Seeing the Whole System: A Critical Systems Heuristics Perspective on the Ockenden Report

This document presents a brief **Critical Systems Heuristics (CSH)** interpretation of the **Ockenden Report (2026): Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust**. Rather than simply summarising findings, this uses Werner Ulrich's twelve boundary questions to examine the assumptions about purpose, power, knowledge and legitimacy that shaped the system.

Critical Systems Heuristics (CSH) provides an appropriate framework for analysing the Ockenden Report because the report addresses a complex socio-technical system in which failures emerged not from isolated clinical errors but from the interaction of governance, leadership, organisational culture, communication, resource constraints and stakeholder relationships.

The review demonstrates that maternity safety is shaped by multiple interdependent actors operating across organisational and regulatory boundaries, making it a contemporary ("topical") systems issue rather than a purely clinical one. Consistent with systems thinking, the report moves beyond identifying individual failures to examine the structures, feedback loops and organisational behaviours that enabled harm to persist over more than a decade.

It highlights recurring themes of inadequate learning, poor escalation, fragmented governance and the marginalisation of women, families and frontline staff, illustrating how systemic patterns were reinforced through organisational culture rather than isolated incidents.

CSH is particularly applicable because it critically examines boundary judgements concerning whose interests are prioritised, whose knowledge is regarded as legitimate, who holds decision-making authority and who bears the consequences of system failure.

The report's emphasis on listening to families, improving psychological safety, strengthening governance and redesigning accountability reflects an explicit shift towards broader system boundaries and more inclusive decision-making, demonstrating a mature application of systems thinking to a complex public service challenge.

The Ockenden Report reveals **not simply clinical failure but systemic boundary failure**. The maternity system repeatedly privileged organisational reputation, managerial reassurance and procedural compliance over women's lived experience, staff concerns and learning. Failures persisted for over a decade because those defining "what counted" as evidence, acceptable risk and organisational success excluded the voices most affected.

The report therefore describes a system whose **boundaries were drawn around protecting the organisation rather than protecting mothers and babies.**

1. Sources of Motivation

Who was the client?

Official client
- Nottingham University Hospitals NHS Trust
- NHS England
- Government and regulators

Actual affected clients
- Women
- Babies
- Partners and families
- Clinical staff

The report repeatedly demonstrates that these groups were treated differently. Families were expected to adapt to organisational processes rather than services adapting to family needs.

The Review itself deliberately reverses this by placing families at the centre of evidence gathering, involving nearly 2,500 families.

What was the purpose?

Officially:
Safe maternity care.

Operationally, the system often appeared to pursue:
- avoiding criticism
- maintaining performance indicators
- managing investigations
- organisational stability

This represents a classic CSH distinction between **espoused purpose** and **purpose-in-use**.

What counted as improvement?

Traditionally:
- compliance
- inspections
- governance processes
- incident reporting

The report argues improvement should instead mean:
- women being listened to
- psychological safety
- compassionate care
- transparency
- learning from harm

This is a profound shift in system purpose.

2. Sources of Control

Who was the decision maker?

Formally:
- Trust Board
- Executives
- Clinical leadership
- Regulators

Practically, decisions were constrained by:
- staffing shortages
- financial pressures
- entrenched culture
- hierarchy
- professional silos

The report repeatedly notes that risks had been identified but not acted upon because leadership structures failed to escalate concerns appropriately.

What resources controlled outcomes?

Not simply money.

Critical resources included:
- staffing
- leadership attention
- governance capability
- training time
- psychological safety
- communication systems

These intangible resources proved more decisive than physical infrastructure.

What conditions lay outside organisational control?

Examples include:
- national workforce shortages
- increasing clinical complexity
- deprivation
- health inequalities

However, the report argues these cannot explain persistent failures of:
- listening
- candour

- investigation
- learning
- respectful care

Thus the system often attributed failures to external pressures rather than examining internal choices.

3. Sources of Knowledge

Who counted as an expert?

Historically:
- consultants
- managers
- investigators
- regulators

The Review radically expands expertise to include:
- mothers
- bereaved parents
- frontline midwives
- junior staff
- psychological evidence
- lived experience

This is perhaps the report's most important systems shift.

What counted as evidence?

