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An exploration of midwives' perceptions of the Ockenden review: a qualitative study

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ABSTRACT

Aim: This study aims to understand midwives' perceptions of the Ockenden report.
Background: The Ockenden report was published following an inquiry into maternity services at Shrewsbury and Telford Hospitals NHS Trust. It reports multiple failings endemic at the Trust and concludes with 15 'Immediate and Essential Actions' to be enacted across English maternity services. The report and its recommendations have resulted in changes to maternity practice throughout the UK.
Method: An exploratory qualitative study design, comprising semi-structured interviews with nine midwives between May and July 2023.
Results: Two overarching themes were identified; the context of the report, and the impact of the report, and within them five subthemes. These were: "We've seen it all before"; Change is complicated; A tool for change; Perception of midwifery; and Fuelling the obstetric paradigm. Midwives recognised the importance of the report and many of the concerns it raised and agreed there are significant problems within UK maternity care. However, there was also an expression of concern regarding the lack of evidence supporting some of the recommendations and how the report was impacting practice.
Conclusions: There are significant problems present in maternity practice in the UK. Inquiries may lead to important recommendations; however, they can be difficult to enact and may have unintended consequences. More research is needed looking into why meaningful change is difficult to achieve and how perinatal professionals interact with policy change.

Introduction

Maternity care in the UK has been subject to several high-profile inquiries into services in recent decades, often triggered by patient safety events including deaths of mothers and babies. Inquiries into services in Morecambe Bay [1] and East Kent [2] among others detail significant failings in care contributing to serious avoidable morbidity and mortality, the reports of which often feature long lists of recommendations.

Chaired by Donna Ockenden, the independent inquiry of maternity services at Shrewsbury and Telford NHS Trust culminated in the publication in 2022 of what has become known as 'The Ockenden report' [3]. The inquiry was triggered by the efforts of two families whose newborn daughters died following care at the Trust, in an effort to ensure others did not have to endure the same experiences and outcomes as them. The inquiry eventually grew to include evidence from over 1,500 families, and the report concludes that the Trust "*failed to investigate, failed to learn, and failed to improve and therefore often failed to safeguard mothers and babies*" [3]. Issues including inadequate risk assessment, poor interdisciplinary working culture and poor governance procedures have been raised in similar maternity inquiries [1,2].

The report details examples of sub-optimal and negligent care, concluding with 15 'Immediate and Essential Actions' (IEAs) for implementation across all English maternity services, in addition to 'local actions' intended for the Trust. Shortly after publication, the Secretary of State for Health and Social Care stated in the House of Commons [4] that NHS England would be instructing all Trusts to assess themselves against these actions. There has been criticism by some of the IEAs, for example the recommendations around electronic fetal monitoring and midwifery continuity of carer [5].

This is the first study exploring midwives' perceptions of the Ockenden report. Given its significant impact, particularly the expectation of all Trusts to implement the IEAs, appreciating the way it has been received by practitioners will improve understanding of how the

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recommendations have been interpreted and translated into clinical practice. Midwives are the largest professional group involved in the provision of maternity care, delivering care throughout the perinatal period [6]. As such, the findings and impacts of inquiries such as this are likely to significantly affect the day-to-day practice of midwives and therefore understanding their responses to work such as this is essential. Historically, midwives had a lack of influence in policy development, even in the UK, where midwifery practice is considered autonomous [7]. Midwives' lack of input at policy level may be a barrier to enacting change where there is a failure to consider the perceptions of this key professional group, of problems and potential solutions within maternity care. This study aims to understand midwives' views of this report, the problems it details, and the perceived impact it is having in practice.

Methods

An exploratory qualitative approach, comprising semi-structured interviews was employed, focusing on midwives' understanding and reflections of the Ockenden report, including any perceived changes to practice following its publication. As no prior research exists considering the views of health professionals of this report or indeed any other report of this type, the research was designed to be inductive. A basic exploratory design was chosen with the intention of allowing the generation of new theories from the data relating to the research aims, which can then be used as a basis for the design of more focused future research.

Ethical considerations

Ethics approval was granted by City, University of London Maternal and Child Health Research ethics committee (Application ETH2324-0142). Appendix one lists participants' roles for context, however they are not linked to the pseudonyms used throughout, to reduce the risk of participants being identifiable. The provision of anonymity was paramount, given the political nature of the research, to protect participants from criticism where their opinions might differ from colleagues or from accepted clinical guidelines and practices and allowing freedom to express thoughts honestly.

