

# Clinical Governance Update 2022

Learning from The Ockenden Report

# Failure in Governance and Leadership

- Failings to follow National Clinical Guidelines
- Delays in escalation
- Failure to work collaboratively across disciplines
- ‘Them and us’ culture between Midwifery and Obstetric staff
- Inadequate support from senior staff members
- Investigatory processes were not followed
- Maternity Governance Team downgraded S.I’s to avoid external scrutiny, covering up the true scale of S.I’s at the trust
- Reviews were often not multi-disciplinary and some significant areas of concern were not investigated at all

Throughout the review period: Lessons were not learned, Mistakes were repeated and the Safety of mothers and babies was compromised as a result.

# COMMUNICATION

- Ockenden – Listening to women and their families - **Immediate and essential action.**
- Datix – Regular themes of poor communication.
- Complaints – Women feel they were not listened to.

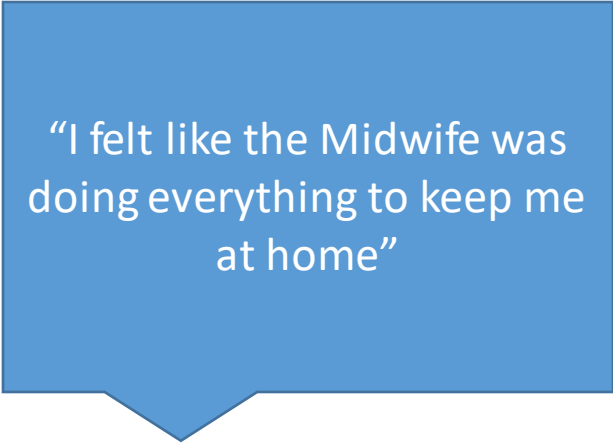
# Thoughts????????

Good advice  
given??




Was she  
listened to??


Did **she** feel  
she was  
listened to??



“I felt like the Midwife was doing everything to keep me at home”



“I felt like I was wasting the Midwife’s time when I called”



“I felt I had no choice and wasn’t allowed to go in”

Learning Point: ARE WE ACTIVELY LISTENING AND COMMUNICATING EFFECTIVELY WITH WOMEN???

DO THEY FEEL WE ARE???

THANK YOU FOR LISTENING

