Cite this as: *BMJ* 2022;376:o860
http://dx.doi.org/10.1136/bmj.o860
Published: 31 March 2022

Ockenden report exposes failures in leadership, teamwork, and listening to patients

Deep soul searching is required by clinical and managerial leaders throughout the health service to understand why the same problems keep reoccurring

Richard Vize *Public policy journalist and analyst*

Donna Ockenden's final report on maternity failings at Shrewsbury and Telford Hospital NHS Trust once again exposes common problems underlying health service scandals: failures in leadership and teamwork, failure to follow clinical guidelines, failure to learn and improve, and a failure to listen to patients.[1]

The inquiry identified "significant or major concerns" in the care involved in nine maternal deaths, 131 stillbirths, 29 cases of hypoxic ischaemic encephalopathy (HIE), and 70 neonatal deaths, as well as around 65 cases of brain damage which were often diagnosed years later.

Failures identified by Ockenden include poor antenatal care for vulnerable women, repeated failures to correctly assess fetal growth, reluctance to refer women to tertiary centres to address fetal abnormalities, poor management of multiple pregnancies, poor management of gestational hypertension, failure to recognise sick or deteriorating women, failure to act on abnormal fetal heart patterns and failure to escalate concerns.

Shortcomings in leadership and teamwork—important factors identified in Bill Kirkup's investigation into failings at the maternity unit in Furness General Hospital, Morecambe Bay—included a culture of bullying and a failure by the board to face up to problems.[2] One staff member who tried to raise concerns "was referred straight to occupational health. It seemed that as I dared to raise a concern I must obviously be mentally unwell... This whole conversation was held in public."

The board failed to understand the depth of the problems in the maternity service, was too willing to put a positive spin on repeated investigations, and lacked a coherent action plan. For two decades, the maternity service and the trust failed to learn from critical incidents.

The review team heard from women who had felt a loss of control and power in the way they were treated. The feeling of not being listened to sometimes resulted in psychological trauma, with women blaming themselves for not being heard, believing they lacked the courage to stand up for themselves or that it "made me feel inadequate as a mother." Women found their dignity and confidence undermined by uncaring remarks, and the trauma of death and difficult births heightened by thoughtlessness.

The Ockenden report reaches strikingly similar conclusions to Bill Kirkup's investigation in 2015. He identified poor working relationships, poor risk assessment, grossly inadequate responses to adverse incidents, lack of board grip, inadequate clinical governance and a focus on "normal birth" at the expense of good care—a problem identified in Ockenden's first report on Shrewsbury.[3]

Two years earlier the Francis Inquiry into Mid Staffordshire rehearsed many of these findings.[4] In particular, Francis highlighted a culture of not listening to patients. The board lacked awareness of what was really happening in the trust, was too willing to hear good news and failed to learn from complaints and serious incidents. Like Ockenden, Francis found a culture of bullying which stopped staff speaking out.

The refusal of parts of the NHS to listen to patients was again exposed in the investigation by Julia Cumberlege published in 2020 into failures around medicines and medical devices, notably vaginal mesh.[5] She uncovered a pattern of women not being heard, not being empowered to make informed choices, and not being believed by arrogant clinicians.

In its response to the Ockenden report, the government has highlighted investment in the maternity workforce, although this is a long way from meeting Ockenden's demand for "a robust and funded maternity wide workforce plan, starting right now, without delay and continuing over multiple years."[6]

Wider questions may be addressed in the review of health and care leadership in England by Gordon Messenger, which is due to report to ministers in the coming weeks.[7]

But far deeper soul searching by NHS England and clinical and managerial leaders throughout the health service is required if it is to understand why the same problems keep reoccurring with such catastrophic consequences—why boards lack insight and grip, why whistleblowers are silenced, why patients are not listened to, and why mistakes are not seized on as an opportunity to improve.

Competing interests: none declared.

Provenance and peer review: commissioned, not peer reviewed.

1 Independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust. March 2022. https://www.ockendenmaternityreview.org.uk/
2 The Report of the Morecambe Bay Investigation. March 2015. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

3 Emerging findings and recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. December 2020. https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2020/12/ockenden-report.pdf

4 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. February 2013. https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

5 Cumberlege J. First do no harm: the report of the Independent Medicines and Medical Devices Safety Review. 2020 Jul 8. https://www.immdsreview.org.uk/Report.html.

6 Secretary of State for Health and Social Care Ockenden Report Statement. https://www.gov.uk/government/speeches/secretary-of-state-for-health-and-social-care-ockenden-report-statement

7 Review of health and social care leadership in England: terms of reference. November 2021. https://www.gov.uk/government/publications/review-of-health-and-social-care-leadership-terms-of-reference/review-of-health-and-social-care-leadership-in-england-terms-of-reference