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jdobson@bmj.com Follow Juliet on Twitter @Juliet_hd

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# Ignoring women's experience led to the NHS's biggest maternity scandal

Juliet Dobson *editor, bmj.com*

The Ockenden review of maternity services at Shrewsbury and Telford NHS Trust uncovered the biggest maternity scandal in the NHS's history. The report concludes that 201 babies and nine mothers might have survived if they had received better care and raises serious questions about how avoidable deaths and injury to so many mothers and babies could have happened (doi:10.1136/bmj.o858, https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions).[1 2]

The findings should provoke "deep soul searching by clinical and managerial leaders throughout the health service" to understand why the same problems keep recurring, writes Richard Vize (doi:10.1136/bmj.o860).[3] Ockenden concludes that the failings were caused by a "toxic mix" of factors (https://www.bbc.co.uk/programmes/m0015vhd).[4] Staffing pressures, training gaps, and overstretched rotas all contributed. But so did a failure to follow clinical guidelines or to investigate and learn from mistakes. Staff did not listen to patient experience, women were blamed or held responsible for poor outcomes—even their own deaths—and there was a lack of compassion in how patients were treated and responded to. Inadequate leadership and a bullying culture left staff feeling unable to raise concerns or escalate problems (doi:10.1136/bmj.o858).[1]

This is not a historic review—the incidents described in the report occurred between 2000 and 2019. Worryingly, in the final stages of the review, staff pulled out, and their accounts were removed from the final report, for fear of being identified, even though they were promised anonymity (https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions).[2] Ockenden told the BBC that staff "still felt unable to speak out, they still had fear of reprisals; there remains to my understanding a very worrying culture in the trust in the here and now" (https://www.bbc.co.uk/programmes/m0015vhd).[4]

It is easy to feel outrage and sadness about the scale of the findings and the impact of these failings on families' lives, but what of solutions? Last week the government failed to listen to calls for a national workforce strategy for the NHS, which is desperately needed to ensure safe levels of care (doi:10.1136/bmj.o871).[5] The issues are not unique to one trust, and Ockenden's report follows a series of other healthcare tragedies, some involving maternity care, and a failure by the health service to learn from previous mistakes or listen to patient experience (doi:10.1136/bmj.o860, doi:10.1136/bmj.o875, doi:10.1136/bmj.o898).[3 6 7]

Is there a failure to listen to women across the NHS? Why are women's voices ignored and their health concerns brushed aside? This is what drives consultant obstetrician and gynaecologist, Geeta Kumar, who has developed a shared decision making aid for women with heavy menstrual bleeding. Her practice is inspired by speaking up for women who haven't received support for their physical and mental wellbeing (doi:10.1136/bmj.o843).[8]

Cian Wade and colleagues remind us that harms from healthcare exacerbate health inequalities, particularly for marginalised and ethnic minority groups (doi:10.1136/bmj-2021-067090).[9] One example they cite is the poor communication and discrimination that women from ethnic minorities experience in healthcare settings, which may explain some of the inequalities reported in maternal health outcomes.

Concerns about widening inequalities have been brought into sharp focus by the cost of living crisis (doi:10.1136/bmj.o866, doi:10.1136/bmj.o759).[10 11] The poorest in society will be the worst affected, and last week's spring statement offered this group the least support. There have been multiple calls for the government to do more to help them—but is the government listening and will it act?

High quality journalism has an important role in bringing these failures to the public's attention and holding those in power to account. Which is why we are considering crowdfunding to expand investigative journalism at *The BMJ* (doi:10.1136/bmj.o803).[12] We welcome your views.

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