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Ockenden – a chance to reset?

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The Ockenden report into the failings in maternity care at Shrewsbury and Telford Hospital NHS Trust in the UK makes sobering reading 1,2. The report focuses predominantly on the period from 2000 to 2019 and estimates that there were significant or major concerns in the care of nine women and over 200 babies who died: many more suffered serious injuries. It was clear that the Trust did not investigate, learn, change, or listen to families when adverse events occurred. The overarching themes that come out of the report are that safe staffing levels, a well-trained workforce, an ability to learn from incidents and a willingness and ability to listen to families are all crucial for a safe maternity care.

The fifteen “Immediate and Essential Actions” advised in the Ockenden report are necessary but insufficient to prevent similar tragedies in the future. Although tempting to try and identify discrete and fixable issues, adverse outcomes in maternity services arise from a complex mix of factors often combined with inadequate leadership and the wrong culture. Unfortunately, there are fewer indicators of a struggling maternity service compared with other areas of hospital care: there are no waiting lists, and “process outcomes” such as rates of induction or caesarean section which are only weakly informative. Ockenden highlights the ‘hidden in full view’ problem in Shrewsbury and Telford, where countless opportunities for both internal and external stakeholders to pick up problems were missed. It is the latest in a repeated pattern of such failings in maternity care. 3 4 5 Addressing these wider issues of culture and leadership is crucial.

This latest system wide failing has been widely reported as resulting from an “obsession with natural childbirth”. In fact, the problem is not with “natural childbirth” per se but with “natural childbirth at all costs”- at the expense of safety and choice. Ockenden points to a lack of safe and personalised care, where women are not the heart of decision making. Sadly, similar issues were identified in the independent report into the management, delivery and outcomes of care provided between 2004 and 2013 by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust 3.

It is hard to escape the conclusion that sexism and misogyny within the NHS is denying pregnant women the right to fully participate in decision making about their care. Although much has changed in obstetric care in the UK since the 1970s, when interventions such as episiotomy were performed regardless of women’s wishes or clinical need, in some cases women’s care is still provided according to the preference of individual clinicians or local culture. Sadly, this lack of individualised or “respectful” maternity care is evident in low resource settings too 6.

In other units over-protocolisation of care diminishes genuine choice too. Well-intentioned but dogmatic adherence to guidelines and targets can override the woman’s individual wishes. Despite a commitment to personalised approaches in national guidelines 7 8, defensive practices, stretched resources and a blame culture when things go wrong, can make it hard to achieve this aspiration. It requires sufficient staff with the time and skills to listen to women, discuss options, and support decision making. It also requires a culture with
the humility to admit that doctors, midwives, and managers do not know better than women themselves when it comes to decisions. Genuine choice requires systems that respond to women’s preferences, putting women at the heart of care.

Ockenden will result in more guidance, but services are overwhelmed with recent guidelines without sufficient resource to implement safely or assess impact as a whole. With finite resources, adding new initiatives inevitably means taking something else away. Protocolising care is easier than offering true individualised care. Health care providers need to start being honest about the tension in a stretched service between safety and choice.

Strategies are needed for early identification of maternity units that need more support, aligned to a true “no blame” culture where a request for unit (or individual) support is seen as an opportunity to improve, and therefore rewarded. Ockenden vividly describes the fear that silenced many staff. Issues relating to culture and leadership are difficult and complex but true change is unlikely until these are tackled.

In addition to individual and system failings, a lack of effective prognostic, diagnostic and therapeutic tools continue to compromise effective maternal and fetal health care. We and others have described the lack of pharma incentives to develop therapies for pregnant women\(^9\)\(^\text{-}12\). There is imprecision in strategies for determining individual risk for a woman and her baby in labour, and fetal monitoring is poorly evidence based. The only effective treatment for fetal hypoxia is expedited delivery. Ockenden rightly criticises the lack of adherence to NICE (National Institute of Health and Care Excellence) guidance on fetal monitoring in labour, but the guidance is based on a limited evidence base (14 studies, 4030 women) of moderate to very low quality demonstrating “conflicting” diagnostic value.\(^7\)

Pregnant women and their babies deserve better.

The failings of Shrewsbury and Telford Hospital demonstrate that we need a system where health care organisations understand the essential features of safe care, can recognise in near real time when these features are not present, and have resource to quickly address and help units in difficulty. Recommendations and guidelines are not working. We need to address the more complex issues around culture and leadership; with a focus on ending the damaging and pervasive blame culture and ensuring women and their families at placed the heart of care. This will enable safe and personalised care, allow parents’ voices to inform and improve care, and improve the experiences of healthcare professionals, women and their families.

950 words

**Conflicts of interest**

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