Responding to the Ockenden Review: safe care for all needs evidence-based system change - and strengthened midwifery

Editorial for Midwifery

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Downe and Heazell were Maternity Advisors to the Independent Expert Panel of the Health and Social Care Committee for their 2021 review of maternity service commitments, and Downe was a member of the NHS England Better Births stakeholder council

Sandall is Head of Maternity and Midwifery Research in NHS England and Improvement and writes in a personal capacity

Renfrew was Lead Adviser to the Nursing and Midwifery Council for the new standards for midwives, 2017-2020

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Note
We use the words women and woman throughout this paper, recognising that this reflects the biology and identity of the great majority of those who are childbearing; for the purpose of this paper, these terms include girls, and people whose gender identity does not correspond with their birth sex or who may have a non-binary identity. All those using maternity care and services should receive individualised, respectful care including use of the gender nouns and pronouns they prefer.

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The Final Report of the Ockenden Review examined the care of 1486 families who experienced adverse outcomes in one hospital Trust in England, the majority of whom received care between 2000 and 2020 (Ockenden 2022). It describes the damaging outcomes and experiences caused by poor care for women and babies in pregnancy, labour and birth. Multiple individual actions recommended by the report are resulting in immediate and extensive changes across the maternity services in England. The report findings are relevant across the whole UK, and to international efforts to improve safety and quality in maternal and newborn care systems.

The review resulted from campaigning by women who were injured and traumatised and by the families of the women and babies who died, and it is essential that their voices are heard, and radical changes made. The report findings resonate with previous reviews and wider service failings in the UK (Government of Wales 2021, Health and Social Care Committee 2021, Healthcare Improvement Scotland 2017, Kirkup 2015, Francis 2013). They are a wake-up call to all involved in funding, designing, leading, regulating, monitoring, and providing health care, and to the public who use maternity services. But the actions recommended are not enough to ensure safe, quality services for all. Transformative change must be informed by addressing the root causes, and this requires the best available evidence and expertise in health professional education, health policy, and implementation.

What has gone wrong?

Failures of care at this scale and duration stem from failure of the maternity and wider health system and a lack of political will to support a high quality national health service (Health and Social Care Committee 2021, HM Government 2021). Multiple structural reforms of the National Health Service (NHS) and a decade of severe NHS budget cuts have led to chronic underfunding of the maternity workforce, resulting in shortages of midwives, sonographers, and doctors, cutbacks in professional development and training, limited time to care, burnout, low morale, and unprecedented retention problems (RCM 2022, Health and Social Care Committee 2020, Hunter et al 2019). A failure of organisational governance at all levels, a culture of cover-ups and defensive behaviour, and deficient clinical and managerial leadership and decision-making have amplified the problems. The Ockenden report (2022) describes mistakes and mistreatment by health professionals and managers including neglectful, unkind, even abusive behaviour towards women and families, and bullying and silencing of staff. This and previous reports describe institutionalised service provision in which people – women, babies, families, midwives and obstetricians alike – have become of secondary importance to the institution itself.

The final report of the Ockenden Review has been published at a time when the maternity services are in crisis as a result of the ongoing pandemic (Health and Social Care Committee 2021), and birth itself has become politicised; the discourse around safety in maternity care is dangerously polarised (for example Bennett 2022, Johnson 2022, Newburn 2022, Lintern 2021). Reports of service failures have dominated the headlines and overshadowed the many positive developments in place across the country. Some professional, political, and media responses to this and previous reports are feeding a narrative that blames midwives and the physiology of birth itself despite clear failings by multi-professional teams and organisations.

The search for someone or something to blame has led to the notion of a widespread 'ideology of normal birth at any cost' as the scapegoat for complex system-wide failings, despite a lack of evidence for this in the reports themselves. Inaccurate use of terminology confuses the issue. For example, in the Ockenden report (2022) the term 'vaginal birth' included mismanaged forceps births and the over-use of synthetic oxytocin; such practices are not related to normal physiological labour and birth. The term 'unassisted birth' used in the Health and Social Care Committee report (2021) to describe non-instrumental births diminishes the skill and importance of midwifery care at this critical time. A hostile social media environment obscures the underlying issues and acts to silence informed, evidence-based debate about safe maternity care. This narrative runs counter to much of the evidence and world-wide action which demonstrates how quality midwifery practice can improve care quality and safety (Nove et al 2021a, Nove et al 2021b, WHO 2019, Renfrew et al 2014).

