Policy Briefing:
The Ockenden review

This briefing examines the Ockenden review through the lens of race equality and makes recommendations for best practice in the future.

Background

There is a growing body of evidence showing that ethnic health inequalities exist throughout maternal and neonatal care.[1 2 3] As argued in our recent rapid evidence review, the NHS Race and Health Observatory is one of many organisations advocating for targeted interventions to improve health outcomes for ethnic minority women, people, and their babies.

Independent reviews have a critical role to play in driving improvement across health and care. The Ockenden review, led by Donna Ockenden, focused on maternity services at the Shrewsbury and Telford Hospital NHS Trust (SaTH). The review looked at 1,592 clinical incidents involving 1,286 families. It conducted clinical and governance reviews and engaged with family and staff voices. The size and scale of this much needed review was unprecedented in the NHS.

The review's report was released in March 2022 and included many key "Immediate and Essential Actions" (IEAs) for the improvement of maternity and neonatal services. As with all reviews that aim to improve the quality of care in the NHS, we believe it is important to examine the review's methods, findings, and IEAs through the lens of ethnic health inequality.

The NHS Race and Health Observatory works to mobilise insights and evidence on ethnic health inequalities; offer evidence-based recommendations for change; and to meaningfully support the NHS and other bodies to deliver that change. As such, this briefing aims to provide future healthcare reviews - including the 2022 review into maternity services at Nottingham University Hospitals NHS Trust - with theoretical and methodological advice to support a sustained and meaningful focus on tackling ethnic health inequalities and inequities.

Lessons learnt and future considerations

Drawing upon the review of maternity services at SaTH, there are lessons that should be considered when planning for the maternity review at Nottingham University Hospitals NHS Trust and other future reviews of similar scope and scale. This briefing contains three such lessons.

1. Representation of families from ethnic minority and socially deprived backgrounds

In all reviews that aim to draw conclusions about population health needs, it is vital that explicit consideration is given to ethnic minority communities.

The Ockenden review's report explained that the Black, Asian and minority ethnic population served by SaTH was lower than the equivalent national population (10% compared to 19-22%).[4] However, the review also acknowledged that 9% of the trust's overall data was missing ethnicity coding. The lack of accurate patient ethnicity data is not unique to the trust, but it serves as an example of a broader issue that, without action, will continue to hamper such reviews. As we have argued in previous research, the lack of uniformity in relation to ethnicity coding is a national challenge that must be acknowledged and prioritised to avoid inaccurate assumptions about ethnic inequity.

Whilst current literature and evidence show that there are poorer health outcomes for Black, Asian and minority ethnic communities, a lack of focus on these communities often limits our ability to draw conclusions about the relationships and correlations between ethnicity, social deprivation, poor birth experiences/outcomes, morbidity, and mortality. Significantly more nuanced consideration of intersectionality is therefore required in future reviews.

When we consider the approach of such reviews to gathering qualitative data, we need to be aware of potential self-selection bias in those who choose to come forward and those who do not. It is often the case that families self-refer to a review panel after having heard about the review from others, or from traditional or social media sources. However, a lack of trust can prevent certain communities from coming forward to speak to a review panel. Our work suggests this is true among people from Black, Asian and minority ethnic backgrounds, people who face linguistic or cultural barriers, and undocumented migrants. Biases in recruitment of participants can translate directly to biases in a review's conclusions, so careful consideration needs to be given to both the style and methods of communication deployed during engagement.

In addition, more needs to be done to (re-)build levels of trust and confidence between healthcare organisations and the marginalised communities they serve.

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2. Workforce representation and culture

Trust is also key to creating and maintaining an inclusive and compassionate workplace. Poor workplace culture is often a significant contributing factor in the adverse incidents that occur in the delivery and experience of care. During the Ockenden review, poor psychological safety, an "us and them" culture, poor team cohesion, and high levels of stress were all reported at SaTH. It was also reported that staff often do not raise concerns due to fear of repercussions.

This culture may go some way to explaining the low numbers of staff who got involved with the *Staff Voices* engagement strategy set up by the review to engage with the workforce. Several staff members redacted their involvement for fear of repercussion from the organisation, a factor that can be an especially significant barrier to people from marginalised communities. The Francis Report on speaking up found that staff from Black and minority ethnic backgrounds were less likely to raise concerns due to fear of referral to professional regulators and fear of harsher sanctions. This group was also generally seen to be more likely to experience detrimental treatment in response to speaking up.

Relatedly, the most recent NHS Workforce Race Equality Standard (WRES) data show that ethnic minority staff across the NHS continue to report higher levels of bullying, harassment, and discrimination, and are more likely to be referred to disciplinary processes than White colleagues.[5] Similarly, data from the NHS Staff Survey show that registered nurses and midwives experience a higher incidence of bullying, harassment and discrimination compared to other health professionals.[6] This is particularly concerning given that 40% of all staff in the nursing and midwifery profession across the NHS are from an ethnic minority background, compared to 22% in the NHS more broadly.

There are strong correlations between the experiences of Black, Asian and minority ethnic staff at work, and patient satisfaction and safety.[7] [8] The lack of representation from ethnic minority staff in senior levels within nursing and midwifery further contributes to this and we know that diversity within leadership structures can create services that are better equipped to meet the needs of our diverse communities.[9] The National Guardian's Office's report - *Difference Matters: The impact of ethnicity on speaking up* - outlines some of the reasons that staff from Black and minority ethnic backgrounds might be reluctant to raise their concerns.

