AIMS For a better birth...

# AIMS critique of the Ockenden Report

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*By the AIMS Campaigns team*

The Ockenden review[1] of maternity services at the Shrewsbury and Telford Hospital NHS Trust provided a long overdue opportunity for parents who had suffered the devastating results of sub-standard care to have their stories heard and their concerns taken seriously.

It also identified a range of underlying issues that contributed to these tragic outcomes, including:

- Failure by midwives and junior doctors to escalate concerns in a timely manner
- Failure of senior obstetricians to respond when concerns were escalated
- A bullying culture, with midwives being reluctant to raise concerns because of previous hostile responses from other midwives or obstetricians
- Failure to listen to women
- Failure to support informed decision-making

These issues appeared to be independent of the setting, occurring in both the obstetric unit and midwife-led units.

We have published a detailed critique of Chapter 8 of the final Ockenden report, which covered findings about intrapartum care. In this article we discuss the issues raised by the findings, as well as a number of questions about the report itself: how useful is it as a contribution to the debate and how valid are its recommendations?

Included in the body of the report are a number of 'Local Actions for Learning' (LAfLs) which are summarised in Chapter 14. Chapter 15 has a list of 'Immediate and Essential Actions (IEAs) to improve care and safety in maternity services across England.' These "complement and expand upon" the IEAs identified in the interim report[2], published in December 2020.

**Concerns about non-evidence based recommendations**

As our detailed critique of Chapter 8 shows, it is not always clear how the LAfLs at the end of each section arise from, or would help to address, the issues discussed. There are also several cases where LAfLs would seem appropriate but have not been made. Similarly, there is a lack of clarity as to how the national IEAs were identified, and how they link to the findings of the review. There is little reference in the report to either the research base or existing guidelines.

A critical reading of the report reveals that in many cases the recommendations for both LAfLs and IEAs are not clearly supported by evidence in the report. In particular, it is bizarre to recommend that the Continuity of Carer (CofCer) model "must be reviewed and suspended until all Trusts demonstrate staffing meets safe minimum requirements on all shifts," when this model was not in place in the Shrewsbury and Telford NHS Trust and therefore had no bearing on any of the cases reviewed. In making this recommendation the team appear to have exceeded the scope of their remit, and it is a concern that a recommendation that is unsupported by any evidence is being accepted uncritically. Indeed, had CofCer been in place, it would have enabled women to develop a relationship with a trusted midwife, which might have helped to avoid some of the problems that arose from their concerns not being listened to or taken seriously.

Another IEA is that "Centralised CTG monitoring systems should be mandatory in obstetric units across England to ensure regular multi-professional review of CTGs." This recommendation has been made despite the authors acknowledging that, "FHR (fetal heart rate) abnormalities during labour rarely correlate with fetal compromise because the FHR is highly sensitive to hypoxaemia/hypoxia (both common during labour), but lacks specificity for fetal acidosis, the end point of intrapartum hypoxia." In other words, as is widely recognised, continuous monitoring is not much help in identifying which babies really are in trouble (see the AIMS Birth Information page Monitoring your baby's heartbeat in labour).[3]

A move to centralised monitoring and a narrow focus on the monitoring trace could increase the risk that other warning signs may be missed. As described in our detailed critique, the section of Chapter 8 on '**Failure to recognise and/or escalate the abnormal CTG in early labour**' details a number of cases that seem to relate to failure to act on other concerning signs rather than failure to recognise or escalate an abnormal CTG. The authors have not presented any evidence that centralised CTG monitoring would have helped in these or similar cases.

Another concern with a move to centralised monitoring is that it could - especially in times of severe staff shortage - easily lead to the situation where one midwife monitors a number of labours remotely, rather than providing the one-to-one relational care which we know is so important.

Another matter of concern to AIMS is the Immediate and Essential Action stating that "DHSC and NHSE&I must now commission a working group independent of the Maternity Transformation Programme (MTP) that has joint RCM and RCOG leadership to make plans to guide the Maternity Transformation Programme around implementation of these IEAs and the recommendations of other reports currently being prepared." (p5) RCM and RCOG have now announced the launch of an Independent Maternity Working Group "to review the MTP's assessment of how it will deliver against the IEAs set out in the Ockenden Review and to advise on how those may be refined."[4] AIMS is very concerned that this appears to put the future direction of the Maternity Transformation Programme firmly in the hands of the professional bodies, in contrast to the existing Stakeholder Council that includes both professionals and lay representatives. Given that the issues identified in the Ockenden report have arisen in great part from a failure to listen to maternity service users, surely the last thing we need is for the voices of maternity service users and those who represent them to be side-lined in the national debate?