Factors in the wider context of maternity services have an influence on safety and the quality of care, but are not addressed in the reviews of service failures. There are marked inequalities in outcomes related to ethnicity and socio-economic deprivation (Jardine et al 2021, Knight et al 2020). Bio-medical interventions in labour and birth are at their highest levels ever recorded (NHS Digital 2021, Public Health England 2021, Public Health Scotland 2021), raising questions about effectiveness and sustainability and the potential for avoidable adverse consequences (Sandall et al 2018, Shaw et al 2016). At the same time, there are barriers to the implementation of evidence-based midwifery interventions including a lack of resources and training and of senior support and leadership (McInnes et al 2020, McLellan et al 2019, Rayment 2019, McCourt 2018). This is especially true of continuity of midwifery carer, where high-quality research demonstrates that it is a powerful intervention that impacts positively on survival, morbidity, women's experiences, and midwives' job satisfaction (Hanley et al 2021, Sandall et al 2016); yet it is commonly contested and there are barriers to its universal implementation (Walton 2022, McInnes et al 2020, Taylor et al 2019).

What is needed?

Sustainable, large-scale improvement is urgently needed to tackle the inter-related underlying issues that result in poor care and traumatic outcomes and experiences. A credible whole-system national plan is needed (Ham et al 2017). Actions are already being implemented, but it is important to ensure that all actions are evidence-based and cost-effective, with transparency and accountability, and monitoring and evaluation. All changes must be undertaken with the genuine engagement of a diverse range of women and families throughout. Embedded patriarchal attitudes and behaviours must end; actions to empower and involve women and ensure equity must sit at the heart of all maternal and newborn care and services.

Rectifying the root causes of system failure is a fundamental first step. Ensuring that women, babies and families are central to all maternity system re-design is key (Ham et al 2018). The voices of health professionals and managers must inform work to increase staffing levels, support staff, students and educators, and pro-actively tackle retention and recruitment of staff (VanGompel and Main 2021). Reformed organisational structures and effective leadership are needed to develop an enabling, supportive, and collaborative culture and environment. This environment should ensure that staff have time to care and that students and staff have time to learn and reflect (Hunter et al 2019). Action is needed to minimise the burden of

administrative tasks, and fully address the institutionalised thinking and bullying culture identified in the Ockenden report.

High quality evidence is essential to ensure effective and cost-effective care and to avoid mistakes and unintended consequences, and it is imperative that research evidence and ongoing evaluation are incorporated into all recommended actions and programmes of improvement. Research evidence for the Ockenden report's recommended action on centralised fetal monitoring systems, for example, is absent and its implementation risks distancing decision-making from women (Small et al 2022, Transforming Maternity Care Collaborative 2021, Brown et al 2016). The recommended action to discontinue the implementation of continuity of midwifery carer, even though this model of care was not practised in the hospital reviewed, runs counter to evidence-based maternity policy and planning in the four UK countries (eg NHS England 2019, The Scottish Government 2017, NHS England 2016) and to consistent evidence that women want this form of care (Care Quality Commission 2022, Downe et al 2018). It undermines years of accumulated evidence and the experience of those managing and working in this field. It is a missed opportunity to accelerate the sustainable implementation of the single most effective intervention in maternity care with a direct impact both on outcomes and women's experiences (Sandall et al 2016). Support and funding for full-scale implementation would be a rapid route to the safe, quality, personalised care and safety net for all that Ockenden calls for.

Optimum safety – physical, psychological, social and cultural - requires universal access to respectful, empowering, individualised, skilled, evidence-based care together with appropriate use of technological interventions (Tuncalp et al 2015, Renfrew et al 2014, Enkin et al 2006). Bio-medical interventions are essential and life-saving when used appropriately. They are important for women who want them, but women are not always involved in decision-making about their use (Coates et al 2019), and they can have adverse consequences (Peters et al 2018, Sandall et al 2018, Hobbs et al 2016, Rowlands and Redshaw 2012). Multidisciplinary team working and effective involvement of women in decisions is needed to achieve the optimum balance between under- and over-use (Miller et al 2016).