Historically:
- incident reports
- mortality data
- governance papers
- audits

The Review adds:
- family narratives
- staff testimony
- repeated patterns
- organisational culture
- psychological harm

CSH would describe this as expanding the system's epistemic boundary.

What worldview dominated?

The historical worldview assumed:
If governance processes exist, safety exists.

The Review replaces this with:
Safety emerges from relationships, culture, listening and learning.

This is a fundamentally different systems model.

4. Sources of Legitimacy

Who represented those affected?

Historically:
Very few.

Families repeatedly describe:
- not being believed
- not being listened to
- exclusion from decisions
- defensive investigations

The Review itself becomes the first legitimate forum where these voices shape the system.

How were those negatively affected protected?

The report concludes:
They largely were not.

Examples include:
- delayed investigations
- repeated failures to learn
- poor Duty of Candour
- bullying
- inadequate bereavement care
- prolonged psychological harm

The "compounding of harm" described in the report is essentially a failure of system legitimacy.

What worldview made the system appear acceptable?

Several implicit assumptions persisted:
- inspections equal improvement
- good intentions equal good care
- isolated incidents rather than recurring patterns
- organisational reassurance over organisational learning

The Review challenges every one of these assumptions.

Boundary critique

Perhaps the strongest CSH insight concerns **boundary judgements**.

Whose knowledge was excluded?

Repeatedly excluded:
- women
- partners
- whistleblowers
- junior clinicians
- minority communities
- bereaved families

Yet these groups identified problems years before formal governance did.

What problems were defined as “outside the system”?

Examples include:
- psychological trauma
- racism
- bullying
- organisational culture
- communication
- post-death care

Initially these were treated as peripheral issues.

The Review reframes them as **central determinants of safety.**

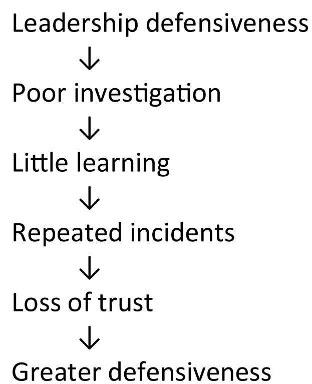
What counted as success?

Previously:
- regulatory compliance
- completed investigations
- performance reporting

The Review argues success should instead be measured by:
- women feeling heard
- safe clinical outcomes
- compassionate communication
- staff psychological safety
- continuous organisational learning

System archetype – reinforcing a "toxic culture"

Viewed systemically, the report illustrates several reinforcing feedback loops:



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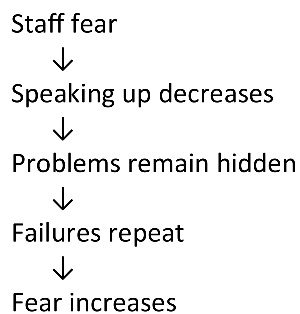

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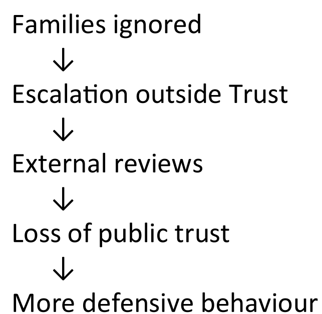

These are classic reinforcing loops that perpetuate system failure.

Overall CSH assessment

The Ockenden Review is fundamentally **a critique of boundary judgements rather than merely clinical performance**.

It demonstrates that maternity failures were sustained because:
- the wrong stakeholders held decision-making power
- the wrong forms of knowledge were privileged
- organisational legitimacy was based on compliance rather than trust
- success was measured by governance activity rather than lived experience
- systemic learning was constrained by defensive organisational boundaries

The report's Immediate and Essential Actions can therefore be interpreted as attempts to **redraw the system boundary** so that women, families, frontline staff and transparent learning become central rather than peripheral to governance. This represents a shift from an organisation-centred system to a family-centred learning system.

From a Critical Systems Heuristics perspective, the report's central lesson is: the maternity service did not fail because it lacked information—it failed because its boundaries determined whose information, whose values and whose experiences were considered legitimate. The Review seeks to redefine those boundaries as the basis for safer and more accountable care.