**Concerns about recommendations that are absent**

In contrast, there is a lack of any recommendation about a number of serious issues raised by the case reviews. The report does not specifically identify the issue of lack of support for informed decision-making, but in many cases it appears that women were not given full information about the risks and benefits of *all* of their options, or were 'not allowed' to make certain choices. The only reference to this we could find was in discussion of how a care plan should have been determined (paragraph 8.46), which says that "the family should be involved in a Montgomery compliant manner." (p114) This displays a worrying lack of understanding on the part of the authors of the Montgomery case and the principle of informed consent, since it is not the family but the woman, or birthing person, who has the right to be given information and to make decisions about care, not merely to be 'involved'. AIMS believes that there should have been a recommendation both in the LAfLs and the IEAs for all staff to be educated about the principle of autonomy and how to enable informed decision-making.

Another surprising omission is any recommendation about guidance or training in the use of oxytocin, given that there are examples (paragraphs 8.8, 8.13) of inappropriate use of oxytocin, even in the presence of concerning signs in baby or mother.

**Concerns about lack of quantitative information**

Details of the individual cases and the large number of cases make for horrifying (and headline-grabbing) reading, but while the report includes a large amount of qualitative information, it is regrettably lacking in quantitative data. We are told that the review heard of "nearly 1600 incidents" dating back to 1972, with approximately 1300 families affected over the period 2000–2019 but there is little information to

help the reader set this in context. It would have been helpful to include a breakdown year by year of the number and severity of cases compared with total births per year.

There is one mention that there are around 5000 births per year at the Trust. Assuming an even distribution of cases across the period, this means there were around 65 cases per year i.e. 1.3% of all births. What the report does not tell us is whether cases were evenly distributed through the years or was there evidence of an increase or decrease over time. Neither do we know how this level of incidents compares with other Trusts.

There are some very shocking cases of negligent care and poor care – but how much of the care was like this is unclear. The Review team say they did come across examples of good care. It would also be of great interest to know, year by year, how many cases by severity of outcome were considered to have had poor care and how many had good care, and how many of the cases investigated gave no cause for concern. It would also have been useful for the review team to look at a random sample of cases to determine what the 'usual' level of care looked like in comparison to those cases with poor outcomes.

In the light of one comment from a member of staff "on the appointment of an individual consultant in 2018 who changed the culture 'in terms of consultant engagement… and was the start of potentially the tide turning with what was quite an old and staid consultant body…'" (p128), it would also be interesting to know whether the cases were limited to specific consultants or teams or were more evenly spread.

Governance was clearly an issue, but again it is hard to know whether and how this changed over the period of the review. We would have liked to see an assessment of the quality of governance in segments of 3 or 5 years through the whole period.

**Concerns about what the report does not tell us**

Given the huge number of cases that the team had to review it is perhaps understandable that the report says little about the wider picture. However, to understand and learn from the issues in Shrewsbury and Telford we need more answers.

What was the problem? Why was the Trust apparently such an unhappy and chaotic place and why were maternity services in particular apparently so dysfunctional? Was it, as one member of staff suggested (paragraph 9.36) due to "an old and staid consultant body" ? Did the rurality of Shropshire and the fact that Telford is an unfashionable place to work make recruiting and retaining good staff difficult? What is the demography of the population served, and does it vary much between the Trust sites? There is no mention of the campaigning, going back years, to keep the FMUs open and fully in use as birth settings as well as clinics; nor details of how often these were left under-staffed. What was and is now the situation of the local ambulance service? Are transfers well-supported?

As the NHS Race and Health Observatory have pointed out in their Policy Briefing,[5] the parents interviewed by the review team were self-selected, and there may have been under-representation of "people from Black, Asian and minority ethnic backgrounds, people who face linguistic or cultural

barriers, and undocumented migrants". (p2) Similarly, they discuss the possibility that "staff from Black and minority ethnic backgrounds were less likely to raise concerns" despite the fact that they report "higher levels of bullying, harassment, and discrimination, and are more likely to be referred to disciplinary processes than White colleagues." (p3) We hope that future reviews will address these important considerations so that the voices of all maternity service users and staff can be heard.