It is essential to recognise that midwives are the only professional group who are by a woman's side from her first contact with the health services until after she and her baby are settled together, or during and after care for perinatal loss (NMC 2019). Skilled midwifery care can prevent problems, support early identification of and referral for complications, and promote multiple positive outcomes including physical and mental health and well-being (Renfrew et al 2014). Midwives are especially important for women who have additional care needs, whether physical, psychological, social, or cultural. Knowledgeable and skilled midwives who are enabled to practise the full scope of midwifery care are fundamental to safe care; delivering that safe care for all depends on understanding, valuing, and implementing the different and complementary roles of midwives, obstetricians, and all members of the multidisciplinary team (Aggarwal et al 2021).

The whole maternity journey matters. The majority of maternal deaths occur postnatally, often related to problems occurring before and during pregnancy (Knight et al 2020), mortality and morbidity are strongly related to deprivation and ethnicity (Aizer and Currie 2014, Shahzad et al 2019), and women's mental health before and after birth is critically important (Knight et al

2020). To develop the full scope of midwifery knowledge and skills, newly qualified midwives must gain experience across the whole continuum of care and in all settings.

Strengths-based approaches to implementing optimum safety and quality for all

Lessons from safety in other healthcare environments demonstrate that a positive, strengths-based approach with trusting relationships and effective participation and engagement is needed to implement sustainable change (Breckenridge et al 2019, Hollnagel et al 2015, McInnes et al 2020). Examining what went wrong may not identify solutions or characteristics of successful organisations. There are strong positive foundations on which to build, and an effective, large-scale change programme needs to bring together all existing positive developments to avoid confusion, duplication, and inadvertently cutting across established success. Transformative new standards of proficiency for midwives provide a foundation for practice and for midwifery students to be skilled in physical, psychological, social and cultural aspects of safety and to learn human rights-based, evidence-based, quality care, enhanced leadership skills, and multidisciplinary working from the outset (Nursing and Midwifery Council 2019). Strong maternity policy in the four UK countries focusses on woman-centred, evidence-based care for all and is informing national improvement and transformation programmes (eg NHS England 2016, The Scottish Government 2017). There are multiple positive examples of services and education programmes with excellent leadership and implementation of quality care underpinned by quality learning that can inform and inspire reform. Descriptions of some of these are available on the websites of All4Maternity and the Royal College of Midwives, but an open access multidisciplinary forum is needed to share information on excellent services and leadership more widely,

Education is a key component of effective change; behaviour change is complex and needs a supportive learning environment in both clinical and academic settings (Michie et al 2011). Multidisciplinary staff need access to funding for appropriate ongoing education and training, knowledgeable educators, time for reflection and discussion, and a physically and psychologically safe environment to allow them to develop new ways of working and confidence in their capabilities (Liberati et al 2021). All midwives and doctors must become skilled in genuinely respecting, involving, and empowering women (Birthrights 2022); this will take time and requires a diversity of voices from women themselves in the education and training of health professionals.

We cannot shy away from the embedded contentious issues. Change is always difficult and if instigated by grief and trauma, is especially demanding. We must act collectively and respectfully to address the barriers to implementation of evidence-based care for all. Finding a way forward to effectively implement continuity of midwifery carer will take a combination of policy, politics, funding, leadership, and multidisciplinary collaboration (McInnes et al 2020). Investment is urgently needed to enable midwives to fulfil their potential to contribute to safe, quality care by implementing the full scope of midwifery care. The problematising of midwifery and of normal physiological processes must be resolved to ensure the best health and well-being outcomes. We owe it to women, babies, families, and the staff who care for them, to get this right.

Conclusion

This challenging time offers a critical opportunity to shift perspective on safety in maternity care and services. The traumatic experiences described by women and families, the long-term

under-resourcing of the maternity services, and the failure of governance of organisations at all levels demand system-level change. Getting the response right is essential to improve safety in the UK, and could help to inform safe maternal and newborn services internationally.

A credible plan for sustainable change must be informed by knowledge and expertise in research, education, and implementation, as well as strengths-based approaches. Supporting all multidisciplinary staff and students is an essential foundation, and there is a special need to focus on midwives to enable them to provide the preventive and supportive care needed by all women, babies, and families.

We already have good quality evidence, strong national policy, transformational UK-wide midwifery education standards, positive change programmes, recommendations for increased resources, and skilled and committed multidisciplinary professionals. There are informed and engaged advocates for women and families, and examples of excellence to draw on. A radical focus on implementation of evidence, equity, the empowerment of women, and quality care for all must form the foundation for maternal and newborn care and services now and in the future.

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