wishes respected and often have had confusing and inconsistent advice. There is room for very significant improvement in this component of quality. This review proposes a midwife led model of care incorporating at a minimum continuity of carer in the antenatal and postnatal period and aiming to extend this to the intrapartum period. The aim of this model of care should be to ensure care is delivered as close to home as possible, to reduce inconsistency of advice in both the antenatal and postnatal periods as well as increasing women's satisfaction with the service.

In measuring if a service is high quality it is critical to maintain a very high level small number of indicators in each component. Performance against these indicators should be available to everyone up to the most

senior level of oversight, alongside a dynamic overall risk register for the service. There is a need to identify, and agree, the critical indicators that would enable a judgement as to whether or not maternity services are high quality.

This review has identified cultural problems within the practice of the maternity pathway, that can specifically undermine the confidence of women and their families. These can be minimised when everyone works to agreed guidelines and policies and when an overarching statement of values and behaviours that will be upheld across the service. These should detail the importance of respectful and compassionate behaviours to each other and to women and be agreed and adopted by all contributors to the pathway. It is very difficult to challenge the behavioural problems that can underpin a poor culture without such a framework.

One area which we are told has caused particular difficulty in Jersey Maternity services is that of infant feeding. Evidence is clear that for the majority of women breast feeding is the option which promotes maximum benefit for a woman and her baby. All professionals should promote breast feeding. However, this must be done in a way which does not make a woman who does not wish to or cannot breast feed feel judged and if it is her decision to bottle feed this should be discussed and supported in a way which ensures she understands the benefits/risks of different feeding methods but which fully accepts and supports her ultimate choice.

In England following the Ockenden Review (2020) an immediate action was to state the need for an independent senior advocate role to ensure that women and their families are listened to with their voices heard. Establishing this role in Jersey would be a powerful statement to complement the existing maternity services, particularly where there has been an adverse outcome.

There is the need for a coherent workforce strategy to underpin the current maternity service as well as to support a new maternity strategy. This should include a leadership structure that is appropriate for maternity. The relationship with the University of Chester for specific training courses for Jersey students is a very positive development. It has the potential to support the development of a more sustainable on island workforce, which increases the employment opportunities on island.

The establishment of the Maternity Voices Partnership (MVP) is a very welcome development and is an excellent vehicle for enhanced communication between the department and women and to ensure continuous involvement of and feedback from users.

The effect of Covid-19 across the world has been unprecedented in terms of the challenges presented. The response from the Jersey maternity care team must be seen in the context of this wider international problem where services had to react to a very fluid situation with very little global evidence of success. The submissions to the Panel have highlighted that while there were unwelcome restrictions the majority of women and their families understood the changes imposed on them during this period. This risk averse approach was pragmatic and broadly consistent with the majority of the response from similarly developed nations. The Covid situation has led to some positive clinical ways of working that are likely to continue as the maternity services return to business as usual. These include the introduction of virtual consultation as appropriate, using video conferencing and the improved handovers of care, due to less activity in the hospital.

2. APPROACH

In 2015, the previous Health Minister claimed that the safety of Jersey's maternity operating theatre was "borderline unsafe". Following these comments, the Director of the Hospital, at the time, admitted that Jersey's maternity unit was in need of major investment to bring the unit up to acceptable standards. It was further suggested that the Department would be unable to continue performing in its current state until a new hospital was built (which at the time was anticipated for 2023).

In September 2020, the Health Department lodged an application to upgrade the maternity unit, for the first time in 25 years and partly in response to Covid-19. According to the application, the unit needs expanding, and several areas require updating in line with modern practices (despite the development of the new hospital). Whilst the Panel itself hasn't received any direct concerns from members of the public regarding maternity services, a number of concerns were brought to the Panel's attention in 2020 by Deputy Doublet. Primarily, Deputy Doublet had been contacted in respect of complaints regarding maternal mental health and the support available. The Panel was advised that some members of the public had mentioned an absence of leadership and direction in this area and the lack of expertise/training of staff. The Panel felt that the combination of issues as well as the fact that maternity was not included in the general overview of services in the Jersey Care Model (JCM) meant that it was timely for them to take a comprehensive look at the island's maternity services. Deputy Doublet was co-opted onto the Panel for this review.

Attain was commissioned to advise the HSSSP in February 2021. The approach to the review has been to review all evidence to the Panel, including reviewing written responses from a survey of women, interviewing key stakeholders involved in the maternity services, seeking written responses from the Health Department and supporting the Panel in a formal Public Hearing with the Minister and his team. In addition, the Panel has seen previous reviews undertaken into the maternity services and a survey of midwives. We have also been able to review the results of focus groups undertaken by 4Sight.

3. KEY FINDINGS

Since this Scrutiny Panel review has been launched women have been given a voice, based on their real experience to share their positive and negative experiences. It is vital that this voice must be able to be heard and their views acted upon beyond the life of this single HSSS Panel review. This is fundamental to shaping the new strategy and sets a bar for acceptable standards. While Jersey is different to any other jurisdiction, expectations of high quality are not. In fact arguably as a geographically contained environment with a relatively small number of births, Jersey should aspire to an even higher level of quality of experience than is found elsewhere.

We have no major grounds for concern in terms of the physical safety of women experiencing the maternity service, but in this review we do raise concerns for their emotional safety based on numerous examples submitted by women who have experienced the service. We have received verbal assurance that quality issues raised under previous reviews are subject to their own action plans, and we understand for instance that the previous review undertaken by the Royal College of Obstetricians and Gynaecologists will shortly be re-assessed.

At the Ministerial Hearing and in the written response (March 2021) we were told that that consideration was being given to a new midwifery-led workforce model with the aim of transitioning into a more midwifery led care service in the community. The full detail of this model has not been shared although several discussions referenced a community/ parish led maternity service which would support choice and continuity of carer as well as being in keeping with the Jersey Care Model, which promotes community based care. If this model is to be developed to encourage care to happen at a local level rather than in hospital, there will be several aspects to consider not least:

- The number of deliveries per parish and the necessary workforce
- Whether a combined urban and rural model akin to that adopted by the health visiting service is most appropriate
- Whether midwives provide full continuity of care (covering antenatal, postnatal and labour care) and the potential need for innovative employment contracts to enable this.

The maternity strategy, this review proposes, will be vital to establishing a modern maternity service that meets the needs of the population, outlining the strategies, intentions (based on evidence, such as preventative public health) and defining implementation targets, against which progress can be monitored. This strategy needs to be a system wide collaborative approach involving all parties to move away from this being a hospital-centric model of care.

Recommendation: Develop a system wide maternity strategy including values, model of care (including choices of maternity care and continuity of carer), maternity care pathway (community/parish led maternity service), expected outcomes, performance measurement framework with KPIs/benchmarks and the approach to oversee policy development.

In the short-term establishing a Maternity Services Task and Finish Group to drive forward the necessary transformation in maternity services is recommended. This will be a project team, made up of lead professionals (e.g. midwives, medics, GPs, Health Visitors, Public Health) and lay members (e.g. recent mothers), reporting to the JCM, to provide sufficient momentum and capacity to develop this strategy and deliver the wider recommendations in this review, and others recently commissioned by the HCS, by the end of 2021. The reason it is called a task and finish group is that it has a short term focus to deliver a defined remit. This would be distinct or re-purposed from the Task & Finish Group that was created in September 2020 as part of the Women and Children's Care Group Task and Finish Programme to assure the Executive Group of the implementation of the local improvement plan. There are key activities we expect to be developed and delivered by the newly formed Task and Finish Group.

This Task and Finish Group should be responsible for the project plan that outlines the: what, who, how and by when, the key tasks in transforming the maternity services highlighted in this review. A dedicated project manager should be assigned to this Task and Finish Group, that is only in place to deliver this work, to ensure that there is appropriate resource to complete all tasks. It is proposed that this Task and Finish Group report to the JCM Board as a demonstration of how service transformation could be undertaken to achieve the Jersey Care Model approach outlined to the States Assembly in November 2020.

Recommendation: Establish a system wide Maternity Task and Finish Group that is accountable to the independent JCM board.

4. TERMS OF REFERENCE

4.1. Are the current maternity facilities in the General hospital and the planned upgrade of works appropriate and adequate?

There has been a considerable amount of evidence submitted to the Panel that concurs with the view of the previous Director of the Hospital in 2015, that the current maternity facilities are not fit for purpose. Written submissions and survey feedback indicate that the refurbishment of the facilities is essential. Due to the Covid restrictions this review team has not been able to physically visit the facilities however written evidence from women and staff refers to women showering without adequate privacy, shared toilets in corridors for labouring women and several written references to sewage backing up, all of which are clearly completely unacceptable and shockingly bad.

The deficiencies also impede the desire to modernise maternity services. The information that has been seen as part of this review suggests that here has been little active involvement in the refurbishment plans by women who are recent or future service users or the midwives providing services. Whilst we have been advised that an aim is to develop more midwife led care and that there is a desire to enable partners to be as involved as they wish including staying overnight, we have not seen policies related to these desires nor seen concrete evidence of their consideration in the planning process. We therefore have very limited assurance that the planned refurbishment will fully address these.

During this review there have been several suggestions of a standalone midwife led unit being commissioned instead of simply updating the current unit in the hospital to provide two midwife led rooms, however it is not clear how fully this option was considered. Evidence is clear that a standalone maternity unit is a safe and cost effective choice for women experiencing a normal pregnancy. Upgrading two rooms does not necessarily equate to a midwife led facility. A clearer statement of what is intended in the operating policies and procedures in the creation of midwife led rooms is required.

This review has not been privy to the options appraisal or the business case for the refurbishments and as a result, raises serious concerns about the length of time for the project to complete, the experience of women while the work is completed and the rationale for not decanting the service to elsewhere on the hospital site or to a temporary modular facility. It is understood that the construction of a modular unit outside of maternity unit connected to the delivery suite was considered in relation to a midwifery led unit (MLU) and after exploring the different options, it was felt that the most financially and operationally viable approach would be to have the MLU co-located within the maternity unit.

The budget for the refurbishment is considerable (£6 million), which is a testament to the paucity of the current facility and also to the commitment from the Government to address these issues. Without a clear strategy for the maternity services the planned upgrade works appear to have been led by the need for improved estates rather than a chance to improve the model of care. This seems to be an opportunity missed. Ideally the options appraisal/business case should be revisited to include this, and the options appraisal published especially as there is no clear timetable as to the new hospital build but on the other hand there is a strong case to be made for getting on with the upgrade over as short a period as possible.

Recommendation: Engage an independent estates expert to assess the options and provide a more rapid response, two years is not acceptable.

4.2. Is there suitable antenatal and perinatal mental health care and services available to new parents?

It appears that, at the present time there are numerous services available for women to access, however interviewees and responses from women indicate that, because there is lack of consistency in the way that the mental health of women is assessed antenatally and postnatally, these services are not consistently accessed. The services are also inadequately resourced impacting particularly on the education and training of midwives and GPs and then on the provision of specialist care.

In addition, women often feel poorly supported as new mothers particularly in relation to infant feeding but also in discussing their birth experiences and how these have left them feeling. Continuity of carer which is addressed under section 4.3 needs to be improved as there is clear evidence that it impacts positively on the emotional wellbeing of women.

