The Times view on dangerous maternity care: Safer Births

Too many NHS maternity services are unsafe. Systemic change is needed

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The Ockenden report on maternity care at Shrewsbury and Telford Hospital NHS Trust, published at the end of March, made for sombre reading. It detailed an astonishing litany of failures, including 1,592 clinical incidents of poor care that led to 201 avoidable deaths, comprising 131 stillbirths and 70 neonatal deaths. Mothers were blamed or ignored, and stillbirths were not investigated.

At a single trust, recklessness and incompetence on this scale would be a scandal. But *The Times* reports today that the problems in maternity care may go far wider. Of the 193 NHS maternity services in England, 80 — that is, 41 per cent — are rated by the Care Quality Commission (CQC) as "inadequate" or "requires improvement", which means that they fail to meet basic safety standards. Eight have been given the lowest rating, and only two have the highest.

Most worrying of all is the lack of improvement at trusts where historic failures are well known and have already been investigated. Families raised the alarm about babies dying at Nottingham University Trust seven years ago. In April 2016, Harriet Hawkins was delivered stillborn after 13 catastrophic failures in care. An investigation found that her death had been preventable. But services at the trust are still rated inadequate. Another "inadequate" trust is Morecambe Bay, seven years after the Kirkup inquiry concluded that a lethal mix of failings had led to the deaths of 11 babies and one mother, and that urgent action was needed. A CQC report on Morecambe Bay last year said that the trust was still failing to keep women safe.

The prevalence of low CQC ratings is a concern, in part, because the ratings may not tell the whole story. The Ockenden review found that systems for external scrutiny of Shrewsbury and Telford, including the CQC, did not work properly. In 2015 the regulator rated services at that trust as good. A report in 2019 said that the service managed safety incidents well. Similarly, at the time of Harriet Hawkins's death in Nottingham, maternity services at that hospital were rated "good".

Donna Ockenden, the senior midwife who conducted the investigation into Shrewsbury and Telford, has called for systemic change. That shift is clearly needed across the NHS. A recent report by the health and social care committee in parliament noted that eight out of ten midwives had reported that they did not have enough staff on their shifts to provide safe service. Staffing must be an immediate priority. Ockenden also recommended that a proportion of maternity budgets be ring-fenced for training in every maternity unit.

Equally important, though, is a change in culture. A toxic obsession with "normal" births, which led to so many deaths at Shrewsbury and Telford, should be banished from the NHS. Trusts need to react with humility to safety incidents, focusing on what they can learn rather than on covering their backs. Quite apart from being the right thing to do, this will also be in trusts' own interests in the end. Hushing up failures leads only to more catastrophic outcomes, more recriminations and heavier repercussions further down the line. Sajid Javid, the health secretary, needs to make these changes his personal mission. Sadly it appears that, left to their own devices, failing trusts may not take action with the urgency that is so obviously required.