AIMS For a better birth...

Getting to grips with the first Ockenden Report and what it means for the Maternity Transformation Programme

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By the AIMS Campaigns Team

Donna Ockenden and her team's first – interim – report was published in December 2020. It starts to lay bare how the maternity services in the area 'served' by Shrewsbury and Telford Hospital NHS Trust have, over the years, surely failed far too many families. On one point of detail alone, it is shocking to read that women's deaths in some cases were not investigated, let alone properly investigated (para 4.71). What does that say about how we value the lives of mothers and babies, and those who come after them?

Despite pockets of excellence across the country, and despite the ongoing efforts of hard-working maternity staff, AIMS fears that the maternity services will continue to fail a significant proportion of families, in a myriad of ways that are discussed in, but also go beyond the scope of, the current report. That is why AIMS is a stakeholder in the effort to improve maternity services across the UK and has been for the last 60 years. Most recently, we have supported Better Births (2016) in offering a solid framework for the transformation of maternity services across England, and we continue to support its implementation. In this context, the first Ockenden Report certainly shines a light on a service which falls

far short of the Better Births vision. AIMS is keen that the new evidence presented by the Ockenden team prompts renewed reflection on how well the existing Maternity Transformation Programme is working to put an end to the current postcode lottery that is today's maternity services, where families across England cannot be sure that they are receiving a high-quality service in line with the Better Births vision.

The first Ockenden Report is thus an important and welcome – if deeply troubling – document. It gives us confidence that the final report, due later in 2021, will further provide a compelling case to redouble efforts to implement the ongoing Maternity Transformation Programme across England.

So if this report is so useful, it is also important to consider how it has come about. AIMS believes that it was absolutely right that ministers eventually took action to commission this review into identified local failings: the allocation of sufficient public funds to support the work of Donna Ockenden and her team is key. But it is also important to note that this careful scrutiny is being enabled only through the efforts of local bereaved families. They are the ones – as others before them – who have continued in the worst of circumstances to insist on learning and action, to improve the maternity services for others. Yet again, this is a reminder that service user voices are a key element of the maternity improvement agenda: without the steadfast efforts of service user families repeatedly raising their concerns, the Ockenden Review Team would not be at work today. In that context, and in support of those families, AIMS believes that the strengthening of what we currently know as the PALS (Patient Advice and Liaison Service) function in hospital trusts is absolutely crucial and is pleased to see that this is a key element of the report's recommendations for national 'immediate and essential actions'. More generally, we wholly agree that how the maternity services listen and hear, throughout the maternity pathway, is critical to the provision of improved care and safety in maternity services.

But what of the role of others – both within the system and outside, whether individuals or organisations – to ensure that serious failings in our maternity services are addressed? What transformation needs to take place in order to ensure that in future others can play a more effective role in rooting out and addressing serious failure? Some patience is required here. AIMS will be looking carefully at the final report to see how others (maternity staff, managers, board members, etc.) – some of whom presumably also had concerns about the service in the geographical area covered by the Ockenden Review – were able to voice these. What were the barriers they faced to being heard, to being listened to? What elements of the system, in place to protect against such failings, seem to have failed us, and how? AIMS believes that such a focus will be hugely helpful as we move forward. We need to understand what structures to create and strengthen, in ways that embed transparency and accountability. We need to ensure that all scope for improvement in the maternity services is always honestly mapped, even if the task to respond to it seems daunting, and to understand how the actioning of that improvement needs to be sequenced over time.

Crucially, AIMS believes that we need to see the final recommendations of this review rooted in a secure understanding of the basic physiology of birth and how this is best supported for a safe, healthy and

positive outcome for all. We need to think about what is going well, and what not so well, during the whole maternity care pathway. So many of the vignettes presented in the first report seem to raise questions about the quality of care over the whole maternity pathway, questions that go far wider – for example – than skills in relation to foetal monitoring during labour.

In conclusion, this interim report, and the vignettes it presents, raises many questions. For our part, AIMS – as a critical friend – will be in touch with the review team to raise questions and also to offer our thoughts on the additional considerations that might helpfully be taken into account in the next stage of the review, so that it can properly, and most effectively, inform the ongoing maternity transformation process in England. We will make that contribution public. And we will also be offering a word of caution: despite the understandable, appropriate and searing call to immediate action, there are likely few – wholly effective – 'quick fixes' to be found.