It is clear from evidence provided that recently there has been considerable focus on developing the mental health offer, with a new consultant led perinatal health clinic established. A business case for a comprehensive, multidisciplinary perinatal mental health service based on internationally accepted best practice has been submitted to the Department in 2021. As a result, there will be an additional two sessions of time for a Consultant Psychiatrist with expertise in perinatal mental health to support the development of the perinatal pathway as well as funding for an additional specialist nurse to join that service. This is being piloted in 2021, with the intention, subject to business case approval, to roll out the more comprehensive service, including the recruitment of specialist midwives, going into 2022 as part of the Government Plan.

The new service outlined will seek to use a more sophisticated mental health assessment tool, and to apply this tool more often for each woman antenatally and postnatally. There is also a plan to assess for alcohol consumption. The improved service will be supported by further training to ensure all staff are trained to deliver the universal tier of the service ensuring consistency in assessment and referral as necessary to more focused services. GPs will need to be trained using the GP perinatal mental health toolkit.

It is critical that the key role of a specialist midwife is appointed to before 2022 and that the role of this midwife should be to ensure the education and training of all midwives to assure that there is consistent assessment and referral across all services.

Part of the future offer should include a systematic approach as to who accesses the debrief system following birth. That this service exists is good practice, but the offer should be a universal adequately resourced offer of which all women are made aware postnatally in hospital but also when home.

It is essential that women are well briefed as to services that are on offer. It appears that this is not currently the case and too dependent on whether individual professionals adequately cover this topic. Consistent, accessible information about services should be available to all women translated into the most commonly used languages on the island. One of our interviewees mentioned that there is a team who are producing a

resource pack to make sure women know about all services available so some of this work may be in hand and simply requiring support and resourcing to ensure quick completion.

These are undoubtedly positive developments in the field of perinatal mental health but progress needs to be made quickly and the impact of the investment must be monitored. We encourage continued scrutiny to ensure collaborative working between maternity and mental health services and to ensure consistency of education and approach of all professionals.

Recommendation: The appointment of a specialist midwife in perinatal mental health is made before 2022.

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

We have heard during our interviews that the provision of care along the maternity pathway is given by a range of professionals in a range of care settings. There is inconsistency in the implementation of the pathway which means that there is unacceptable variation in the service experienced by individual women. However, generally, in Jersey most women see a GP when they are first pregnant, some women then go on to have the majority of their antenatal care from midwives and some have a mixture of GP/midwife care. If pregnancy is complicated women see hospital-based midwives and obstetricians. The majority of deliveries are supported by midwives and medical professionals in the hospital setting, although there is an increasing number of homebirths, which is a positive development for women assessed as meeting the criteria. Midwives employed by HCS will provide at least the first ten days of postnatal care and then hand over to the Health Visiting service from the Community Nursing services.

The term 'safe' is just one of a number of components of a high quality service. The Care Quality Commission (CQC) considers that the components of a high quality service are safe, effective, caring, responsive and well led therefore this review discusses them all not just safe and effective.

Jersey maternity services, if considered through the lens of major empirical measures such as perinatal mortality or major physical trauma to mother and baby do appear to be 'safe '. However, as noted above, this is not enough. For women to experience a caring and responsive service it is necessary that they are 'treated respectfully, have choices, are involved in decisions and feel listened to. In other words, emotional and mental health needs as well as their physical health needs must be met. It is this emotional component of quality that ensures that women embark positively on their parenting journey. It is also now recognised that it is not just the mother but the whole family that need to be supported and involved throughout pregnancy, birth and postnatally.

Giving birth is a potentially wonderful and memorable highly personal journey, one in which strong experiences would be expected. Having said that, results from elsewhere suggest that most women would usually be broadly satisfied with the overall experience of their maternity pathway. The evidence in Jersey however contradicts this. The expected bell curve of women's experience is replaced by a much more polarised set of responses, with both extreme positive and negative stories of women's experience. This

extreme inconsistency can be seen in the written submissions to the Panel's own open survey at the start of this Review and is reinforced by the more structured process of focus groups managed on the Panel's behalf by 4insight. We have seen shocking testimonies from women where they have not been treated with compassion, not had their wishes respected and many women tell of having confusing and inconsistent advice.

Given the importance of the emotional component of quality and its dependency on a positive culture referred to later in our review, and the broad range of responses identified by 4insight on this issue, it is particularly worrying that the clinicians own input to the focus groups was at such a low level.

Integration/midwife led care/Continuity of carer

Other factors of concern related to this TOR are the lack of acknowledgement of the key role that midwives play in the care of all women and the lack of continuity of carer throughout the pathway Feedback about the service model from both verbal and written evidence suggests that the service needs to change to be less hospital centric, less medically led and less paternalistic with more integration across the length of the maternity pathway and the promotion of greater continuity of carer for women.

- **Integration of services**

A range of organisations are involved in the delivery of the maternity pathway and there is a need for collaborative working between them. Throughout the review there has been recognition that the maternity system often works because Jersey is small, and people know each other. Interviewees told us that delivery of high quality integrated services is often dependent on good relationships between different organisations rather than on systematic integrated policies and collaborative working. We were told that multi-disciplinary cross organisational teams are sometimes being established to support care (e.g. in relation to the perinatal mental health pathway), which is positive, but it was suggested by several interviewees that having a single model of care that is clear and coherent would enable greater service integration. It was felt that the lack of this is one factor than can lead to women receiving inconsistent service delivery.

Several of the interviewees referenced the on-going island wide digital programme that should support more integrated care provision. There is a wish for a shared IT system that includes primary care and Family Nursing and Home Care (FNHC) as well as in-hospital services to support improved handover of women's care notes and to reduce the regular re-telling of history and recent interactions. There is work being undertaken in this area so ensuring the timeline and impact on maternity services is known by the clinical teams, across the pathway, will be beneficial.

- **Midwife led care**

Women experiencing an uncomplicated pregnancy and labour do not require the involvement of obstetricians in their care and even women who require their input should have much of their care from midwives. The development of a woman centred midwife led model of care enables women to receive the majority of care in community settings with a focus on normality, the family and a positive transition to becoming a mother.

A consideration, if Jersey wishes to move to a midwifery model of care, is the role of GPs. In the UK GPs now play a minimal role in the provision of maternity care with women seeing a midwife as soon as they are pregnant. However, if GPs are prepared to retain an expertise in care of low risk pregnant women and to be part of multi-disciplinary training, education and updating there is no reason why they could not be part of a system helping to ensure women centred continuity of care.

- **Continuity of Carer**

Evidence is clear that continuity of carer results in greater satisfaction but if this continuity can be extended into intrapartum care it also results in better outcomes such as more successful breast feeding and fewer premature labours.

While we have been advised verbally of the intent to provide a service model based on greater continuity of carer we have not seen any written support for this strategy. The belief of some interviewees that continuity of carer is already quite good and has simply been disrupted during Covid is not evidenced by the survey of women in which women giving birth outside of the pandemic report limited continuity. That there is more progress to be made was acknowledged at the Ministerial Hearing. Evidence provided to the review through correspondence and interviews indicates that there are women who are seeing multiple midwives or multiple doctors in their pregnancy pathway.

Recommendation: Define a midwife led model of care incorporating at a minimum continuity of carer in the antenatal and postnatal period and aiming to extend this to the intrapartum period. The aim of this model of care should be to ensure care is delivered as close to home as possible, and to reduce inconsistency of advice in both the antenatal and postnatal periods as well as increasing women's satisfaction with the service.

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Performance framework

All parties are genuine in their intent to have the best service in place for the women of Jersey, their babies and families. Currently there is no system wide agreement to a single maternity strategy which describes agreed outcomes and performance goals for maternity services. This is a serious deficit as there is currently no apparent way that all parties involved in the delivery of maternity services can adequately assess how well the services are performing.

During the Ministerial Hearing the Chief Nurse referred to a "comprehensive list of standards, which is over 240" that is being reviewed. This is too many metrics. We have also seen a number of different documents covering a number of different indicators. It is critical to maintain a coherent high level small number of indicators in each of the CQC categories that are available to everyone up to the most senior level of oversight, including the previously proposed independent JCM Board, alongside a dynamic overall risk register for the service. As a priority there is a need to identify, and agree, the critical indicators that would enable a judgement as to whether or not maternity services are high quality. It is essential that these are monitored regularly and that statistical analysis charts are used which allow trends that might indicate a problem to be noted early and remedial action taken. Such indicators must include the views of users and ideally a staff survey should be undertaken on a yearly basis.

Such indicators should pick up areas for improvement such as breast feeding targets, not only for the number of women breast feeding on discharge from hospital but also at two weeks and six months and targets relating to the number of women experiencing continuity of carer.

To be useful it is essential that these indicators are benchmarked against peer norms or international comparators. It is recognised that direct comparators are a challenge in a small island-based service but many maternity outcomes, are related to the characteristics of populations not to size and geography. For inputs the Jersey service could access three sources: the Royal College of Midwives (RCM) blue top guidance programme "RCM standards for midwifery services in the UK", Royal College of Obstetricians and Gynaecologists (RCOG) guidance and NICE guidance. All three have regular update reviews to incorporate new trials and studies so are kept up to date, and all three have key specific measurement criteria. Every service can point to unique elements of a given service and it will be helpful to have comparators with services with comparable numbers of births per year, and relative isolation. If possible, it would be constructive to identify some overarching metrics that will indicate relative investment levels (e.g. workforce) so that expectations against similarly high investment services can be used for comparison.

In terms of measuring experience, this component needs to include a method of gaining feedback from those involved at all stages of the maternity pathway and should separately identify the experience of those whose service is entirely publicly funded from those who buy extra private services. In addition, most questions in the CQC yearly review of maternity services that could be used in a regular survey of women which would allow very useful comparators on progress towards a woman centred, midwife led, continuity of carer service. Similarly, the NHS staff survey could be a useful tool on which to base a comprehensive workforce survey.

Recommendation: Establish a comprehensive system of performance management including a regular user survey and regular staff survey, which enables benchmarking against other appropriate maternity services.

The establishment of the Maternity Voices Partnership (MVP) is a very welcome development and is an excellent vehicle for enhanced communication between the department and women and to ensure continuous involvement of and feedback from users.

Recommendation: Maternity Voices Partnership to report to the HCS Board on an annual basis.

In addition to a system of robust performance monitoring it is essential that the audit programme, which is just starting, is developed further. An audit programme should be linked to a system of continuous improvement and should be focused on key clinical guidelines and standards for example waiting times for pain relief, decision to caesarean timing, record keeping assessments to check informed choice and regular assessment of need. Where action is agreed due to not meeting the desired performance levels there needs to be clarity of who will do what, in what timescale, checked through which assurance platform.

We are aware that there have been a number of reviews of the HCS led aspect of maternity services particularly the hospital-based component and that there is a Local Improvement Plan, in place to lead on recommendations and ensure progress. This plan does identify those accountable and timescales. They meet the Executive Team monthly (having previously met weekly) to identify progress. This plan needs to

be completed with a degree of urgency but whilst it is important it can only be seen as a partial aspect of a more comprehensive quality improvement framework.

It is strongly suggested that the Jersey Care Commission could be engaged to support the maternity system to establish a robust and measurable quality framework.

Recommendation: The Jersey Care Commission should be engaged to support the maternity system to establish a robust and measurable quality framework, with suitable resources allocated.