Considering the above, it is important that any future review into similar issues gives proper consideration to the relationship between workplace culture, safety, and patient outcomes. These reviews should also consider the particular challenges faced by Black, Asian and minority ethnic staff.

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3. Suspension of Midwifery Continuity of Carer (MCoC) can further increase health inequalities

The Midwifery Continuity of Carer (MCoC) model – whereby women and pregnant people receive support from the same midwifery team throughout their pregnancy - is an important tool in combating well-evidenced health inequalities amongst Black, Asian and ethnic minority communities. The model is designed to ensure trusting and respectful relationships between healthcare providers, women and pregnant people. The NHS Race and Health Observatory's rapid evidence review highlighted evidence on the particular importance of the MCoC policy for people unfamiliar with the NHS or experiencing multiple disadvantages, especially where there are linguistic challenges or variation in cultural orientation.[10]

One of the Ockenden review's IEAs was the suspension of MCoC unless safe minimum staffing levels could be guaranteed on all shifts. The review suggested that MCoC should not be reinstated until robust evidence is available to support its reintroduction. While we appreciate the intentions of this IEA, it is important that maternity services fully explore the potential and disproportionate impact that suspension of MCoC may have on marginalised groups.

The NHS England response to the Ockenden report rightly highlighted matters of health and safety associated with workforce capacity as a paramount consideration, and further stressed the urgency of increased efforts to ensure safe staffing levels. Whilst workforce capacity has been a long-standing challenge for the NHS, and must be a fundamental priority, it is also important that any such shifts in policy also mitigate the potential harm of abandoning the key principles of MCoC: respectful listening, building trust, and providing ample opportunities for women and pregnant people to express their concerns. If MCoC is suspended, it must not mean the abandonment of these critical principles, which are evidence-based and known to be vital in tackling ethnic health inequalities.

Recommendations

Based on our review of the Ockenden Report, and in light of the coming review in Nottingham, the Observatory recommends the following actions.

Engagement

- In all future reviews looking at patient safety in the NHS, sustained and meaningful engagement with local communities and stakeholders from diverse and socially deprived backgrounds is paramount. Review teams should take a targeted approach to engaging with specific ethnic minority communities where insights suggest they may have experienced adverse incidents. This engagement should also include co-production and user validation of recommendations.

- Future reviews should apply the principles outlined in the recently published *Working in Partnership with People and Communities: Statutory Guidance*, which clearly outlines the multiple benefits of partnership working diverse with people and communities. Furthermore, systemic changes outlined in the Maternity Transformation Programme should be employed to ensure a robust process for hearing all voices.

Data and insight

- NHS England should ensure that patients' ethnicity is recorded accurately in all interactions with NHS staff. NHS Digital should provide national NHS statistics on service use by ethnic group, age, and gender (at a minimum) and allow for clinical data to be linked across datasets in order to improve the monitoring of clinical outcomes for ethnic minority populations.

- In future reviews, where it is identified that the quality of quantitative data is limiting the ability to draw meaningful conclusions about the impacts of ethnicity and/or other protected characteristics, efforts should be made to fill these gaps with targeted qualitative work.

Equality impact assessments and workforce culture

- Teams should give careful consideration to equality impacts throughout the course of such a review, including at the design stage, throughout the review itself, and in the development of its recommendations. Equality impact assessments undertaken for these reviews should be published at the outset and continuously reviewed. Recommendations from these assessments should be made publicly available and referenced in the final reports.

- Future reviews should fully recognise and acknowledge the impacts of workforce race inequality in the healthcare system and should give careful consideration to the impact of workplace culture on patient outcomes. Reviews should look at current Workforce Race Equality Standard data within the trust(s) being reviewed, as well as trends from Freedom to Speak Up data, as part of their methodological approach.

Endnotes

1 The NHS Long Term Plan - https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

2 MBRRACE-UK Saving Lives, Improving Mothers' Care - https://www.npeu.ox.ac.uk/mbrrace-uk/reports

3 Equity and equality: Guidance for local maternity systems - https://www.england.nhs.uk/statistics/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf

4 MBRRACE-UK Perinatal Mortality Surveillance Report - https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/perinatal-surveillance-report-2018/MBRRACE-UK_Perinatal_Surveillance_Report_2018_-_final_v3.pdf

5 NHS Workforce Race Equality Standard 2021 data analysis report for NHS trust - https://www.england.nhs.uk/wp-content/uploads/2022/04/Workforce-Race-Equality-Standard-report-2021-.pdf

6 NHS Staff Survey 2021 national dashboards - https://public.tableau.com/app/profile/piescc/viz/ST21_national_data_2022-03-30_PIEFH25/Aboutthissurvey

7 Dawson et al, Does the experience of staff working in the NHS link to the patient experience of care? (2009) - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215457/dh_129662.pdf

8 Links between NHS experience and staff patient satisfaction: Analysis of surveys from 2014 and 2015 - https://www.england.nhs.uk/wp-content/uploads/2018/02/links-between-nhs-staff-experience-and-patient-satisfaction-1.pdf

9 A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS - https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf

10 Rayment-Jones H, Harris J, Harden A, Khan Z, Sandall J. How do women with social risk factors experience United Kingdom maternity care? A realist synthesis. Birth. 2019;46(3):461-474. doi:10.1111/BIRT.12446