AIMS For a better birth...

Placing the Ockenden Report in context

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By Cyril Chantler

The Ockenden report details harrowing accounts of avoidable human distress in a service dedicated to caring, kindness and the relief of suffering. It contains many recommendations for improvement. It is, however, sadly not the first such report - there have been others in the recent past such as Morecambe Bay, and there are others already in preparation for Kent and Nottingham. Thus the Ockenden report does need to be considered in the light of these other reports, begging the question as to why these awful events keep happening and whether we can reduce the number of times things go wrong and the number of places where this occurs. Ockenden does note that regulation does not seem to have been the answer.

There are multiple contexts to be considered and not only for the report itself but also the media's reporting of it and the Government's response. This requires reflection. One context is the overall safety of maternity services in England. As was noted by Donna Ockenden and the Chief Nurse and Medical Officer of NHS England in a letter to the Times, England is one of the safest countries in the world in which to give birth.[1] Not only that, but the stillbirth rate has fallen by 25% over the last 10 years, equivalent to 753 fewer stillbirths than there would have been in 2020 if the rate had remained at the 2010 level. The equivalent figures for neonatal deaths are a reduction of 36% or 412 fewer deaths. The media's response to the Ockenden report did not seem, at least to me, to recognise this context, which cannot have improved the morale of the many staff who have worked mightily to improve services over this period.

Another context to be considered is the other reports and recommendations for improvement that have been produced over this period. Amongst these is the National Maternity Review commissioned by NHS,

and its recommendations in its report, Better Births, published in 2016. Over the last 6 years the Maternity Transformation Board (MTB) and our Stakeholder Council, which itself represents a large number of charitable and voluntary organisations that are working hard to improve services for women and families, have striven to get these recommendations into the service to produce more personal and safer care. Much has improved but there is more that must be done and Ockenden helpfully emphasises this. We know that it is vital to learn from mistakes and it was at our instigation that the government extended the remit of the Health Service Investigation Branch to include maternity, so that a consistent, no blame process involving the family and the staff is now available across the country. We have consistently argued that we need an administrative process, not one based on litigation, to support the families and to enable learning for the clinical teams when things go wrong, as has happened in Sweden. The Health and Social Care Select Committee now supports the introduction of such a system. It is interesting to reflect on what the doctor who oversees the system in Sweden said, when interviewed by the Health Select Committee. In his view, the main reason why the system works is the improvement in the culture that has occurred since their new system was introduced. As Ockenden emphasises, it is this culture that we all agree needs to be addressed. Personally I hope the Department of Health will reconsider their opposition to the administrative system that we recommend at least for maternity, though not necessarily at this stage for the NHS as a whole. There are 28 recommendations in Better Births and the Maternity Transformation Board has put many of these into practice. One that has not yet happened, in spite of much effort and money, is a digital maternity care plan and record 'owned' by the mother but connected to all who are caring for her through the pregnancy, delivery and beyond. The Ockenden report recommends that it should be done!

In conclusion, there is much from which we can learn in the Ockenden report as indeed there has been from the other reports over the years. The emphasis on workforce issues is especially important. There is, however, a risk that if we don't consider the report within its wider context we may cease to sustain initiatives that are improving services whilst we adopt the new changes that are necessary. As we all recognise, it is urgent that we support the staff up and down the country who are working in such difficult circumstances at this time.

Author Bio: Professor Sir Cyril Chantler, whose early career focussed on kidney problems in children and who subsequently worked very broadly in healthcare leadership roles, was a member of the National Maternity Review team established in 2015 and chaired by Baroness Julia Cumberlege. That Review resulted in the Better Births report, which continues to underpin the work of the ongoing Maternity Transformation Programme in England. Julia and Cyril continue to support the implementation of the Maternity Transformation Programme in their respective roles as Chair and Vice Chair of the Maternity Transformation Programme's Stakeholder Council.

AIMS Campaigns Team Comment:

Following the publication of the final Ockenden Report on March 30, 2022, AIMS published two commentary documents.[2] [3]

The AIMS Campaigns Team is now pleased to publish here these reflections from Cyril Chantler. We agree entirely with his suggestion that the Ockenden Report - and indeed the reports from East Kent and Nottingham currently underway - must be placed in the context of the ongoing Maternity Transformation Programme.

As members of the Stakeholder Council, the AIMS Campaigns Team commits to supporting that call and Journal readers might also be interested to read our statement prepared for the extraordinary meeting of the Stakeholder Council on April 8 2022.

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[1] Editor's note - This is true except that, when compared only with other European countries, there is still room for improvement. https://www.statista.com/statistics/1240400/maternal-mortality-rates-worldwide-by-country/

[2] AIMS (2022) Ockenden 2022: if we want to see real change, then transparency and accountability is key.

https://www.aims.org.uk/campaigning/item/ockenden-2022-if-we-want-to-see-real-change-then-transparency-and-accountability-is-key-says-aims

[3] AIMS (2022) AIMS Campaigns Team comment on the Ockenden Report and next steps. https://www.aims.org.uk/campaigning/item/aims-campaigns-team-comment-on-the-ockenden-report-and-next-steps