Culture

Culture and communication between different professional groups has been raised as an issue through interviews, surveys and in the Ministerial Hearing. There are several different aspects of culture which have been drawn to our attention by interviewees and women which must be addressed:

- Doctor/midwife i.e. inter professional relationships – in assessing the safety of maternity services it is now widely recognised that multidisciplinary working between midwives and obstetricians based on mutual respect of their different, but complimentary roles is critical. Whilst relations between midwives and doctors are said by many to be good these good relationships as described to us appear to be based on an old fashioned concept of the obstetrician being in charge and 'owning' the woman and thereby being accountable for her care. Midwives are accountable in their own right for the care they give. As noted earlier all women need a midwife but only some need an obstetrician and it is mutual acknowledgement of this concept that needs to inform the day to day culture in any maternity service. There are examples in Jersey where the respective roles and responsibilities have not been clear enough to ensure that the midwife takes accountability for the care of low risk women or to ensure that the midwife voice is heard in key meetings and in multi-discipline team working. This has at times resulted in conflict between the doctors and midwives in the approach to care provided.
- Intra professional relationships– there are also instances where women and professionals have reported observing conflict between individual from the same profession. This is often over specific clinical care and leads to inconsistent advice resulting in confusion amongst women but also to them reporting poor attitudes in their care givers. Whilst care will often need to be tailored to meet the needs of individual women and their circumstance it appears that too often individual professionals 'do their own thing' for no clear reason.
- A poor workplace culture affects women. Apart from inconsistent advice we heard from women that they had experienced poor attitudes from both doctors and midwives. They reported instances of being belittled, of not being listened to and of not being involved in decision making. Such lack of care and compassion is unacceptable and must be addressed. Another aspect of the cultural challenge is where submissions from women provide examples of situations where the clinician has not respected the choice of the women or not ensured that the emotional wellbeing of the women and her family has been central to the care provided.

All of these cultural problems can be minimised when everyone works to agreed guidelines and policies and when there is an overarching statement of values and behaviours that will be upheld across the service. This should detail the importance of respectful and compassionate behaviours to each other and to women. It is very difficult to challenge the behavioural problems that can underpin a poor culture without such a framework.

We propose that determining culture is best expressed as answering the question, "What kind of service will be delivered, what are the expectations of professional inputs and what will be the user experience as a result?" As much of the service takes place out of the hospital or out of hours, how will professional behaviours be embedded to give the strongest possible assurance of consistent high quality advice and support, irrespective of the practitioner? These are not simple questions but are fundamental to developing the positive culture that all parties are so keen to see in place for Jersey. As this overarching statement of values and behaviours is developed it needs to be linked to regular multi-disciplinary continuous improvement training and could be part of developing a partnership with a bigger mainland teaching organisation to embed a stronger culture.

We have been told that a Culture Summit was held in April 2021 and another is planned for May 2021. We understand a Local committee has been set up and will come together to develop the basis of the culture and behaviour strategy, which will include the organisational values. The Culture strategy will provide a framework that supports and promotes regular appraisals, one to ones, improving communication and enhancing interpersonal relationships within maternity services. These are very positive progress steps and should be the start of an on-going process to embed a more cohesive culture that has the involvement of participants from across maternity services.

Recommendation: The Local Culture committee should include multi professional and across sector representation and the Culture strategy be published as an integrated part of the maternity services strategy. This culture strategy should be a statement of the overarching values of the maternity service and the behaviours that will underpin those values. Such a statement should be referenced during all staff appraisals.

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

Throughout this review the evidence from contributors including women indicated that whether or not women can make informed choices is inconsistent at best and random at worst. There is not a clear culture to uniformly encourage informed choice by the service, instead it seems much more to be driven by the women themselves. Many sources in this review, specifically the midwife survey and Panel's survey of women, have highlighted that there are high expectations of the maternity services in Jersey. These high expectations are recognised by the Minister and his team and at the Panel Hearing there was a determination to focus on delivering on the choices of women.

It is positive that the number of women giving birth at home is on the increase month on month, and with good outcomes. Alongside this there is progress in terms of developing breastfeeding champions (currently there are six) and achievement of the Baby Friendly Initiative Level one.

There have however been examples highlighted along the pathway such as not all women feeling they were told their options as to place of birth, not all women feeling involved in terms of their choice of pain relief and women feeling pressurised to breast feed. Taken together this indicates that further training and communication is required within the service and also with women about what the options are available to them, with clear explanations given in a non-judgemental way of what the individual risks and benefits of their choices might be.

If choices are to be consistent and available to all women the following must be considered.

Clarity is needed as to what choices are planned to be offered to all women accessing the Jersey maternity services, for example is the service going to be developed to ensure all three choices of place of birth i.e. home birth, midwife led unit (stand alone or alongside) and obstetric unit are available, what choices of pain relief are going to be available (e.g. water birth, epidural); and are partners going to be offered the choice of staying overnight after their baby is born or before birth if their partner is admitted antenatally?

Material needs to be developed (or accessed from widely available resources) which presents the evidence for each of the choices available to women and their relative risks and benefits for individuals. Such information should underpin women's discussions with professionals.

Information also needs to be developed which will help professionals and women to have constructive discussions around the choices that women may wish to make but which may not fit with best practice or evidence based guidelines.

One area which we are told has caused particular difficulty in Jersey Maternity Services is that of infant feeding. Evidence is clear that for the majority of women breast feeding is the option which provides maximum benefit for a woman and her baby. All professionals should promote breast feeding and it is positive that current data shows that over 75% of women in Jersey choose to breast feed and initiate breast feeding at birth. However too often women find it hard to continue breast feeding because the system lets them down. The promotion of breast feeding has to be underpinned by women having ready access in hospital and at home to well trained professionals and support staff who give them consistent support and advice. This support should also be readily available to women who have made an informed choice to bottle feed their baby and their choice to so should be respected.

The gold standard in relation to infant feeding covering both breast and bottle feeding is for a maternity service to achieve BFI accreditation. As noted above both the health visiting services and midwifery/ neonatal services in Jersey have now achieved BFI level one and we have been told that all relevant staff have attended the standard of 15 hours training in relation to infant feeding. We were also told at the Hearing that there is a plan in place to achieve BFI level 2 within the next 12 months and, subsequently that the service intends to be subject to assessment for full accreditation (Level 3) in Spring 2023. Submissions seen by the Panel indicate health visiting services have shown the strongest commitment to achieving BFI status. It is vital that from now on the achievement of full accreditation should mean that all women are supported in their choice of feeding method and receive consistent advice and support from knowledgeable professionals before and after birth. It is vital that the whole maternity system, including GP, midwifery, neonatal and health visiting services, demonstrates a commitment to achieving Baby Friendly status and that the plan to achieve BFI full accreditation by Spring 2023 is owned by every service, adequately resourced and closely monitored.

Recommendation: The whole maternity system, including GP, midwifery, neonatal and health visiting services, demonstrates a commitment to achieving Baby Friendly status and that the plan to achieve BFI full accreditation by Spring 2023 is owned by every service, adequately resourced and closely monitored.

Another problematic area is that of women choosing to have a caesarean section when it is not considered to be necessary for either the safety of the woman or her baby. Evidence based guidance is clear that a woman ought to be able to make this choice but that such a decision should only be finalised after a full discussion with a suitably qualified professional. Women may be choosing such an option because of a fear of vaginal birth or a prior traumatic birth. Such fears can be alleviated through skilled communication and considered birth planning. Many units in the UK now have clinics led by midwives to give specific support to women on this issue. Continuity of carer throughout the pathway may also help women who have experienced a traumatic first birth.

Finally, it is necessary to develop a policy as to how women will be supported who chose a place of birth despite them having risk factors which mitigate against that choice.

Recommendation: Provide a consistent offer of choices to women and agree an education programme to ensure all providers understand the choices that are to be offered to women from the first appointment with the health service and the evidence base supporting this offer.

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

There are two types of policies that are generally seen in health services, clinical standards and organisation-specific policies that outline the measurement of performance and action/ risk assurance approach.

There are clinical policies in place across the maternity services pathway. However, interviews suggested that there is an opportunity to improve the governance process of ratifying policies and standard procedures, as well as ensuring these are shared across the entire system for example to new midwives, junior doctors, as well as to GPs, Health Visitors, Peri-natal Mental Health specialists. This could improve consistency of practice, encourage evidence-based practice and thereby potentially improve patient safety and risk.

Many of the policies are based on RCOG, RCM and NICE guidelines, however there is no automatic process to adopt these guidelines for Jersey. The translation of UK policies into Jersey policies is time consuming and it may be that for the majority of policies a simple process could be established allowing endorsement of a wider policy quickly with only a few policies requiring substantive change.

In September 2020 there was an external independent review of Obstetrics & Gynaecology Services at Health and Community Services, Jersey General Hospital, undertaken that highlighted there is a need for the governance structure to encourage a more devolved, collective ratification and approval process. Our review concurs with these prior findings and encourages more rapid progress to be made not just with ratifying policies but as importantly with communicating and monitoring adherence. There is also an urgent need to ensure adherence to policies is audited.

A set of organisation policies and standards are also in place and again there appears to be a requirement for greater communication and adherence to those policies throughout the maternity service. Many of these policies are for hospital based services so may need to be revisited in line with any proposed midwifery-led community service.

Recommendation: Undertake to complete all actions from the previous independent reviews (within the last three years) of maternity services on Jersey and to have a complete set of key organisational policies for maternity services by the end of 2021.

In the written correspondence to the Panel and in the survey of women there were several instances where the complaints were made following their maternity experience. Unfortunately there are scenarios where care is perceived to not meet the expectations of the women. In this report we cannot give a view on individual cases however in England following the Ockenden Review (2020) an immediate action was to state that all Trusts must create an independent senior advocate role which reports to the Trust and the Local Maternity Service Boards. Establishing an advocate role to ensure that women and their families are listened to with their voices heard would be a powerful statement to complement the existing maternity services. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.

Recommendation: Create an independent senior advocate role for maternity, which reports to the HCS Executive.

4.6. Are sufficient capacity, resources and skills available to deliver the best care?

Internationally the healthcare workforce is a significant challenge for all care systems, this is witnessed in Jersey too. On the face of it the maternity service has a good ratio of midwives employed to the number of births (47 FTE for 800 birth/ year) and there is on-going work to refine the shift patterns to support capacity across all shifts. In addition, there has been recent work done in relation to the medical workforce with an increase in the numbers of obstetric consultants and changes in their working patterns to ensure a greater consultant presence and more support for junior doctors.

However in order to assess whether the midwifery workforce is adequate for a new model of midwife led service with continuity of carer it will be necessary to reassess midwifery numbers. Ideally this will be done using Birthrate Plus, the maternity workforce planning tool recommended by NICE.

Staff retention is mixed, with low churn of midwives. However there has been double digit turnover in the medical team over the last 5 years, even excluding junior doctors, who you would expect to rotate. It is likely that some of the leavers were locums who were always due to be short term. The reason for the high turnover is not fully understood and it is suggested that staff who leave, locum or substantive, should have an exit interview where these issues are explored and alternative models discussed.

There are shortages in specific areas of care including perinatal mental health services, and specialist midwives. There is a particular need for a practice development midwife and adequate numbers of midwives with specialist expertise in relation to breast feeding.