Participants and recruitment

Eligible participants were registered midwives working in an NHS midwifery role. Recruitment took place via Twitter, Instagram and Facebook by voluntary response to a recruitment flyer (Appendix 2). A participant information sheet (Appendix 3) and consent form (Appendix 4) were shared by CF prior to the interviews taking place. We aimed to recruit 8–12 participants, ideally with a range of experience, backgrounds and levels of seniority. Those who expressed interest were provided with the information sheet and given the opportunity to ask questions prior to consenting.

Thirteen individuals expressed interest; four were not current NMC registrants and therefore excluded. The remaining nine met the inclusion criteria, were interviewed and subsequently included in the study. Participants represented a range of roles, clinical and managerial, with some directly involved with projects which related to the inquiry; two worked in strategic roles that involved local and national initiatives. Several of the midwives held or were studying for post-graduate degrees.

Data collection

Semi-structured interviews lasting 40–70 min were conducted using the video conferencing software Microsoft Teams between May and July 2023 Audio-video recordings were transcribed verbatim using an orthographic transcription method [8], prior to deletion. Participants were asked to share opinions of the Ockenden report and any changes to practice which they perceived or knew to have been triggered by its publication. An interview guide (Appendix 5) helped shape conversations.

Analysis

Given the exploratory nature of this research, thematic analysis was chosen due to its flexible approach and value in providing new insights where prior knowledge is limited. This method can be readily embraced by those with limited research experience [9] but still requires a thorough approach to coding and analysis. An inductive approach to analysis was undertaken, employing Braun and Clarke's [8] framework for systematic thematic analysis, ensuring all data was subject to the same level of scrutiny and allowing phenomena to emerge without preconceived notions or existing theories influencing analysis.

Stage one involved interview transcription and multiple readings to become familiarised with the data. Brief notes were made at this stage by hand with key words and phrases highlighted. This step was undertaken as soon as possible following interviews, in order to minimise misinterpretation or misunderstanding and to prevent findings from future interviews from influencing notes, particularly in the early stages of data collection. Stage two was the systematic coding of the entire dataset, designed to identify in particular commonly occurring words, phrases and concepts throughout the dataset. This was undertaken line by line using NVivo 12 [10], resulting in 78 codes (Appendix 6). Stage three organised codes into wider themes, considering relationships between codes and beginning the process of conceptual development. Stage four involved reviewing and developing emergent themes by revisiting the entire dataset to ensure themes were representative of the data and relevant to the research aims. Included in this stage was the independent review by CM of a number of interview transcripts. Stage five refined, defined and named codes leading to the development of two themes and five sub-themes within the conceptual framework. Finally, findings were reported, with writing being undertaken in an iterative and reflective manner.

Analysis was validated through discussion and independent review by CY and CM at stages two, four and five to highlight any data or themes which may have been overlooked and confirming or challenging emerging theories thereby minimising bias and adding rigour to the process and ensuring themes and findings were truly reflective of the data.

Reflexivity

Research is inevitably influenced by the researcher [11], but it was essential to minimise the extent to which the researchers' preconceptions impacted the process. This was achieved by ensuring each step, from the study design, through all stage of analysis was reflexive. Interview questions were designed to be general and open ended, allowing for honest discussion without any prior expectations being brought to participants and responses during interview were neutral. A reflective journal was kept during the data collection process to note and challenge any assumptions and discussed contemporaneously with co-researchers.

Discussion at various stages of the analysis process with co-researchers provided ample opportunity to reflect on emerging findings and acknowledging our own thoughts, considering how they may be prevented from influencing findings. While CF is a practising clinical midwife, co-researchers are both non-clinical academics and therefore did not share the clinical experiences of either CF or the research participants, which was helpful while reflecting throughout the data collection and analysis in providing a different view.

Findings

Two key themes were identified from the data. The first related to the context in which the inquiry was undertaken and report written. Within

this were two sub-themes: '"We've seen this before"' and 'The problems are complicated'. The second theme related to the impact the report was perceived to be having in practice. Identified with in this were three further sub themes: 'A tool for change', 'Perception of midwifery' and 'Fuelling the obstetric paradigm'.