**How useful is the report in terms of national service provision?**

Overall the report feels like an account of many individual cases of poor care leading to serious outcomes and distress, illustrated with telling anecdotes, rather than an illuminating story detailing what has been the situation over time, and how the picture has changed across the years, if it has. It simply isn't clear how national recommendations can be made from this, without a clear account of the local findings (split by severity and shown year by year), without remit to make such recommendations, and without national evidence to adduce and a rationale for moving from local findings to national evidence to national recommendation.

AIMS notes that similar issues have also been found in other reviews of maternity services. These include the Kirkup review[6] of the care by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust back in 2015, and the independent review of maternity services at the East Kent Hospitals University NHS Trust that was published in October 2022.[7] Another review led by Donna Ockenden, this time into the Nottingham University Hospitals NHS Trust, has just been launched. This suggests that, rather than being a feature of a small number of dysfunctional maternity services, the problems identified in the Shrewsbury and Telford review may reflect underlying problems with the culture and organisation of the maternity services generally. As the introduction to the final Ockenden report[2] says: "At this very moment there may be other maternity services across England which are facing challenges that impact on their ability to provide a safe service as a result of insufficient staffing levels, substandard governance processes, and structures which impede learning." (p18) Indeed, the AIMS Helpline frequently hears from people who feel that they have not been listened to, not given the information and support they needed to make decisions, or not had their concerns taken seriously. These enquiries concern a wide range of maternity units indicating that these issues are probably widespread.

Repeated reviews of individual Trusts do not seem to be resulting in improvements nationwide. Whilst they may be drivers for change at the local level, we need to ask how useful such piecemeal reviews are in bringing about change at the national level. Meanwhile, NHS England's Maternity Transformation Programme has been in place for six years and, whilst there has been some progress, it has not so far brought about an obvious transformation to the "safer, more personalised, kinder, professional and more family friendly" (p9) care called for in the Better Births' vision.[8]

So, what is needed? AIMS would like to suggest the following:

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Recognition that 'Maternity Transformation' requires a change in the mind-set of all decision-makers, managers and staff, with genuine buy-in to the fundamental changes required of them

- Support and training for implementing changes including cultural changes
- Transparency around how Trusts are implementing recommendations and monitoring of their effectiveness

AIMS recognises that at a time when maternity services are seriously over-stretched, with many staff suffering burn-out, embracing radical change may feel like too much of a challenge – but it is a challenge that must be faced if we are not to see a continuing cycle of reviews and recommendations, but no real change.

Staffing is a fundamental issue, and it must be recognised that it is extremely difficult for midwives or doctors to provide good care - let alone consider taking on new ways of working - when overstretched and dealing with their own stress. An adequate level of investment in maternity staff, whilst essential, is unlikely to provide a complete answer.[9]

The report has done a great service to the parents concerned in enabling their voices to be heard. Hopefully, it will provide the incentive to make the improvements that are needed within the Shrewsbury and Telford NHS Hospital Trust. Whether it will do much to improve maternity services nationwide - or whether we will continue to see yet more reports highlighting similar problems in individual Trusts - seems less certain.

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[1] Ockenden Report Final 30 March 2022 OCKENDEN REPORT - FINAL

[2] Ockenden First Report December 2020 OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

[3] AIMS (2017) Monitoring your baby's heartbeat in labour. www.aims.org.uk/information/item/monitoring-your-babys-heartbeat-in-labour

[4] RCOG (2022) New Independent Maternity Working Group to guide the Maternity Transformation Programme in England www.rcog.org.uk/news/new-independent-maternity-working-group-to-guide-the-maternity-transformation-programme-in-england

[5] NHS Race and Health Observatory Policy Briefing: The Ockenden review September 2022

[6] Dr Bill Kirkup CBE The Report of the Morecambe Bay Investigation March 2015The Report of the Morecambe Bay Investigation (publishing.service.gov.uk)

[7] Kirkup B. (2022) Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation. assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1111993/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_web-accessible.pdf

[8] Better Births national-maternity-review-report.pdf (england.nhs.uk)

[9] Lisa Common, RM. "A Colossal Failure of Workforce Planning": exploring the 2021 NHS Midwifery Crisis AIMS Journal 33:4 December 2021