Maternity Team Review: case study

2023

This is an illustrative case study drawn from our own experience of delivering team reviews.

Context

Medium size maternity unit (2500 deliveries).

Recent CQC rating of ‘requires improvement’ for the safety domain.

Outlier for number of HSIB1 cases.

NHSE Maternity Improvement Adviser notes ‘team dysfunction’.

Rural area, nearest level 3 Neonatal Unit 50 miles away.

O&G trainees have reported ‘bullying and harassment’ to deanery.

Midwives have raised numerous ‘near misses’ involving locum consultants.

New consultants report feeling unsupported.

Why Team Review?

Medical Director thinks team issues are complex and multidisciplinary dynamic is not understood.

No single individual appears to be culpable.

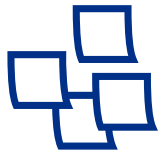
MD wants professional relationships to improve but needs to understand reasons for the poor relationships.

What did we do?

We appointed two reviewers, one with clinical experience and one with experience in organisational development.

We sent out a questionnaire, exploring communication, culture, collaboration, team support, and team effectiveness.

We held individual interviews with core members of the team and focus groups with the wider team (20 team members).



From the information gathered in this way, we identified key themes (set out on next slide)

Key themes

- Key senior team members had recently retired.
- A number of vacancies had not been substantively filled, with a series of locums filling these posts.
- Key leadership posts remained vacant, including that of a labour ward lead and consultant midwife.
- Under current interim leadership a culture had developed where feedback and healthy challenge gave rise to conflict. Feedback and challenge was therefore discouraged in order to try and avoid conflict and foster good working relations. However, this caused compromised learning from clinical incidents.
- Individual poor behaviours (e.g. undermining of junior doctors, midwives) by certain individuals, was not challenged.
- Lack of professional respect between midwives and consultants.
- There was a reluctance to refer patients to the nearest tertiary unit, preferring to ‘manage internally’.
- Senior leaders outwidth the maternity team showed little interest in maternity services.

Team Review report

The information shared was distilled into a report setting out:

What did the Team Review add to what was known?

The impact that the vacancies in leadership positions had had on the unit culture.

The impact that the culture had on professional relationships.

The impact that professional relationships had on patient safety.

The lack of referral pathways internally and externally for specific maternal and fetal conditions.

What did we do next?

Met with the MD and Head of Midwifery.

Provided management plan setting out options for how to take matters forward.

Offered to provide feedback to the team.

Continued support to the MD and Head of Midwifery through the link Adviser.

The Trust's response

The summary key issues had been shared with the team and created an opportunity for discussion about change.
A new clinical director and labour ward lead had been appointed.
Clinical referral pathways were developed.
The MD had met with the team a number of times to foster closer working relations.
External support had been sourced to advance a change programme.
Team objectives had been developed reflecting the 3-year delivery plan for maternity services.
Strengthened induction and support for new staff.