The context of the report

The context in which the inquiry was undertaken was a key theme, relating to the background against which the report was written. This included clinical and systemic issues in maternity care and the NHS more widely, in addition to the some of the triggers for the report.

"We've seen this before"

All participants referred to other maternity inquiries, citing their overlapping findings as indicative of endemic issues. Several recognised the same problems within their own services imagining "*it could happen anywhere"* (Selina), a sentiment shared by every participant. There appeared to be a sense of inertia regarding their findings and subsequent lack of impact.

> *"I was thinking um you know here we go again to some extent…we'd already had um, the Francis reports we'd already had the Morecambe Bay stuff." (Jamie)*
> *"And I don't know what the next one's gonna say…but you feel like [laughing] what's gonna change?" (Elle)*

Most midwives highlighted overlapping issues often identified, including culture, poor inter-disciplinary teamworking and inappropriate risk assessment. While these were recognised as requiring significant improvement, the fact they had been highlighted repeatedly was felt to be indicative that inquiries and their recommendations were not improving practice. Some argued that attempting to tackle individual problems which are the result of deeply embedded systemic problems is ineffective and that change would only be achieved on a macro-level, advocating for radical change.

> *"…the model of care that we have…is not really working…especially because it's the third or fourth report…and then we continue to build on what we have already… I feel like we really have to scrap completely what we're doing and start from scratch." (Weronika)*

The lack of robust governance processes was also noted. Participants felt that in addition to letting the families of those affected down, not adequately investigating serious incidents, the Trust was failing to learn. This was understood not to be unique to Shrewsbury and Telford and something to be considered a warning to others.

> *"I think it's really important that Trusts are just really honest with themselves…I think if we start to act like, 'Ohh, we're so much better than that and that will never happen to us' You know, I think that's where we're not gonna make a change in maternity services" (Alex)*

The problems are complicated

The second sub-theme flows from the first. The repetitive nature of reports was understood to be partly because the problems they highlight are complex and deeply embedded. 'Solving' these types of problems, particularly in a very large institution like the NHS, was felt to be exceptionally difficult. The failure of recommendations to consider the underlying causes and their potential for unintended consequences were both frequently raised.

The complex nature of problems was evident in the way in which participants differed in their opinions on some of these underlying factors and their potential solutions. One contributory factor to poor outcomes at Shrewsbury and Telford was felt to be the chronic shortage of midwives, described as *"a massive issue for most trusts" (Alex),* experienced by every participant. However, the introduction of specialist midwifery roles was contentious. While providing an opportunity for targeted support and for staff progression, it was perceived by some as exacerbating existing understaffing issues.

> *"…there's just so many band seven roles, it's like it's been this explosion and that's great for everyone that wants to do something a bit more exciting and progress, but it has decimated the shop floor." (Izzi)*

There were also differing opinions surrounding the recommendation to suspend midwifery continuity of carer. While some felt the model contributes to understaffing and therefore the suspension was justified, others cited the significant evidence supporting this *"very safe model of care" (Jamie)*.

Differences in the interpretation of the IEAs was also raised, with some feeling senior management were likely to be influenced by their own priorities, thus leading to inconsistencies across different Trusts. Applying recommendations across the NHS was felt to be problematic, due to differing populations.

> *"Having worked in three different hospitals, all relatively similar in terms of complexities but with different financial situations and different, very different, cultures from the demographics of the staff and the patients. It was three different experiences…but the same targets". (Sam)*

Most midwives raised that maternity inquiries are often critical of culture, but that as a concept it is very difficult to define, and subsequently to change. For example, hierarchy and status within the multidisciplinary team and lack of psychological safety was felt to be a considerable barrier to escalating clinical concerns, particularly where there was disagreement between clinicians from different professional groups.

> *"…we know culture is a problem but like that is the hardest thing to fix isn't it, really? It's really easy to write 'escalate things if you're concerned'…but actually it's really hard to do it in practice." (Elle)*

The impact of the report

The second theme relates to the impact the report was perceived to be having in practice, both as a result of the IEAs and more indirectly. The subthemes demonstrate mixed feelings about whether the report was having a positive or negative impact in practice; the first subtheme highlighting the largely positive impacts attributed to the changes triggered by the inquiry, the others revealing more negative impacts perceived.