There does not appear to be a coherent workforce strategy underpinning the current maternity service far less to support a new maternity strategy. This is critically needed. The maternity service is currently reliant

on locum staff (largely responsible for the turnover) and 45% of midwives are due to retire within 10 years, while the potential for new roles such as maternity support workers which are well embedded in other maternity services are only just being considered. There is the opportunity to reconsider the traditional role demarcations across professional groups and to think about the function of support roles and specialist roles that can lead to more stability, increased sustainability as well as career progression.

This review acknowledges the challenges of maintaining competency amongst obstetric junior doctors with small caseloads and encourages further development of off island rotations as a potential solution. There is the possibility to assess improved links to the mainland for rotations and on-going professional development. An option that we discussed several times was to partner with a bigger UK Hospital(s) to enable more structured integration of medics to retain clinical development and ensure service continuity for the Jersey maternity service.

The relationship with the University of Chester for specific training courses for Jersey students is a very positive development. It supports the development of a more sustainable on island workforce, which increases the employment opportunities on island, and provides a consistent training approach for all staff working on the island to enhance the consistency of delivery of care. This is a fantastic statement for young people to become highly trained and support their local economy and also enable the island workforce to become more self-sufficient. The potential for this approach to be extended to other health and care related professions could be explored, as there exists a worldwide chronic shortage of appropriately qualified practitioners across many such disciplines, and anything that extends Jersey's ability to develop its own workforce would be a strong strategy.

The current leadership structure for the maternity service is not ideal and in the view of our interviews is not appropriate in terms of providing leadership to the work that is required, particularly developing a strategy, ensuring a consistent clinical model and a robust system of clinical governance in the maternity service, which addresses questions regarding culture, education and training and the use of guidelines. The Care Group model adopted with the Associate Medical Director effectively the lead despite being part of a triumvirate model does not appear to be optimum if the current challenges are to be met. The feedback from engagement is that the voice of the midwives is not heard in the right fora. It is important that both the midwifery leadership and the medical leadership must be for the entire maternity pathway not focused on just the hospital component. What needs to be achieved in a time when major change is required is a leadership structure which ensures that the two most significant professional groups delivering maternity services i.e. midwives and obstetricians are at all key strategic and operational meetings and that the voices of these clinical experts along with those of women are heard at every forum about maternity services.

It is suggested that the triumvirate leadership of HCS maternity services is a Director of Midwifery and an Associate Medical Director who is also Lead Obstetrician supported by a Business Manager. The people in post should be appointed on the basis of them possessing leadership as well as professional competencies.

The influence of the central civil service approach to recruitment and job descriptions is not appropriate for clinical services. The model that one size fits all might indeed mitigate against high quality leadership for maternity services. This has recently been demonstrated by the failed recruitment process for a new Head of Midwifery, where a compromised job description did not attract any suitable candidates.

Recommendation: Develop a maternity workforce strategy to consider future workforce requirements, assess different roles to support all aspects of maternity care and explore options for staff rotations with partner organisations.

Recommendation: Develop appropriate leadership team for maternity services and appoint to a Director of Midwifery and an Associate Medical Director who is also Lead obstetrician.

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

This review has shown that there is a real intent from the Executive and Ministers to continue to enhance maternity services for women and their families. The recent reviews have provided multiple recommendations that the teams are looking to address.

Defining the full maternity pathway and the roles and responsibilities along the pathway will lead to greater clarity for all parties from professionals to women and their families. Currently there is a lack of clarity which unhelpfully undermines confidence. It is important that everyone whether GP/Midwife/Health Visitor /Obstetrician understands their role, the standards they need to adhere to and the education they must access to support them delivering to this standard. Each role along the pathway should have clarity on what the service expectations are of them and their elements of the pathway delivery. It may be that the role of some participants might have to change or be more focused to provide high quality and consistent care. For example, it might not be appropriate for all GPs to provide maternity care, instead further training can be provided to those that want maternity to be a recognised specialty.

The quality of communications both within the department and between the department and women has started to improve with the introduction of the Maternity Voices Partnership and must improve further. It is interesting to note that the Maternity Service website was redeveloped on the initiative of several new mothers rather than from within the service. This review has provided very rich feedback from the public and staff that should be used as the basis to further enhance the communications across all parties involved in the maternity service.

Confusion in understanding the way maternity services are provided can be exacerbated by the different options available for those looking to access private care. It would be beneficial to define the publicly funded service offer and be clearer on the additional offer possible through the use of private funding to demonstrate the high quality of the public offer and what any enhancements are. Further transparency of privately funded services would enable greater awareness of the impact on the public services. For example, visibility on the use of publicly funded resources (such as staff, buildings and equipment) for private activity and the level of compensation to the public purse would encourage confidence in the equality of service provision.

The different systems that co-exist can create different incentives for staff which can become problematic as there is no system wide leadership to ensure any conflicts are managed. The business model for the private work of hospital based consultants is different to the business model operated by GPs and they have different impacts on the patient care. For example, there is general acceptance that midwife led care

enhances a woman's experience and that even if some women need specialist care from an obstetrician, they should also get midwifery care which tends to focus much more on the education, support and emotional well-being of women rather than just coming from a medicalised approach of a problem to be cured. If private care is given by an obstetrician, women can lose out on this.

4.8. What impact has Covid-19 had on the provision of maternity services?

The effect of Covid-19 across the world has been unprecedented in terms of the challenges presented. The response from the Jersey maternity care team must be seen in the context of this wider international problem where services had to react to a very fluid situation with very little global evidence of best practice. The submissions to the Panel have highlighted that while there were unwelcome restrictions the majority of women and their families understood the changes imposed on them during this period. This risk averse approach was pragmatic and broadly consistent with the majority of the response from similarly developed nations.

The most difficult aspect of Covid rules was the inability of partners to attend antenatal appointments in the hospital especially ultrasound appointments and limits on post-natal visitors. During this period some mothers have felt very isolated and their partners not fully engaged with the full pregnancy experience. This led to distress for some people, which has been acknowledged by the Minister and his team. An unintended consequence of this however is that some interviewees reported that attending antenatal visits alone enabled women to open up with professionals to seek support, whereas they might not have done if others had been attending visits with them. Space for women to do this should however be in place regardless of Covid.

On the postnatal wards there have been several reports that the limits of visitors have had a positive impact on post-natal attachment for mothers and their new babies as there have been less distractions from visitors. However, in the postnatal period reductions in services left many women isolated at home with a new baby with negative impacts on their emotional wellbeing.

Several of the decisions reflect aspects of the service that have been highlighted elsewhere in the report. Part of the rationale for reducing footfall in the hospital facility was due to concern over vulnerability of the service should key members of staff become ill. This highlighted the need for greater resilience in workforce planning to cover such situations. This issue was recognised early by the hospital team and since then several colleagues have been trained to provide additional key skill capacity and give a more robust contingency plan.

The Covid situation has led to some positive clinical ways of working that are likely to continue as the maternity services return to business as usual. These include the introduction of virtual consultation, using video conferencing and the improved handovers of care, due to less activity in the hospital.

Recommendation: Continue with recent innovation and pathway improvement that was instigated by the Covid pandemic.

5. RECOMMENDATIONS

This report has proposed ten recommendations to support the on-going development of the maternity services on Jersey, these are:

1. Develop a system wide maternity strategy including values, model of care (including choices of maternity care and continuity of carer), maternity care pathway (community/parish led maternity service), expected outcomes, performance measurement framework with KPIs/benchmarks and the approach to oversee policy development.

2. Establish a system wide Maternity Task and Finish Group that is accountable to the independent JCM board.

3. Engage an independent estates expert to assess the options and provide a more rapid response, two years is not acceptable.

4. The appointment of a specialist midwife in perinatal mental health is made before 2022.

5. Define a midwife led model of care incorporating at a minimum continuity of carer in the antenatal and postnatal period and aiming to extend this to the intrapartum period. The aim of this model of care should be to ensure care is delivered as close to home as possible, and to reduce inconsistency of advice in both the antenatal and postnatal periods as well as increasing women's satisfaction with the service.

6. Establish a comprehensive system of performance management including a regular user survey and regular staff survey, which enables benchmarking against other appropriate maternity services.

7. Maternity Voices Partnership to report to the HCS Board on an annual basis.

8. The Jersey Care Commission should be engaged to support the maternity system to establish a robust and measurable quality framework, with suitable resources allocated.

9. The Local Culture committee should include multi professional and across sector representation and the Culture strategy be published as an integrated part of the maternity services strategy. This culture strategy should be a statement of the overarching values of the maternity service and the behaviours that will underpin those values. Such a statement should be referenced during all staff appraisals.

10. The whole maternity system, including GP, midwifery, neonatal and health visiting services, demonstrates a commitment to achieving Baby Friendly status and that the plan to achieve BFI full accreditation by Spring 2023 is owned by every service, adequately resourced and closely monitored.

11. Provide a consistent offer of choices to women and agree an education programme to ensure all providers understand the choices that are to be offered to women from the first appointment with the health service and the evidence base supporting this offer.

12. Undertake to complete all actions from the previous independent reviews (within the last three years) of maternity services on Jersey and to have a complete set of key organisational policies for maternity services by the end of 2021.

13. Create an independent senior advocate role for maternity which reports to the HCS Executive.

14. Develop a maternity workforce strategy to consider future workforce requirements, assess different roles to support all aspects of maternity care and explore options for staff rotations with partner organisations.

15. Develop appropriate leadership team for maternity services and appoint to a Director of Midwifery and an Associate Medical Director who is also Lead obstetrician.

16. Continue with recent innovation and pathway improvement that was instigated by the Covid pandemic.

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Appendix 3: Focus Groups – 4insight Report

Report for Health and Social Security Scrutiny Panel

Review of Maternity Services

April 2021

Contents

Executive Summary

There were consistent themes emerging from these Maternity Services focus groups and interviews throughout the different stages and a clear need highlighted to provide:

1. Better continuity of care
2. Better communication, both between professionals and with mums and partners
3. Improved culture so that mums feel listened to
4. Respect for birthing plans (and checking birthing plans)
5. Better and more consistent breast-feeding support
6. Better mental health support
7. Support in baby loss and miscarriage situations
8. Improved showering/bathing facilities. There's a lack of dignity /respect having to be in a corridor with a curtain around the mum who can see all the feet of those walking by
9. Improve situation for mums and partners with respect to COVID implications

Key aspects by stage were as follows:

- Pregnancy:
    - Overall lack of continuity of care, parents seeing multiple different midwives throughout the pregnancy causing lack of trust and feeling of unpreparedness
    - Overall lack of communication between the professionals, mothers having to explain their situations numerous times
    - There was a strong feeling of a lack of communication from their midwife. Some mothers felt that they were not reached out to as often as they had expected, some having to chase for appointments themselves.
    - Some mothers reported having great experience when pregnant, they had one consistent midwife throughout and felt well informed and often contacted.
    - Those who felt unsupported reached out to use private support such as GP or HypnoBirthing. Overall the experiences of private support were positive. Parents felt well informed and well looked after.
    - Some mothers mentioned rude attitudes from some of the staff at the hospital.
    - The expectant mothers had varying situations and scenarios. Some had experienced the hospital facilities and felt they were outdated and in need of an upgrade. Two mums-to-be were yet to experience the ward and were doing their best to keep an open mind, despite hearing lots of negative thoughts prior to and during the group.

