

Briefing Document for the attention of:

**Greg Dix** (Executive Nurse Director)

# SUMMARY OF A TARGETED INTERVENTION PROCESS AT THE PRINCESS OF WALES LOCALITY MATERNITY UNIT

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## **PURPOSE**

The briefing paper will summarise the targeted intervention programme undertaken, at the Princess of Wales (POW) locality. Following the identification of issues and concerns during the multi-disciplinary incident review meetings the programme was implemented. It will explain the actions undertaken and its impact on improving safe care for women and their families and the developmental support it has provided for clinicians within the service.

<b>SITUATION</b>	<p>In the period April 19 (at merge of POW to the Health Board) to December 19 the maternity service reported 3 serious incidents. To mid may in 2020, 9 serious incidents had been reported. There were a number of recurring themes:</p> <ol style="list-style-type: none"><li>1. Identification and escalation of abnormal and deteriorating CTG</li><li>2. Surveillance during induction of labour</li><li>3. Timely escalation by midwives and junior doctors</li><li>4. Clinical obstetrics reviews being undertaken by telephone rather than face to face</li><li>5. Inappropriate allocation of complex cases to junior midwifery staff</li><li>6. Identifying appropriate clinical area for care</li></ol> <p>The MDT team agreed to support the use of a targeted intervention tool to support a wider body of work to address and support the required improvement relating to these themes.</p>
<b>BACKGROUND</b>	<p>The targeted intervention tool was commenced on the 26<sup>th</sup> May. Requirements included:</p> <ul style="list-style-type: none"><li>• 3 times a day review by the midwifery matrons to complete the assurance required by the tool</li><li>• Provide on the spot coaching for clinicians to support a culture of proactive support and timely oversight and review of women in labour</li><li>• Promote closer MDT working and communication, promoting fluid, seamless care</li><li>• Enhanced communication with obstetricians and midwife co-ordinators to explain the aims of the tool and their role in supporting the process.</li></ul> <p>The tool's frequency was stepped down, initially after 2 weeks on 5<sup>th</sup> June, then to once a day from 12<sup>th</sup> June. It continues once a day.</p> <p>The Health Board appraised both the Welsh Government and the Independent Maternity Oversight Panel at the earliest opportunity.</p>
<b>ASSESSMENT</b>	<p><u>General</u></p> <p>Safety and governance has undergone significant investment, both in terms of dedicated clinical roles with specific responsibility and through awareness and education of individual responsibility in delivering a safe service and the monitoring of quality and safety.</p> <ol style="list-style-type: none"><li>1. Operational band 7's (2 x WTE) have responsibility to undertake first line review of moderate harm incidents within 72 hours, organising and participating in a full MDT review. They have had datix training and ongoing support to be skilled to undertake this role in a time efficient but thorough way.</li><li>2. There is a dedicated locality Risk Midwife (0.6 WTE) responsibilities include:</li></ol>

- Leading weekly MDT risk meeting
  - Thorough learning from incidents is implemented and recorded
  - Oversight of appropriate data management of low or no harm incidents
  - Oversight of appropriate process of SUI management
  - RCA training, skills and knowledge within the team is developing
  - Advice and support to colleagues in matters relating to risk
  - Feeding themes to Risk and Governance Matron to ensure appropriate safety briefing's and appropriate information for monthly risk newsletter
3. The obstetric risk lead has 2 dedicated sessions (increased from 1) in her job plan to facilitate learning throughout the department and leadership of the governance agenda.
  4. The obstetric lead for Labour Ward role has been separated from the obstetric governance role
  5. Improved collaborative working with our paediatric colleagues enabling:
    - Term admissions to neonatal unit national audit work (ATAIN), has commenced and is on target to complete historic backlog by September 2020, contemporaneous review is now well established
    - Perinatal mortality national audit work (PMRT) has completed historic backlog of neonatal deaths, has a clear work plan for historic stillbirths and contemporaneous review is now established.
  6. Locality Interim Deputy Head of Midwifery (April – Sept 2020) has enabled support and clear leadership to shape and develop a locality risk MDT that is fit for purpose moving forward. This role has also enabled improved communication pathways and collaborative working within the ILG structure.
  7. Weekly senior team oversight of moderate harm and above incidents, assurance of robust mechanisms of learning required, ensuring across site high quality standards are maintained.
  8. Full transparency with Welsh Government and IMSOP to ensure this process of learning and development was supported and delivered appropriately.

Implementation of tool

Weekly reviews were completed and shared with the Executive Director of Nursing and Director of Midwifery, to ensure the tool was robustly adhered to and was a supportive mechanism.

The review has highlighted the following:

1. Themes

Theme identified	Re-emerging during process	Make safes	Education and training
1. CTG interpretation	No		
2. Surveillance during IOL	No		
3. Escalation from midwives and trainees	No		
4. Face to face review	No		

5. Junior staff allocation	Yes – 2 incidents	- amended assessment unit documentation - clinical support and supervision to individuals involved	- band 5 meetings for peer support and training -band 7 meetings to encourage development of proactive support skills - supporting all band's to attend risk review meetings
6. Area for care	No		

2. Serious Incidents – 3 identified during the targeted intervention period

SUI's identified	Trigger for SUI	Initial findings
1.	Maternal admission to ICU	HDU level care required – not available in POW maternity unit
2.	Maternal admission to ICU	HDU level care required – not available in POW maternity unit
3.	Neonatal re-admission from community in a serious condition	Early review – appropriate actions taken to stabilise, appropriate transfer to UHW initiated in a timely manner

No early themes from SUI's align to themes from targeted intervention.

3. Collaborative MDT working in harmony. Theme 3 identified timely escalation/review by appropriate obstetric colleagues for women with complex needs. The implementation of the tool highlighted how appropriate referrals meant a significant increase in workload for the trainee and SAS tier of obstetricians. This resulted in some concerns of capacity of the speciality and also the appropriateness of all referrals. Communication channels were improved, and midwifery managers supported training and support for all midwives to understand appropriate referral pathways. There continues to be a review of medical establishment to ensure it is fit for the demands of a service with ever increasing complexities.

**WHERE ARE WE NOW?**

- Although the intervention has now been stood down - the assurance tool has been adopted and continues to be completed once a day by the matron to document and support continuing oversight of the themes in the clinical area. The senior team value it's role at present but continue to review to ensure its relevance
- Review of medical staffing establishment of trainee and SAS tier continues
- Further development of collaborative working with our colleagues in Neonatology especially "go to" clinicians for MDT review on an ad hoc basis and senior consultant oversight of all national audit work and MDT routine meetings. Further MDT working is planned in line with the action identified in the recent neonatal RCOG/RCM benchmark
- Clinicians are challenged within a supportive environment to incorporate risk/incident management in their day to day work, it is now more *usual business* for all professionals
- The full roll out of the ILG structure facilitates an opportunity to ensure governance within the locality continues to develop and improve.
- Improved mechanisms for positive feedback where care was excellent

**SUMMARY**

Whilst the initial identification and rapid roll out of the intervention was without doubt upsetting for the clinical team, there was an overwhelmingly positive repose and engagement with the process.

Much of the intervention has now been integrated into normal business and this is lending itself to a more self-sufficient identification of issues and solutions

The increased support to all staff has been well received, particularly by the band 5 midwives who now have more face to face planned support and as a result there has been increased support to completing competency packages.

Co-ordinators have appreciated an opportunity to define their role further and going forward we are planning band specific development sessions