A tool for change

All participants had recognised changes directly resulting from the inquiry; described as *"the business case of all business cases" (Sam)*. These included a significant drive to increase staff numbers and protected time for mandatory training.

The inquiry report was praised as a chance *"for those people to be heard and for their experiences to be acknowledged" (Jamie)*. The public awareness was felt to have empowered others to raise concerns, and the escalation to parliamentary level prioritised maternity care for increased support and funding.

> *"…obviously all Trusts got funding off of the back of Ockenden, and then looking at that, those like immediate actions and working out the areas that we aren't doing so well on…how can we use this money to help us?" (Alex)*

Improvements to multi-disciplinary (MDT) working relationships was highlighted and the creation of specialist midwifery roles was considered positive in bringing a midwifery perspective and input to clinical specialties where previously it had been excluded. A recognition of the continuity provided by specialist roles was also noted.

"…so they've implemented a lot of very specific [MDT] clinics…preterm clinic, a multiple birth clinic, a maternal medicine clinic… [the clients] should get much more tailored treatment." (Aoife)

The focus on *"looking for learning" (Jamie)* and strengthening governance was also felt to have enacted positive change, ensuring robust investigation processes were in place and improving candour and family engagement.

"I think that Ockenden has really helped…really fight to strengthen governance, which I think is a really big part of Ockenden, is about our governance processes" (Alex)

One midwife however, while appreciating that the report was vital to improving local services questioned the validity of applying national recommendations based on a single failing service.

"…the jump from investigating one Trust, and finding errors in their practice to then making these national recommendations based on a failing system. That's what I find quite challenging." (Elle)

Perception of midwifery

The fourth subtheme relates to the perception of midwifery and midwives. This was felt to be largely due to the negative, often misleading media reporting which was seen as *"shaming midwives" (Izzi)* and undermining public trust in midwifery care.

"What does that mean for midwifery in the long run?" (Jamie)

One midwife felt the media focus was largely on midwifery-led services, despite the inquiry clearly reporting problems which were multidisciplinary or obstetric-led.

"…like these are across services, in terms of some of the issues in midwife-led care are the same with obstetric-led care and shared care. So I feel it was maybe unfairly targeted…" (Elle)

Social media was a source of concern, from which a *"backlash, particularly on Twitter" (Selina)* was felt. This especially related to a central tenet of midwifery practice; the support of physiological processes of pregnancy and birth. Midwives vehemently denied wanting to pursue 'normality at all costs', one stating it was "*the last thing people's mind [laughing] …we've got such an incredibly high caesarean section rate." (Elle)*. This narrative, along with the aggressive pedalling of a 'them and us' culture between midwives and obstetricians was considered sensationalist reporting not reflective of reality.

"…you know people in the in politics, in media, sort of really want that polarisation at the moment and it just fits in well with that doesn't it?" (Katy)

Some felt a devaluing of certain elements of midwifery-led care and physiological pregnancy and birth; a *"reluctance to talk about normal birth" (Katy)*. This was particularly the case regarding the recommendation suspending midwifery continuity of care. One participant argued it had served as an 'excuse' to withdraw support for the teams they had in place, despite them having had no bearing on understaffing at their unit.

"…because Ockenden then recommended…everyone was like, 'great let's scrap this…we have had enough of this continuity of care. We don't want to do it'." (Weronika)

Other aspects of midwifery-led care were also perceived to be under threat. One participant shared a frustrating conversation with a consultant obstetrician, who, when discussing plans for a midwifery-led unit responded *"well we won't get one of those now, not off the back of Ockenden" (Izzi)*.

Fuelling the obstetric paradigm

The final and largest sub-theme relates to perception that the report had fuelled the 'obstetric paradigm' of pregnancy and birth. Participants reported that practice was already dominated by obstetrics, with most women being subject to highly medicalised pathways due to fear of adverse outcomes and subsequent litigation. This was seen as having been exacerbated by the report.

"It already feels like…a lot of the decisions, especially by the obstetricians…they do such…unnecessary interventions because they're worried about the what ifs and maybes" (Izzi)

This type of defensive practice was considered damaging to midwifery-led care and choice. However, this was also perceived as emblematic of the valuing of obstetric-led over midwifery-led care and unsurprising in the context of a hierarchical, medicalised system. Some of the recommendations were particularly problematic from a midwifery perspective.