- Birth and Labour:
    - Those with 6 month - 3 year old children had massively varied experiences of labour in Jersey. All gave birth in the Hospital and no-one had a water birth. Many had planned water births however they were either not a feasible option after complications or their birthing plan had not been considered.
    - There were 4 Mothers who had given birth in the last 6 months. Two of the Mothers had awful experiences in the hospital and 2 had very positive experiences. The 2 Mothers who had positive experiences felt listened to, knew their options and enjoyed the care of the midwives in the hospital. One Mother had a very traumatic experience and said never again.

- Some mothers felt there was a lack of communication between health professionals. Some had multiple shift changes of midwives and felt they were telling each one the same information repeatedly.
- There were different experiences relating to choices during labour. Some mothers felt very listened to and in control whereas others felt very pressured to do things a certain way i.e. breastfeeding or being induced.

- Post-natal
  - Those who had given birth in the last 6 months, expressed feelings of lack of emotional support once the mother had taken the baby home. One mother was extremely vulnerable and struggling however couldn't get any support from MESH or other services.
  - The mothers with 6 month-3 year old babies expressed that overall receiving health visitors is "potluck, it was consistent pre-labour but then the home care was different luck of the draw".
    A few had great experiences with health visitors, however others either experienced a lack of continuity of health visitors or lack of overall communication and support.
  - For the mothers of 6 month-3 year old babies, their experiences of breastfeeding support were mixed. Some experienced brilliant support from the midwives with help to latch, express and breastfeed. However others found they had no support at all and really struggled.
  - The experiences from the mothers of 0-6 month old babies was mostly strongly negative. Many felt there was no support at all or too much pressure to breastfeed. Some experienced midwives being very "pushy" and "forcing" breastfeeding despite mothers requesting not to. A few mothers reported having been given multiple conflicting pieces of information from different professionals which caused a lot of anxiety.

Background

The Health and Social Security Scrutiny Panel are conducting a review into Maternity Services here in Jersey. As part of their review 4insight was commissioned to conduct qualitative research with women and families.

The qualitative research project **aim** was to provide information to help the Panel understand and assess current maternity care provision. Also any impact because of COVID-19 and any resulting effects on mothers, fathers/partners and families was to be assessed.

This research acknowledges there will be a new hospital at some point and the plans of September 2020 by the Health Department to refurbish delivery rooms, include ensuite bathrooms, provide better heating and cooling systems, a new nurse call system and expansion of the Special Care Baby Unit. However as a recent UK investigation following baby deaths actioned, it is critical to listen to women and their families.

The specific research **objectives** were to assess:

- Are the current maternity facilities in the General Hospital and the planned upgrade of works appropriate and adequate?
- Is there suitable antenatal and perinatal mental health care and services available to new Parents?
- Is the care that is provided during the antenatal, intrapartum, and postnatal stages of pregnancy delivered safely and effectively?
- Are women able to make safe and appropriate choices of maternity care for themselves and their babies?
- Are all the support services needed available eg breast-feeding support, pain relief?
- Are the relevant policies appropriate and are they utilised in a suitable manner?
- Are sufficient manpower/resources/skills available to deliver the best care?
- How can maternity services be improved to meet the needs of families?
- What impact has Covid-19 had on the provision of maternity services?

Research Scope, Sample and Methodology

The scope of this research was Jersey parents to be/parents who had experienced Jersey Maternity Services within the last 3 years.

The target sample was as follows:

- expecting mothers
- new parents, mothers, fathers/partners of babies < 6months old
- new parents, mothers, fathers/partners of babies 6 months to 3 years old
- ideally an optional addition – midwives/health visitors/maternity nurses

Invitations to participate in this **independent** research were developed together with Scrutiny and sent to potential respondents, all being GDPR compliant;

- by 4insight to their panel of over 3,800 islanders
- by 4insight on social media
- promotion of the focus groups by the Scrutiny Panel on social and traditional media

When potential respondents contacted 4insight they were screened to an agreed screener questionnaire, which included a broad mix of socio-demographics including income level, ethnicity, family situations, age etc.

The screening criteria were discussed at the project kick off briefing meeting, along with the actual target structure for each focus group. The screener questionnaire was designed by 4insight as well as reviewed and agreed with Scrutiny prior to use

4insight had proposed that to meet the aim and objectives of the research that independent qualitative research in the form of **online focus groups** was undertaken. This enabled us to ensure that we truly get the level of depth and understanding needed from BOTH the rational and emotional perspectives.

The qualitative research conducted involved **6 online focus groups in total and 6 depth individual interviews:**

- 1 group with expecting mothers
- 2 groups with mothers of babies 0 to 6 months old
- 2 groups with mothers of babies 6 months to 3 years old
- 1 group with fathers/partners
- 2 depth interviews with mums of babies under 6 months old
- 1 depth interview with a dad
- 1 depth face-to-face interview with a lady who had lost her baby at 19 weeks
- 2 depth interviews with professionals; 1 midwife (by phone) and 1 Health Visitor (online)

Unfortunately the planned 2 focus groups with professionals were not possible as not enough were either interested or comfortable with participating. Two depth interviews were achieved as mentioned above.

All the focus groups and 4 of the 6 interviews were conducted online on a secure online professional research platform there were 2 benefits of this approach:

- it allowed recent parents to be based in their own home with their new babies/pregnancy, (practical)
- it fitted to latest COVID-19 guidance

4insight recruited 7 participants per focus group. The qualitative focus groups were professionally moderated by 4insight's Director. The focus groups and interviews were conducted to an agreed topic/discussion guide prepared by 4insight with appropriate projective techniques then reviewed and agreed prior to use by Scrutiny.

Each focus group lasted about 90-100 minutes and interviews varied between 35 and 60 minutes. All groups were digitally recorded and professionally analysed by 4insight.

Qualitative insight results

All respondents were asked 'What are the first words/associations that come to mind when I say "Jersey's Maternity Services?"
The respondents typed their answers into the chat at the start of their group as a kick-off exercise and to gauge experiences. The resulting Word Cloud of responses is shown below:

Pregnancy

A main theme that came out from these focus groups/interviews when talking about the maternity services for pregnancy was the overall lack of continuity of care. This was mainly the changing of doctors and midwives for each appointment. Many had different doctors/midwives throughout their pregnancy, some felt it was due to COVID19. This lack of continuity caused issues such as not creating any rapport with professionals and feeling unsupported. This also made them feel unprepared for the birth of their baby as they hadn't been well informed of support choices, antenatal classes/programmes or birth choices. Some mothers were not told about Baby Steps or that Baby Steps had gone online during the pandemic until the end of their pregnancy when it was "too late".

They also felt there was a lack of overall communication between the professionals, having to explain their situations many times, for some this was draining as their situation may be sensitive or complicated.

Many reports of midwifery services being understaffed, midwives leaving the island or leaving their role. There were multiple occasions where the mothers were not told about their midwife's departure.

There was a strong feeling of a lack of communication from their midwife. Some mothers felt that they were not reached out to as often as they had expected, some having to chase for appointments themselves.

Some mothers reported having a great experience when pregnant, they had one consistent midwife throughout and felt well informed and often contacted.

Those who felt unsupported reached out to use private support such as GP or HypnoBirthing. Overall the experiences of private support were positive. Parents felt well informed and well looked after.

Some mothers detailed instances of rude attitudes from some of the staff at the hospital - the "older midwives" being unsympathetic and unkind. This made the mothers feel disheartened and anxious.

Baby Steps was overall perceived positively, it gave expectant parents a chance to engage with other expectant parents and talk through birthing options. Baby Steps was affected by the pandemic, so some mothers-to-be had to attend online which wasn't preferable. However, some mothers-to-be were not told about Baby Steps and would have preferred to be involved. Overall the mothers expected this should be offered to all expectant parents.

Some mothers also used the service of the Bridge …. the midwives were kind however some experiences were similar to the hospital, having a lack of continuity with staff.

The main improvements requested were:

- Consistency and continuity of midwives. Preferably having 2 midwives allocated per mother to create rapport and trust for the mother, creating the feeling of being prepared for the birth of their baby
- Improve the cultural attitudes of the midwives and create a supportive, kind and sympathetic environment
- Improve clarity and frequency of communication throughout the staff and from professionals to mothers

"My first pregnancy I saw the same midwife the whole time, 2nd one during Covid you just saw who you got, never got rapport with anybody, so frustrating."

"No one told me I had choices, only point I got info was because I signed up for a course with a midwife, a private course, I got lots of info, but a very expensive course. Midwives didn't tell me anything, running Baby Steps, stuff online, mentioned some of it at the end of the pregnancy, quite late, had so many questions early on, level of detail nowhere near what I learnt privately."

"Different people all the time, the midwife left to be an air hostess, changed midwife a month before due, complications with skin condition, the midwife I saw didn't know anything about it. Midwives at the hospital dismissed it, then a different midwife for birth."

"Everytime you'd see a different one, never have a relationship like a midwife, I spent half the time going through history instead of focussing on where I am now."

"In contrast, I had a positive experience, I had a fantastic midwife, I felt really informed, she gave me all the options, Baby Steps, HypnoBirthing. Midwife was on holiday, I emailed her, I didn't want to bother anyone. She was on holiday and was ringing colleagues to ring me to make sure I was okay."

Birth and Labour

6 month-3 years Labour and Delivery

Those with 6 month - 3 year old children had massively varied experiences of labour in Jersey. All gave birth in the Hospital and no one had a water birth. There were a variety of complications described below which affected experiences and choices during labour. Many had planned water births but these were not a feasible option after complications.

Some mothers felt there was a lack of communication between health professionals. Some had multiple shift changes of midwives and felt they were telling each one the same information repeatedly.

“There can be a real breakdown of communications, they don't know how many babies they're going to birth. It can go from 0 to 10 very fast. You'd think the ones in there would pass the information on. It's down to understaffing I think.”

"I had shift changes, I repeated myself constantly, they were asking nice questions about my wishes but I said it to 6 people. It didn't help that I was just bored in the corner. Why are you asking me again? Write it down!"

There were different experiences relating to choices during labour. Some mothers felt thoroughly listened to and in control whereas others felt very pressured to do things a certain way i.e. breastfeeding or being induced.

"I wasn't given many options, when I was like 'I'm not sure' they put me under so much pressure. I just said 'Okay let's do the induction.' I know they're professionals but they could have given me more information on the options"

"I was lucky, they listened brilliantly. Some friends said they were pushy with breastfeeding, one friend said that the midwife took the baby and put it on her breast when she said not to. I'm an example where them pushing back is good. I was in pre-labour and I was trying to get a C-section and it wasn't required. I'd just had enough. My cousin is a midwife and she explained that it was more risky. She thought I could go through it [natural birth]. They could have maybe explained a bit better why I should just continue"

Those who gave birth during the height of COVID felt they weren’t listened to during labour and that the main objective of the midwives was to get them out of the hospital as soon as possible.

"I had my 4th and I said that I wanted everything I could have, I got none of it, no epidural, no waterbirth, none of it. They said 'If you want to push then push.' I'd never had an epidural and really wanted it...I just had gas and air, I got dressed an hour after the birth and went home"

"I wanted the whole shoot and kaboodle but wasn't I allowed anything, they couldn't reiterate enough how much I needed to get home for safety"

0-6 Months Labour and Delivery

There were 4 mothers in this research who had given birth in the last 6 months. 2 of the mothers had awful experiences in the hospital and 2 had very positive experiences. The 2 mothers who had positive experiences felt listened to, knew their options and enjoyed the care of the midwives in the hospital.

