

Description

Supporting Positive Change: Responding to Ockenden

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Summary



It has been a difficult and challenging time for midwifery, with negative press coverage and the lasting implications of working under the pressures of staff shortages during a pandemic. This year began with many in our profession feeling burned out and under scrutiny. Starting in my new role within the maternity-risk team coincided with the publication of the Final Ockenden Report, Mar 2022, an investigation that lasted a period of years and investigated many aspects of one hospital organisation's maternity and neonatal services. In fact, the report in part precipitated my role, which is Clinical Negligence Scheme for Trusts (CNST) and Ockenden Assurance Lead Midwife. Here I hope to shine a light on my new role and how I utilised social media to form the first national Ockenden Safety Group to share learning and ideas.

Eyed with suspicion

The assurance part of my role is new to me and it has been an enjoyable and steep learning curve. Luckily, we are well supported with a large team of quality and assurance professionals who provide advice and encouragement.

Roles within risk/safety in maternity can be shrouded in mystery and tend to be eyed with suspicion, perhaps because part of our role is to investigate serious incidents. But just like any other midwifery job, it requires compassion and the ability to listen and provide support, particularly when things turn out unexpectedly.

Giving love and support to colleagues and bereaved families in times of difficulty is important for a healthy and open working culture. This is highlighted regularly when working in risk and patient safety and hopefully this blog will give an insight to the day-to-day role of a midwife that works within risk/patient safety.

What does an Ockenden Assurance Midwife do?

> At the heart of the Ockenden Report and the work that we do is improving safety and outcomes for women and their babies

The job was new, so in some ways I have forged my own idea of the role. Fantastic leadership and support within the department has given me so much space and encouragement to do this and has meant I have had time to really reflect on what is needed. I began with the seven immediate essential actions (IEAs) from the Interim Ockenden Report, Dec 2020, and created an infographic to disseminate the information to staff, women and the rest of the world via Twitter.

I familiarised myself with the gap analysis that had been conducted within our Trust[1], ensuring we were compliant with the actions and, if we were not compliant, trying to understand what was required to enhance safety.

From the final report, I identified areas where we could improve women's experience and safety in line with the 15 IEAs, arranged and attended many meetings with various disciplines – midwifery, obstetrics, anaesthetics, neonatologists – and with regional NHS England teams, the Local Maternity and Neonatal System (LMNS) and the Trust's Chief Executives to provide assurance to them that we are implementing the 15 IEAs.

It has been a whirlwind. At the heart of the Ockenden Report and the work that we do is improving safety and outcomes for women and their babies, ensuring safe staffing, and fostering an open and supportive work culture.

We have a patient experience midwife who works side by side with our fantastic Maternity Voices Partnership, and their opinion and advice is sought regularly.

The recent reports have forced us to scrutinise our processes and provision of care, including safe staffing levels and workforce planning, it has also provided an opportunity to review the evidence underpinning guidelines.

My role also includes overseeing compliance with the Clinical Negligence Scheme for Trusts, run by NHS Resolution, working closely with the Bereavement Midwives, and forming part of the group that reviews stillbirths, neonatal deaths, late fetal losses and maternal deaths.

Monitoring audits and producing newsletters is another aspect of the role and I also work one clinical shift per week which I love. Sometimes it feels as though there aren't enough hours in the day.

I realised I needed help

> it would be wonderful to see more staff, from all areas, involved in service improvement.

I am passionate about communication and utilising the power of social media to develop networks, disseminate information and promote connections throughout hierarchies, socially, academically and within the workplace. As soon as I started my role, I was keen to find others working in a similar capacity, who could help me and share ideas.

What better way to improve care for women and their families than finding out about what works in other maternity services and to try it in our own? So, I set about forming the first Ockenden Safety Group on Teams.

I used Twitter to promote the idea and had great feedback. The group was formed, and we now have almost 100 members, including students, obstetricians, patient safety experts, researchers and members of the public. We meet online once a month and so far it has provided an extremely valuable resource to discuss the various nuances found in

the report and to understand how different maternity services are implementing the recommendations.

I was pleased to see the plan for the recommencement of Midwifery Continuity of Carer (MCoC) in the latest CNST publication and I look forward to discussing how other maternity services envisage rolling this out over the next 18 months, particularly considering the continued staffing crisis.

The evidence for MCoC is strong and not only benefits women and their families, but staff too. Building relationships is key to providing supportive, safe and compassionate care, and this needs to feature in all midwifery roles, particularly those that involve bereavement.

One idea I have had to improve engagement between staff and our risk team is to make a series of videos to describe our role, what the implications are for us considering the Ockenden Report, and to encourage staff to share their ideas for improving women's safety and care.

We have strong links with our Maternity Voices Partnership and regularly engage with service users; it would be wonderful to see more staff, from all areas, involved in service improvement. **If you have any ideas or would like to get in touch please do.**

References

1 An NHS Trust is an organisational unit within the National Health Services of England and Wales, generally serving either a geographical area or a specialised function (such as an ambulance service).

Category

1. All4Maternity Blog
2. News & Views

Tags

1. Ockenden
2. Patient Safety

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