Centralised electronic fetal monitoring (EFM) was mentioned frequently with concerns over the time and money being spent, despite it being *"not really evidence based" (Weronika)*. There was also concern regarding the potential for centralised EFM to negatively affect the provision of continuous one to one care in labour.

"…what is sexy is like ohh you get all these machines that bing…isn't it clever that we can sit at the desk…but…that doesn't tell you if the woman's scared does it?' [laughing] Also doesn't tell you if she's vomited all over herself or like her husband is like being a complete arsehole like you just don't know." (Elle)

Katy shared an experience which involved her briefly removing the fetal heart rate monitor to assist her client to change position. This was misinterpreted by the team outside, who entered her room unannounced, turning on the lights, both disrupting the calm atmosphere they had been maintaining and undermining her clinical skills. This overreliance on technological assessments and concurrent devaluing of holistic midwifery skill was echoed by others, feeling that technology *"can never really replace some of the real intuitive skills of midwives" (Sam)*.

A fear of being seen as 'pushing' for physiological birth since the report's publication was also described, accompanied by concerns that this had led to increasing obstetric interventions. This is despite, as one midwife highlighted, much of the criticism within the report surrounded injudicious use of oxytocin and inappropriate instrumental delivery, neither of which are features of physiological birth. High and rising rates of interventions, particularly caesarean sections were mentioned by two thirds of the midwives, several of whom reported working in units with caesarean section rates exceeding 50 % of births. They attributed this recent increase to the negative attention the inquiry had attracted, resulting in more women electing for caesarean sections, and obstetricians being quicker to offer them in labour.

"One of the doctors that I work with sort of started um routinely sort of offering women a caesarean section in labour when there's no indication for it…because their perception is…if something happens…if there's a bad outcome that person can then come back and say well nobody offered me a caesarean." (Katy)

Discussion

The aim of this study was to understand the perceptions of midwives of the Ockenden report including any impact on practice. Participants were aware of previous inquiries having highlighted many of the problems present at Shrewsbury and Telford and expressed little surprise in this repetition. An agreement that the findings and recommendations could be used as a tool to improve maternity services was complicated by the fact that many of the issues it highlighted are deeply embedded, therefore not easily 'fixed' through targeted

recommendations. Fear was expressed regarding the perception of midwifery by the public, and over the exacerbation of the dominance of highly medicalised obstetric practice at the expense of holistic midwifery care.

Lack of progress

Despite public inquiries historically impacting healthcare regulation, the overlap between them is significant [12], indicating that recommendations are not achieving the desired result; a finding echoed by the midwives in this study. In the East Kent inquiry report, Kirkup warns against subjecting maternity services to long lists of recommendations, arguing that historically such policy initiatives do not work; "*At least, it does not work in preventing the recurrence of remarkably similar sets of problems in other places.*" [2] Participants recognised this, arguing improvements were unlikely to be achieved without significant systemic changes.

There was a recognition of aspects of negative culture, such as the difficulty in raising concerns due to a fear of reprisal, however, this was felt to be a deeply embedded problem stemming in part from the disempowerment of midwives and other junior staff within the hierarchical medical system [13]. Cultural change is often called for following inquiries, however the assumption that culture can be purposefully changed has been criticised [14], a view which was echoed by participants in this study.

Inquiries and evidence

Unlike established forms of healthcare research, inquiries are not consistently informed by evidence, but rather shaped by their chairperson [12] and the context in which the inquiry is being undertaken. Unlike other independent reports, such as those formulated by MBRRACE, which look at entire cohorts of women across the UK, the Ockenden inquiry focused on services at a single Trust, a fact which several participants raised. The lack of evidence behind some of the IEAs was voiced and is reflected in some responses by academics in the field. Critics of centralised EFM, for example, argue that it does not reduce adverse neonatal outcomes [15] and risks increasing rates of caesarean section [16] and other obstetric interventions [17].

Another of the recommendations lacking evidence is the move to assess caesarean section rates using the ROBSON criteria. While this recommendation was made with the units lower than average rates in mind, it risks further embedding the false belief that higher caesarean section rates improve safety, an assumption the media perpetuates [5]. Evidence that CS rates beyond the level recommended by the World Health Organisation (WHO) do not improve perinatal mortality is plentiful [18,19]. Despite this, UK maternity care has experienced a steep rise in caesarean sections in the last decade; from 27 % in 2015–16 [20] to its current rate of around 45 % [21].