1 mother had a particularly bad experience with the attitudes of some of the staff. Again, there was a massive perceived lack of consistency amongst the staff. Her whole experience was extremely negative.

"I was induced on Monday, there on Tuesday. On Wednesday my waters broke. Had a max of 4cm then went back down to 2cm. Then had an emergency C-section, it was horrendous, I was pumped with all sorts, I was being sick. I had a very nice midwife on Wednesday but she had to swap shifts and change with another lady who told me I had to sign a sheet for the C-Section. I panicked and they wouldn't let me eat. I was so weak, tired, ready to kill. I was short with her, she did something and then she turned around and said 'At least I'm doing something right!' I was raging. Went into theatre, it was so quick, they kept talking at me. I was being sick into a kidney dish, it was traumatic."

Another felt a similar way in that she experienced inconsistency in the level of care and communications from different staff members. She had a positive experience in the theatre and with her first midwife but a negative experience with everyone else.

"Labour took 15 hours, they had a change of midwives, I lost the people that were with me. That was different, the day staff as opposed to night staff were a lot less caring."

"The delivery room was horrific. I was angry and so upset, one midwife with me and continuous monitoring, she was more interested in what the monitor would say. She kept walking around me even though I'm eagle spread. Another midwife, who I didn't know was one, kept walking in and out stacking the shelves. They had respected me so much but once the nurses changed it was completely different. People were walking in and out, they wouldn't dim the lights. My partner got annoyed, this was meant to be a moment. I was pushing for 2 and a half hours. The way they told us it was time they just handed my boyfriend scrubs. We were then told we were not doing well, it was really rushed. I wasn't appreciated. They then took me to theatre and they were lovely, he was too distressed so I had an emergency C-section. It was quite traumatic."

One of the Mothers with a very positive experience and felt the midwives always explained the options. Even as complications arose she felt comfortable that she knew what was going on.

"I planned a water birth but couldn't because I showed signs of hypertension. Even when the situation changed they gave me options. They were very supportive of the birth plan, even with complications. They talked and explained to my husband the whole way through, they were very inclusive in that instance as well. I never felt I was pushed into anything. If it was dangerous they would explain and if I wanted the danger they'd allow it as long as I knew the risks"

Birth plans

There was a mix in types of birth plans throughout the groups and interviews. Different techniques included natural birth, HypnoBirthing, water birth, different views on pain relief, C section (due to medical complications) and some mothers had no plan at all.

Some of those who had no plan were either “laid back” personalities or hadn't been informed of different options. For the majority of those who had a birth plan, their plan changed, however most of those whose plans did not change felt they were listened to and were respected.

Reasons for their change of plans included changing their mind or complications mid pregnancy or during labour. Those who had medical complications ended up having an emergency C-section or receiving pain relief which they had opted not to use or refused medication. Most of these mothers understood the medical reasoning behind the change of plan, however would have preferred their own option. Some of the mothers felt they were calmly explained about the need for the change, however, some reported no professionals reading their birth plan and feeling as though they were not listened to or respected.

Two mothers had requested and planned to have skin to skin straight away after labour, however were not given the chance.

“No one read my birth plan, I ended up bringing it up a couple times, I wanted a waterbirth, they didn't look at that or check, the pool was never offered or considered. I had asked for no students, brought a student in, I had to send the poor woman away, any other situation I'd accept it but this was my first birth, I was anxious, I wanted a midwife for me not to split.”

“Main thing that shocked me, the anaesthetist ended up recommending me for an epidural, he didn't check my plan or my medical records. I've got scoliosis, you think they’d be aware of what they're doing. It could have gone really wrong. The whole thing didn't get read. The midwife never read the birth plan, she was on the computer typing things most of the time, she’d turn around and say you've done well without drugs you should try without. That was not in my birth plan, a lot of time and effort went into plan and it got ignored.”

“In fact 80% of women I'm friends with recently with babies have all had C Sections, none of them had plans to have one. I wanted skin to skin ASAP, but he went off to be monitored, I was disorientated, everything going on around me but I was forgotten about, thought something was wrong because I wasn't given skin to skin, apparently they changed the way they do it, you can’t do skin to skin in the theatre.”

Choice

The overall perception of being informed regarding choice of births was mixed. Some mothers who had already had babies before felt more confident and well informed. Those who had good experiences with their midwives felt they were given all the information they needed. Others felt uninformed due to a lack of continuity with specialists who they were seeing, making them feel unprepared. Some felt they had to actively request help and information, and some resulted in paying for private care to help them receive the details they needed.

“I also have a Covid baby, negative thing was the appointments, never had the same people, didn't know what was happening. Very little information, I felt very unprepared for community midwives, that part was very poor I felt.”

“No one told me I had choices, the only point I got information was after I signed up for a course with a midwife, a private course. I got lots of information, but it was a very expensive course. Midwives didn't tell me anything. They were running Baby Steps and stuff online. They mentioned some of it at the end of the pregnancy, quite late. I had so many questions early on the level of detail [from midwives] nowhere near what I learnt privately.”

“With it being number 3, I felt very confident, the midwife-led care was fantastic. I felt well informed. Different to Switzerland, options not discussed.”

"I wasn't given many options, they could give more information on options."

"I think basic manners and being supportive, basic customer service, I sort of made my options because it was the 2nd time round. I was the one ringing chasing appointments."

Complications

Many mothers/babies had gone through challenging complications during the pregnancy, during labour and postnatal.

Individual experiences of SCBU:

- Babies' sugar dropped and salt rose and had to be put on a drip, overall in SCBU for 2 weeks. This mother reported her experience with SCBU was positive
- One baby had jaundice, however there was no room in SCBU, lack of support from midwives overall
- Some mothers' experiences with SCBU nurses' attitudes perceived damaging when advising about breastfeeding
- Due to a mother being in ICU with hypertension and other complications, her baby had to receive care from SCBU. Positive experience and she felt it helped her to recover faster
- 2 babies received care from SCBU due to consuming faeces while inside the womb.
- Two mothers felt they had received poor support from SCBU, no communication as to why their babies were in SCBU or what was happening.
- One mother wanted help and was concerned about her baby, contacted SCBU however they did not come for a while, and told her; "we've got something more important and you have to deal with it, a pregnant woman arrived with COVID"

Other individual complications:

- One mother was experiencing lots of pain in the last 2 months of her pregnancy, leading to 20 appointments. She was regularly seen by a different doctor and was not told what was wrong, finally being diagnosed with costochondritis.
- One mother had to go in to hospital a few times for monitoring at the 25 week mark as she was struggling with pre-eclampsia
- 2 mothers had really bad experiences with haemorrhoids;
    - One received no pain relief, despite haemorrhaging 2 litres of blood. No support from midwives, so she went to the Bridge for support but she was seen by a different midwife each time, and received different advice every time
- One mother had been told she had a bladder infection, and carried on feeling immense pain, kept going back, seeing different doctors with different advice and no communication. She started bleeding badly and gave birth at 24 weeks, staying 6 months in the natal unit
- A few mothers had struggled with the recovery of their C-section births such as painful infections

Overall, those who had faced complications requested improvement on attitudes of the professionals, consistency with doctors/midwives and better communication on the wellbeing of their baby if elsewhere on a different ward.

COVID19 impact:

Many felt their experience with maternity services in Jersey was affected by COVID19. Those affected by the virus displayed deep sadness and heartbreak due to their partner/parent of the child not being able to attend the scans. For some, their partner did not attend any scan, just the birth, which did not give them a chance to hear the heartbeat or find out the gender together.

Those who attended appointments during the worst of the pandemic perceived that they were unprepared due to the lack of consistency of doctors/midwives/professionals, this made them feel unsupported.

During the worst of the pandemic, parents who had no family or friend support struggled with balancing trying to look after their other small children and caring for a newborn baby.

One reported not meeting her health visitor at all in person.

"I felt sorry for the men because they can't feel the child or anything, a lot of them missed out, you only get 2 scans for a normal pregnancy, if you're not there you miss it"

"I had no partner at the scans, he never saw the baby or heard the heartbeat or anything, I was in floods of tears for 9 months, it was a very emotional time"

"Heavily affected due to COVID, I wasn't offered any pain relief, just gas and air, they said it was because they wanted me to go home the same day, they made that very clear, they said it was much safer to be at home than in hospital"

"I had an awful experience with the 20 week scan, purely because they picked up on an anomaly, it's all fine now. At the time my husband got kicked out after us being told the news, I had to wait on my own, with COVID he wasn't allowed to wait, it was so traumatic, I had to wait on my own whilst the news sinks in for 45 minutes''

"On my scan from the midwife, my partner came with me, she was very rude, partner hasn't got very good English, she spoke to him but he didn't understand, I tried to translate and she said it again but more abruptly and sent him out, she was rude"

"I could attend some [father talking about scans], we had some issues, it was very strict, there was a line on the floor I had to sit behind. I moved my head over the line and got shouted at"

"Luckily I was able to take my partner for both scans. We sat outside, they called me through and then called my partner through. Made it a long process even though we're the same household. Don't see why we can't sit in the same room, very ridiculous. As soon as the scan was done he had to leave and I had to stay for the check up even though we were seeing the same person. Luckily I didn't see her again"

Miscarriages/baby loss and ectopic pregnancies

The mothers who opened up about their stories regarding miscarriages reported the services as being "cold", "inhumane" and "awful".

Individual stories:

One mother had 3 separate miscarriages and reported feeling "like a piece of meat" due to the lack of emotional support. She had no follow up or one on one support and when asking for help she would receive a different doctor each time, having to explain her traumatic experiences multiple times to different people.

Another mother had miscarried at 10 weeks on Easter weekend, no one was available to do the scan, making her wait a week to see if she had lost the baby. She was then told it could be "mola/cancer". It was then removed however she was then told that she did actually lose a baby. This confusing experience caused her a lot of anxiety and also pain, however she was refused any pain medication.

(Same mother, next pregnancy) "When I went back for a scan early on, 6 week scan, I was worried because they couldn't find him, they scanned again with a different method, and found him. They never did that, first time, then I panicked that they did a D&C on a real baby."

Another mother who had miscarried felt the doctors were not fully equipped to handle the miscarriage. She felt there was something wrong with her baby so went to A&E, they asked her many questions but wouldn't admit her into the hospital.

"They send it all to the UK and it takes 3 months for results, a horrible wait, to figure out, she gave me a call saying they couldn't find anything abnormal".

"I miscarried at 19 weeks, I was going for a gender scan 2 days after. It happened at work, they should have been more prompt in admitting me, I said I felt leakage."

"They were still asking me loads of questions instead of admitting me, I could feel it coming out, took time to organise, there weren't beds ready, I said 'Look I see a bed, put me on there'. I couldn't sit or stand, preparation wise they were slow. The staff were nice. They put me in general ward as weren't prepared, I felt something had burst open, I said I think it's a miscarriage, they responded slowly, I had to tell them look at the bed, then I passed out."

"I think they should have a more personal touch, should be them contacting me not me to them, even one message, like are you okay?"

Miscarriage support:

There was a perceived lack of communication and /or support after a miscarriage for the women.

One mother was asked to join support groups, however she was too emotional to speak to a group of people, and was offered no 1 to 1 support or mental health support.

