Royal College of Midwives

The RCM Response to the Interim Ockenden report

On December 10th 2020, the interim report from the review into the maternity services at the Shrewsbury and Telford Hospital NHS Trust, led by Donna Ockenden, was published.

This interim report is based on a review of 250 cases – there will be a final review in late 2021 to include 1,862 cases. The review was based on interviews with women and families; however, the final report will also include interviews with staff.

The report combines midwifery and obstetric issues, describing them as 'maternity issues'.

The seven critical areas of concern in relation to maternity issues are:

1. Lack of kindness and compassion
2. Assessment of risk around place of birth
3. Management of complex needs
4. Escalation of concerns
5. Management of labour – including electronic fetal monitoring and use of oxytocin
6. Traumatic birth
7. Caesarean birth rates
8. Bereavement care

The report describes a service that lacked 'organisational memory' – with a very high turnover in senior leadership at the Board level. Details highlighting a major loss of confidence in the service, included a lack of preliminary investigations of serious events. The Trust also had an inefficient risk management and reporting system that did not explore or address the root causes of faults or problems.

The focus of RCM in responding to the interim Ockenden report:

1. The review has been taken extremely seriously. The RCM has supported the recommendations and encourages Trusts and Boards to implement the seven immediate and essential actions.

Royal College of Midwives

2. Since the interim report's publication, we have identified the urgent need for significant and ongoing increased investment in maternity services to ensure that they are safe. It is important to address the considerable shortage of midwives in the NHS in England, and also focus on both recruitment and retention. On March 25th 2021, this work bore fruit with the announcement by NHSE/I of significant, recurring, increased funding for NHS maternity services, including a focus on recruiting an additional 1000 midwives, retaining our experienced midwifery workforce and supporting systems for robust continuing professional development for midwives.

3. The report identifies the need for increased obstetric consultant presence but does not highlight the need for improved midwifery leadership. We believe that high- quality midwifery leadership is vital in supporting and developing safe maternity services. The Director/Head of Midwifery (DoM/HoM) role is integral to this, along with the roles of consultant midwives and specialist midwives. We will continue to champion the need for high quality, well-supported midwifery leadership and an increase in the number of consultant and specialist midwife roles to support quality improvement in maternity services.

The RCM would like to see:

• A Director of Midwifery for every Trust or Board, with a Head of Midwifery in every maternity unit
• At least one Consultant midwife in every maternity unit
• Specialist midwife roles in areas including bereavement care, providing direct specialist and expert care to women who need it and advice and guidance to colleagues.

4. The RCM is in the process of developing a range of resources for our members to support them in:

• Developing systems to ensure serious incidents are thoroughly investigated, and lessons are learned;
• Improve ways in which midwives and maternity support workers hear

Royal College of Midwives

women's voices, to help shape maternity service development;
• Create a positive workplace culture, in which all practitioners working in a maternity setting feel confident and supported to raise concerns and work collaboratively.

These resources include a new i-learn module in response to the interim report, now available on our website for members. The RCM will also be offering a range of workshops on creating positive workplace cultures, civility in the workplace, escalating concerns, coproduction of service improvement with women and families and developing assertiveness and confidence.

In addition, we are developing a series of brief evidence-based solutions focussed guidance for our members on the following topics:

1. How to effectively **co-produce** improvements in maternity services
2. The impact of positive midwifery **leadership** – what is it? How can we have more of it?
3. What are the **human factors** in maternity care that can help facilitate positive change or inhibit progress?
4. What works to improve professionals' use and interpretation of **electronic fetal monitoring?**