Browne Jacobson

Shared Insights: Implementing the Ockenden Immediate and Essential Actions for safe maternal and newborn care

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Rachael Morris**, Partner at Browne Jacobson** spoke on how this session would mark World Patient Safety Day which this year has a theme of safe maternal and newborn care. She provided an overview of the implementation of the Ockenden Immediate and Essential actions.

Amelia Newbold**, Risk Management Lead at Browne Jacobson** provided an overview of how Heads of Legal can support clinical improvement work.

We were delighted to be joined by **Dr Angie Doshani Consultant Obstetrician and Gynaecologist at University Hospitals of Leicester NHS Trust** (UHL) and **Elaine Broughton, Head of Midwifery at UHL**, who spoke about the impact of Ockenden at their Trust, the practical steps they have taken to implement the actions required, and shared practical tips for disseminating learning.

The Shared Insights were:

Rachael Morris provided an overview of the four Ockenden Recommendations this session would focus on:

- **Fetal monitoring** – this arises frequently from a claims perspective including situations where the assessment of CTGs is felt to be incorrect or there has been a failure to escalate. The Royal College is currently putting together guidance on standardisation of CTG interpretation. Failure in escalation can be due to communication issues.
- **Risk assessment** – Ockenden is clear there should be risk assessments at every contact in the maternity journey.
- **Consent** - Communication around consent should involve having ongoing conversations with women and evidence-based information in order to make decisions. Document those discussions in as much detail as possible.
- **Culture** – Good culture makes all the other things easier. Share and learn from outcomes of investigations with the whole unit, not just the people involved.

  Communication is a thread running through all of those issues.

Amelia Newbold discussed how improving maternity safety cannot be achieved by clinical staff within maternity units acting alone – it is much wider in scope and we all have a part to play. She explained how Heads of Legal can support clinical improvement:

- **Learning from Claims** - there is a wealth of information that Heads of Legal can glean from reviewing documentation created during the course of litigation which can assist with informing improvement work in this area. HSIB reports will provide learning but for cases outside HSIB's remit, an analysis of claims provides valuable learning about what is happening on the ground. There are various tools available to assist Trusts with this:
  - NHS Resolution Scorecard
  - GIRFT Litigation Pack.

- **Learning from Inquests** - Inquests present a valuable opportunity for Trusts to identify care issues closer to the point of incident and Heads of Legal have a key role to play in ensuring that clinical witnesses have an opportunity to set out their evidence and raise issues prior to the inquest without feeling constrained. Consider smaller PIMs with fewer staff so junior staff in particular feel able to speak up.
- **Resources** – Browne Jacobson have recently launched a Maternity Services Hub and Mock Inquest Films, which anyone in your organisations can access free of charge here to assist clinical witnesses in preparing for inquest.
- **Keeping abreast of National Information/Data** - In addition to looking at learning from individual claims and inquests from within your organisation, there is also a raft of information available at national level which may be useful to help Trusts with improvement work in specific areas within maternity:
  - HSIB and NHS Resolution have both published thematic reports looking at themes arising from the investigations they undertake
  - HSIB quarterly reports identify issues by reference to regions and provide information about what has worked well for other Trusts.
- **Board Reporting** - The Ockenden report identifies the need to ensure the Board are fully sighted on what is happening at unit/ward level and to ensure that there is robust challenge of the assurances provided. Heads of Legal will have relevant information for the Board based on recent/ongoing claims and inquests.

Culture

Dr Angie Doshani discussed the importance of reassuring the public that Trusts have learned from their past mistakes and ensuring learning is embedded and shared.

She spoke of the importance of culture within Trusts and how working as a team is key. Improving morale and having visible leadership on the shop floor is also important along with improving communication between team members.

We heard practical tips and ideas for sharing learning and experiences with staff including ‘tea-trolley’ and ‘sweet trolley’ learning, ‘good news papers’ and regular safety walks.

Consent and Documentation

Amelia Newbold discussed the importance of ensuring consent discussions are tailored to individual circumstances and documented. It is important to remember that consent is an ongoing process– during the antenatal period there is a considerable amount of time to have those discussions. Documenting as much detail as possible of those discussions is key.

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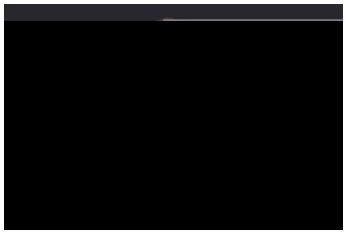

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