Post-natal

0-6 month postnatal support

The mothers with 0-6 month old babies expressed feelings of discomfort with leaving the hospital when not ready to do so, and felt forced out.
Overall, there was a feeling of a lack of emotional support once the mother had taken the baby home.
Individual circumstances included:

- One single mother with no support had been placed on the MESH system, however suffered a meltdown and felt she had to give up her baby. She called up for support but was told they can't leave the office as they were too busy
- One attended a next day consultant debrief after having a c-section, she was told that she can't have a natural birth due to the direction of pelvis, which she felt should have been told to her before as she had to change her plan completely
- One had really supportive breastfeeding help from her community midwife

6 month-3 years postnatal support

The mothers with 6 month-3 year old babies expressed that overall receiving health visitors is “potluck, it was consistent pre labour but then the home care was different luck of the draw”. A few had great experiences with health visitors, however others either experienced a lack of continuity of health visitors or lack of overall communication and support.

Some didn’t meet their health visitor in person at all due to COVID19 restrictions.

Some felt the health visitors were just “ticking boxes” and not fully listening to them, reports of bad attitudes and lack of sympathy for mothers. One also felt the health visitors were suggesting and diagnosing things which they were not qualified to do. Some reported issues with health visitors causing mothers unnecessary worry about the weight of their baby.

Mothers described the maternity services as not being joined up, this included lack of communication between the health visitors/midwives meaning parents would have to explain their story multiple times to different professionals. This was upsetting for some mothers to recount stories of baby-loss repeatedly. A few felt the timings given for appointments were inconvenient and not thought through e.g. a mother without a car given a really early appointment.

One mother had one consistent health visitor despite moving house/parish and was very content with the support.

Two had not healed from their labour and were worried, so tried calling multiple times without response. One had gone into the hospital for help however felt uncomfortable and not welcomed.

Breastfeeding support

For the mothers of 6 month-3 year old babies, their experiences of breastfeeding support was mixed. Some experienced brilliant support from the midwives with help to latch, express and breastfeed. However others found they had no support at all and really struggled.

The experiences from the mothers of 0-6 month old babies was mostly strongly negative. Many felt there was no support at all or too much pressure. Some experienced midwives being very “pushy” and “forcing” breastfeeding despite mothers requesting not to. A few mothers reported having been given multiple conflicting pieces of information from different professionals which caused a lot of anxiety.

Those who had great support had heard of other mothers who had struggled with no support and feel impressed and lucky.

Overall call for more one on one consistent care and support for mothers when learning to breastfeed their newborn baby, as well as a more sympathetic and kind attitude to those who do not want to breastfeed or unsure if they want to.

“I was lucky, they listened brilliantly, friends said they were pushy with breastfeeding, one friends said the midwife took the baby and put it on her breast when she said not to.”

“I missed the breastfeeding support the most, I entered a programme with a health visitor where you get one every week but she had to leave island and it was short staffed, since I gave birth I’ve been told I breastfeed okay, I just need to get used to the pain, crying, painkillers. In 6 weeks I had a breastfeeding specialist and she was the first person telling me what I was doing wrong, it was a nightmare. In the hospital they said that what I was doing was correct, but it wasn't.”

“Mixed messages, no support, never took the time to show you or explain, try and help, try a different thing, different positions, they don't have patience or time. But if you don't do it and go for a bottle you get looked down on and judged.”

Expectant Mothers Antenatal Support

The expectant mothers had varying situations and scenarios. 2 had experienced the hospital facilities and felt they were outdated and in need of an upgrade. 2 were yet to experience the ward and were doing their best to keep an open mind, despite hearing lots of negative thoughts prior to and during the group.

"You don't care about facilities when in labour but when you're there for a longer time, that's when you notice gaps. I'm scarred for life from showers, when you're showering and everyone passes by"

Some had excellent experiences with GPs whereas others did not. Some had GPs leave mid-pregnancy causing confusion.

The ‘young mother’ had issues with her midwife who made her feel uncomfortable and embarrassed to be pregnant as she put a huge onus on her age despite not knowing her situation. She was hoping to change midwives before her next appointment.

"I do also feel like my age comes into factor, I'm 21 and I felt very judged by my midwife……. I felt my age factored a lot, the midwife kept saying I was a young mum. She would say 'you're very close in age to my son and I would never expect him to have a baby that young'...being young and hearing comments from someone who's guiding you makes it more uncomfortable and scary, I'm scared to give her a call with a problem or a question because in her eyes I'm too young"

There were also issues raised regarding COVID impact on husbands’ experience with scans. One was told to leave after not understanding the English instructions [quote above] and another was made to leave after a

scan found an anomaly - leaving the expectant Mum alone for 45 minutes with the news. [Quotes above in COVID Impact overall section].

Dads

The Dads had mixed experiences. Some felt accommodated and included whereas others felt they were not at all welcome. For example, one was offered a crash mat to stay on in the room and another was told off for cuddling his baby.

“I was in there, holding our daughter and a midwife said ‘Why are you holding her?’ I told her I was her dad. She said 'No, she needs to go into her cot.' Was she asleep? Yes. I wasn’t harming her, she didn’t need to go in her cot. She had a feeding tube and a fingertip and toe monitor. She was learning to know her Daddy”

There were perceived needs to improve the consistency of care. There was a feeling that the level of care and compassion depended on luck regarding which staff member was treating you. They felt that *"Some staff were amazing, some were not."* One felt that overall, the culture of the more senior midwives was less accommodating to the Dads than the less experienced midwives.

"It tended to be the more experienced midwives that were less of a fan of Dads, newer staff tended to be like 'What can we do?' More experienced were more 'No, we do it this way' and said 'Come and see them [Mother and child] in 3 days'...The general trend was that the more experienced they were, the less welcoming they were”

The dads were generally happy with the antenatal preparations provided. One had his Baby Steps altered by COVID as as they weren’t providing in-person sessions or online classes at that stage of the pandemic. One Dad felt that the midwives at Baby Steps were too restricted in which feeding options they were allowed to encourage and that they were too focussed on breastfeeding. 2 had used HypnoBirthing. 1 had a massively positive experience whereas 1 had an extremely negative experience and had filed an official complaint.

"On the whole they were good and included the Dads at Baby Steps. Only problem with Baby Steps was the breast-feeding, it's like the gold standard of achievement. They weren't allowed to say anything about any other options. I had to repeatedly ask about other options. Fortunately, my wife was able to breastfeed after a long and painful journey, but give us the options."

"We didn't do Baby Steps, we did HypnoBirthing, you pay for that, that was excellent. It was open minded, gave us choices and information about the birth. It helped me and my wife to be able to find ways of relaxing during birth, covered lots of areas, it was really good."

"We did the birth plan through HypnoBirthing, more through there than Maternity Services. I'm not very happy with HypnoBirthing. I won't say too much, I've already raised issues with their team. Really best to move on or we'll be here all night. It was not the best experience"

80% had excellent experiences with the birthing team during labour. The only negative to come out was during a long labour, the 3rd midwife to take over was not familiar with the Jersey Operating Theatre and this was disconcerting for the expectant parents.

"I can't praise the birthing team enough, it was a difficult birthing experience, many hours and emergency forceps. Not a fun experience but the team were brilliant throughout. Absolutely kept me informed, there were complications so the birthing plan went out the window. These things happen. They always explained what was happening. My wife doesn't remember it but I do."

"We had a midwife who was exceptional, she went off shift and then we had another who was also exceptional and then she left. Then we had one for the last bit who wasn't so good, she was a locum. She gave the impression she wasn't aware. My wife went into theatre...she gave the impression that she hadn't been in that same theatre before"

Overall, the Dads were positive regarding postnatal support offered. One had a debrief to talk the Mother through certain decision points and processes - he felt this was very helpful. Another's wife had an immediate diagnosis of Post-natal Depression - they were then given the appropriate support and felt it was taken seriously and dealt with properly.

"They actually acknowledged from the start that my wife had postnatal depression and got us in touch with the Bridge, we talked to Brighter Futures. We've had a good relationship with the Bridge, they were consistently visiting us. It's been good regarding the mental health side. They acknowledged it and took it seriously. It was a good experience."

Varying experiences with paternity leave. Those who had births after the 6-week legislation came in were understandably much happier than those who had pregnancies before the law was passed. The 2 who had leave before the 6-week law had varying experiences due to their employers.

"My employer at the time was not the most helpful, I had it all setup and then my partner was 2 weeks late. Eventually she was going to be induced so I said 'I'm not gonna be in from Thursday' he then said 'You won't be needed there till Monday so your leave starts then' , I then said that my leave started on Thursday and that I'd be in the Hospital. I was given 2 weeks, 6 weeks would've been nice. We came in just before the 6 week law"

"I had the 6 weeks, it was brilliant. I work in investment. 6 weeks was a good amount of time, I was pleased to be back. It is legislation but yes they [employer] were fine with it"

"I got 2 weeks, they [employer] were very good. They supported me during that time and made sure I wasn't disturbed. We're due another in July, 6 weeks will be really nice. I can choose to take it in 1 go or 3 lots or however I want. I was lucky with the first. Very good"

Facilities

Most felt that the facilities were outdated and old fashioned; however they felt they were clean and did not make them feel they were in an unsafe environment. There were calls for improvements to the water birthing facilities i.e. more baths and not using the room for storage.

"In the current one, where you have a water birth is a storage room. Inflatable bath, I think they clear it for birth but when they show you round it's a storage room. I don't know how they fix these things in the current hospital. Maybe get a real birthing pool"

There was also a perceived need to improve the bathroom facilities; there should be a bathroom accompanying the delivery room as well as a more private showering facility.

"You don't care about facilities when in labour but when you're there for a longer time, that's when you notice gaps. I'm scarred for life from showers, when you're showering and everyone passes by"

"I was in for a while in a private room but non ensuite, if you want a shower or bath you're in the hallway, they keep the door open to hear you, curtain rail around the door but very off putting. You're laying in a bath completely starkers, and see people's feet walking around"

"I had a private room, the shower and bath in the room is one where you have to step in. You can't use it after you've had a C section"

Also, there were massively negative views towards the food in the ward. This was perceived as un-nutritious and bland. Some also felt the heating in the wards and rooms needed turning down as it was too hot.

"The heating, when you're pregnant you get very hot, it took me 2 and a half days to get them to turn the heating off, I had to sleep with the windows open, I could hear all the drunks and all the cars. I got no sleep. In a private room you should have aircon"

"It's the most un-nutritious food, most women suffer with low iron especially after birth, you need your nutrition after a baby"

Maternity Services would be so much better here in Jersey if...

Respondents were asked to complete the above sentence at the end of their group into the chat section of the platform. There were a variety of different proposed improvements but also some popular choices.

Improving the consistency of care was mentioned the most. Mothers and fathers wanted to hear the same advice from each professional they see.

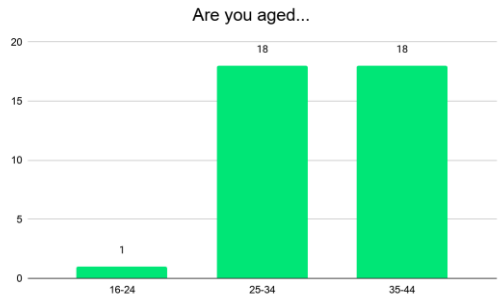
The need to improve communication was the next most mentioned. This included communication between professionals as well as from professionals to mothers and fathers. Respondents wanted increased clarity and frequency of communication.