This lack of evidence supporting recommendations however is not unique to the Ockenden report. Maternity care suffers from many policies and practices which reflect this, particularly common labour and birth interventions. Harris et al. argue that even where evidence exists, clinical practice *"often directly contravenes the research findings"* [22] especially where research supports a physiological approach to care. Some participants in this study felt that the recommendations being lacking in evidence was reflective of the wider political and social discourse around birth in which the inquiry was conducted.

Midwifery and the obstetric paradigm

Participants highlighted the 'Obstetric Paradigm' dominant in UK maternity care, arguing that the report had contributed to an exacerbation of the socially accepted norms that pregnancy and birth are risky and require highly medicalised management. This was perceived to be resulting in defensive practices and increasing intervention rates.

The idea that birth knowledge is perpetuated and justified by the system of beliefs in which it resides is well documented, particularly since Jordan's cross-cultural work [23]. She argues that birth systems use internal processes and knowledge to justify their actions and criticises *"the extraordinary extent to which practitioners buy into their own system's moral and technical superiority"*. This manifests in a need to justify supporting physiology that does not exist for justifying obstetric interventions, despite their potential for iatrogenic harm. [24]. The implementation of centralised EFM contrasted with the reduction in the provision of midwifery continuity of care is a good example of this; while no evidence exists supporting the use of the obstetric intervention, there is significant evidence supporting the midwifery intervention [25]. As Downe and McCourt argue, *"the telling factor which indicates where the beliefs of the current system lie is the allocation of resources"* [26]. This fails to account for the evidence supporting midwifery practices for women at all risk levels in improving perinatal outcomes [27].

The midwives also perceived negative feelings towards midwives and aspects of midwifery care, in particular a fear for those who promote supporting physiological birth being accused of pursuing *'normality at all costs'*, a term widely used in response to this report and others [28].

Moving forward

Though the Ockenden inquiry was considered undeniably important, the report itself was perceived to be having mixed effects. Some negative effects were attributed to the lack of evidence supporting some recommendations.

The recent inquiry into midwifery services in Northern Ireland [29] offers a more evidence-based approach both in its inquiry methods and recommendations. This report takes a whole systems approach and is grounded in evidence throughout the process of the investigation, reporting and concluding recommendations. The involvement of service users, healthcare and other professionals spanning a wide range of experience and specialties and the inclusion of positive examples of practice strengthens the value of the report. The report also emphasised that while the regulation of a consistent set of policies and protocols designed to enhance safety, adaptations accounting for local circumstances may be needed. This may be a more useful model on which to base future inquiries.

Unfortunately, this will not be the final report of maternity service failings. The ongoing inquiry at Nottingham University Hospitals NHS Trust involving more than 2000 families, is due for publication in 2026 [30]. Clearly there is significant work to be done if maternity services are to avoid repeating the mistakes of its' past. Considering the views of and impact of these inquiries on frontline staff responsible for delivering care is vital and should not be overlooked.

Limitations

This study is the first to consider midwives' perceptions of the Ockenden inquiry. It is limited by its' small size, and self-selecting participants. Most of the midwives were very familiar with the inquiry report, which is unlikely to be representative of midwives more generally, many of whom will be less familiar with its findings and recommendations. Additionally, given the political nature of the inquiry and widespread media attention, it is reasonable to think that some midwives would not have felt safe speaking out and therefore did not volunteer to participate.

Conclusion

This study aimed to explore the way midwives perceived the outcome and recommendations of the Ockenden inquiry. It demonstrates a recognition by midwives of the problems identified and a frustration with the lack of improvement within maternity services. Also highlighted was the complicated nature of change as it is influenced by

cultural, social and political pressures. While the report was considered a potential force for good, concerns about its impact on the perception of midwifery, the allocation of resources, and expansion of non-evidence-based practices were raised by midwives in this study. Future research looking at the impact of other maternity service inquiries would be useful in understanding how they impact practice, and in assessing if and how they affect care and outcomes. Research involving other perinatal professionals is also needed.

CRediT authorship contribution statement

Caitlin Foley: Writing – original draft, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Christine McCourt:** Writing – review & editing, Validation, Supervision, Resources, Methodology. **Cassandra Yuill:** Writing – review & editing, Supervision, Methodology, Validation.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.srhc.2025.101166.

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