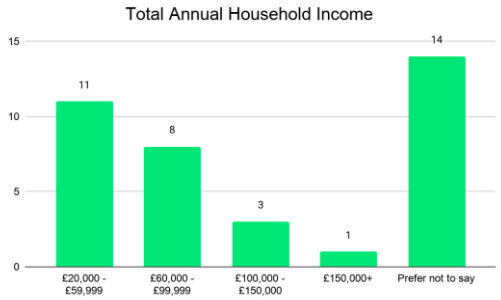
Improvements to both empathy from professionals and facilities in the hospital were both suggested too. . Respondents wanted more empathy and kindness from midwives throughout their pregnancies. Facilities wise, food, climate control and waterbirth facilities were all mentioned specifically.

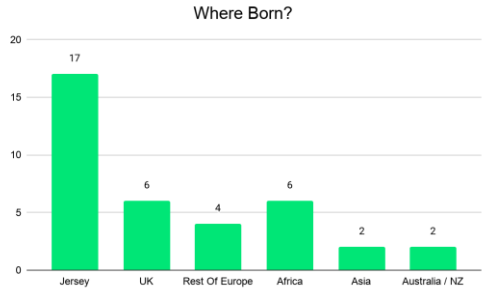
Other proposed improvements included: continuity of care, record keeping, breast-feeding support and more support / provisions for husbands or partners

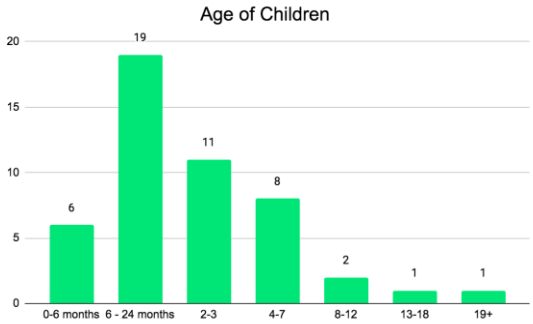
Appendix

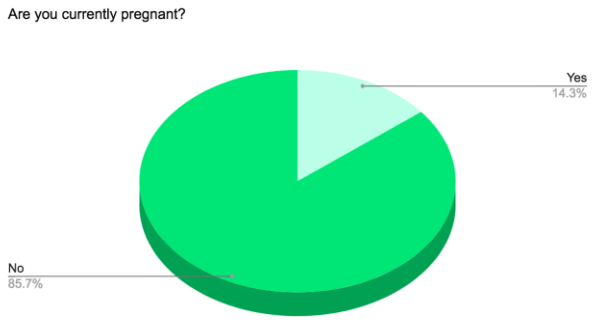
Respondent Demographics

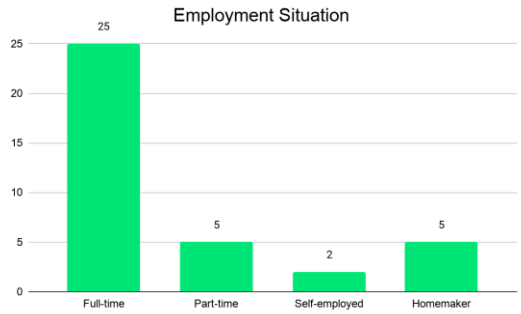


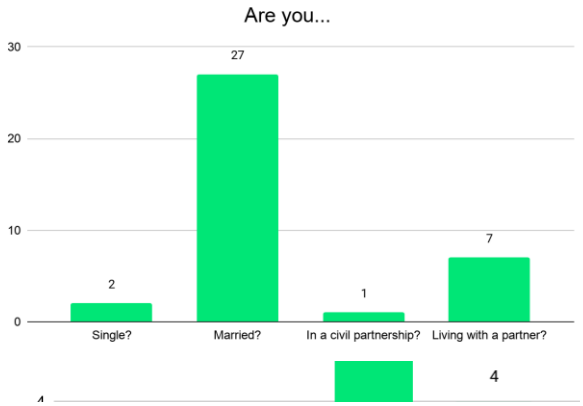


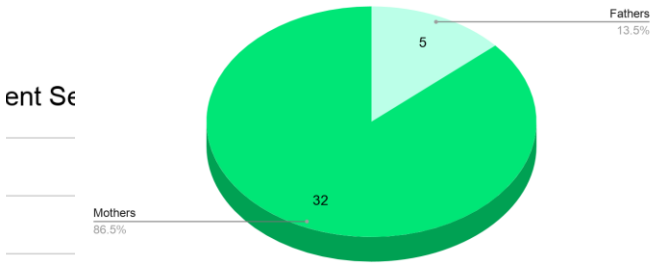


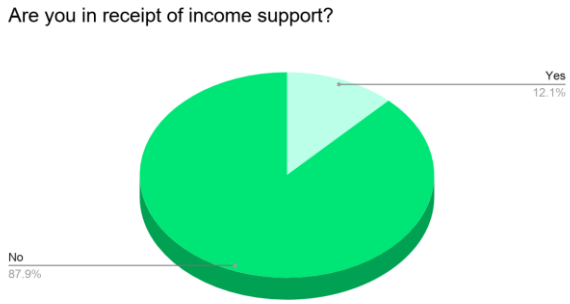


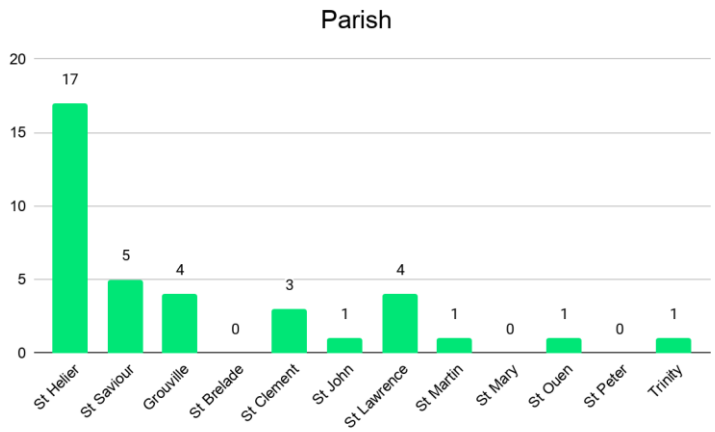





Are you...
30
20
10
0
27
2
1
7
Single?
Married?
In a civil partnership?
Living with a partner?
4


ent Se
Fathers
13.5%
5
Mothers
86.5%
32


Are you in receipt of income support?
Yes
12.1%
No
87.9%


Parish
20
15
10
5
0
17
5
4
0
3
1
4
1
0
1
0
1
St Helier
St Saviour
Grouville
St Brelade
St Clement
St John
St Lawrence
St Martin
St Mary
St Ouen
St Peter
Trinity

Appendix 4: Mental Health Services – Glossary

Mental Health and well-being Services available in Jersey		
Service Provider	Summary	Contact Information
Pregnancy in Mind (PIM)	Pregnancy in Mind is a course offered universally to expectant parents by the National Society for Prevention of Cruelty to Children. This service promotes mental well-being for all with the aim of minimising the effects of anxiety and depression on parents and to support them in building a positive relationship with their unborn baby.	Tel: 01534 760800 Email: learning@nspcc.org.uk
Adult Mental Health Services (AMHS)	Adult Mental Health is a service for clients between the ages of 16 and 65.	Tel: 01534 445841 Email: info@listeninglounge.care
Health Child Program (HCP) (Health Visitor Service)	The Healthy Child Programme is offered to all pregnant women, babies and families on the Island. Mental health is one of the six targeted areas within this programme. This universal service offers an antenatal visit, new birth visit, a six (6) week visit with a one (1) and two (2) year developmental assessment.	Tel: 01534 443600 Email: enquiries@fnhc.org.je
Baby Steps – provided by Family Nursing and Home Care	The Baby Steps Universal Antenatal Programme is delivered by a trained team, which includes Health Visitors, Midwives and trained facilitators. The programme is designed to help people prepare for becoming parents and cope with the pressures of a new baby. It integrates approaches from health and social care with a strong emphasis on healthy relationships and social support. Pregnant women and their partners are offered the opportunity to complete a mental health assessment tool which identifies those requiring additional support.	Tel: 01534 443744 Email: enquiries@fnhc.org.je
Jersey Talking Therapies	Jersey Talking Therapies provide a range of short-term	Tel: 01534 444550 Email: JTT@health.gov.je

	therapy/support to adults over the age of eighteen (18) with mild to moderate mental health issues. There is an exclusion criteria of high risk cases. The team consists of psychological therapists, well-being practitioners and counsellors. There is an option of self-referral. Midwives can also refer to Jersey Talking Therapies.	
Parent and Infant Psychotherapy	Parent and Infant Psychotherapy helps support parents who struggle to relate or have positive feelings toward their baby. The aim of the service is to address the immediate presenting problems and to help the parent/s feel more positive about their interaction with the baby and focus on strengths as well as challenges.	Tel: 01534 445030 Email: hsscamhs@health.gov.je
The Listening Lounge	The Listening Lounge is a service which aims to improve and support Islanders with their mental health and well-being. This is a free service consisting of counsellors and peer supporters and access to online support.	Tel: 01534 866793 Email: info@listeninglounge.care
MESCH	Maternal Early Childhood Sustained Home-Visiting or MECSH is a structured programme of sustained nurse home visiting for families identified to be at risk of poorer maternal and child health and development outcomes.	Tel: 01534 443677 Email: m.raleigh@fnhc.org.je
Brighter Futures	Brighter Futures is a charity that supports parents, carers, children and young people in Jersey.	Tel: 01534 449 487 Email: f.brennan@brighterfutures.org.je

Private Mental Health and well-being Services available in Jersey		
Service Provider	Summary	Contact Information
Jersey Aqua natal	Sharleane, Rachael and Kath are midwives at the Jersey General Hospital and also fully qualified Aquanatal instructors.	Tel: 01534 734524 Email: jerseyaquanatal@gmail.com
Mindfulness (Jersey International Mindfulness Centre)	At Jersey International Mindfulness Centre (JsyIMC) We are passionate about providing both a superior experience and tremendous value for our customers.	Tel: 01534 852953 Email: mindfulness@jsyimc.co.uk
Pregnancy yoga	Kula Yoga is here to guide you; whether you're new to yoga, already a yogi at heart, pregnant, have a child with special needs, or an injury or ailment you'd like to resolve.	Tel: +44 77977 24334 Email: kulayoga@hotmail.co.uk
National Childbirth Trust	NCT Jersey welcomes every new parent. Our local groups, activities and events are run by volunteers. We help forge friendships and raise money for all of NCT's work, locally and nationally.	Tel: 07797777853 Email: jersey@nct.org.uk
Positive Birth Jersey	Positive Birth Jersey was established with the aim of providing parents and birth partners with knowledge, tools and techniques to build positivity, strength and confidence in pregnancy, birth and parenthood.	Email: positivebirthjersey@outlook.com
Mama Mariposa Doula	As a GentleBirth instructor I combine hypnobirthing methods and mindfulness as a powerful combination to help you through pregnancy, labour and postpartum.	Tel: 07797893379 Email: mamamariposadoula@gmail.com

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