



**Programme: MSc Public Health and Social Care in
Practice**

Module: Quality Assurance and Service Improvements

Module Code: LCHS7006

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**Assignment Title: Component 2 Service Improvement
Report**

Table of Contents

1. Introduction.....	4
1.1 Study Background.....	4
1.2 Significance of addressing the identified problem as a concern.....	5
2. Discussion and Analysis	5
2.1 Evaluation and analysis of root causes of the issue using relevant models/frameworks.....	5
Fishbone Diagram.....	5
The 5 Whys	8
The Donabedian Model.....	10
2.2 Strategic Planning through application of SWOT analytical tool	12
2.3 Evidence from previous research works and real-world examples	14
3. Recommendation	16
4. Conclusion	20
Reference List	21

List of Abbreviations

SaTH- Shrewsbury and Telford Hospital NHS Trust

NHS- National Health Service

BBC- British Broadcasting Corporation

GMC- General Medical Council

HCPs- Healthcare Professionals

CQC- Care Quality Commission

PDCA Cycle- Plan- Do- Check-Act Cycle

1. Introduction

1.1 Study Background

The background context is based on failure to provide quality healthcare services by The Shrewsbury and Telford Hospital NHS Trust which resulted in deaths of more than 200 babies and left other infants with life-changing injuries. The maternity ward scandal took place in between 2000-2019 across Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. Review done by Donna Ockenden concluded that better care could have saved lives of 201 babies and 9 mothers (BBC, 2022a). It has been identified that there was lack of oxygen deprivation that led to newborns suffering from skull fractures, broken bones or permanent brain damage (Badshah, 2022). There were also other internal issues related to lack of administration and proper leadership or management of staffs (Ockenden Report, 2022). Therefore, there were concerns related to the maternity care quality provided by the NHS Trust and the report helps in evaluation of the root cause of it followed by providing actionable recommendations.

1.2 Significance of addressing the identified problem as a concern

Significance of addressing the identified problem are as follows:

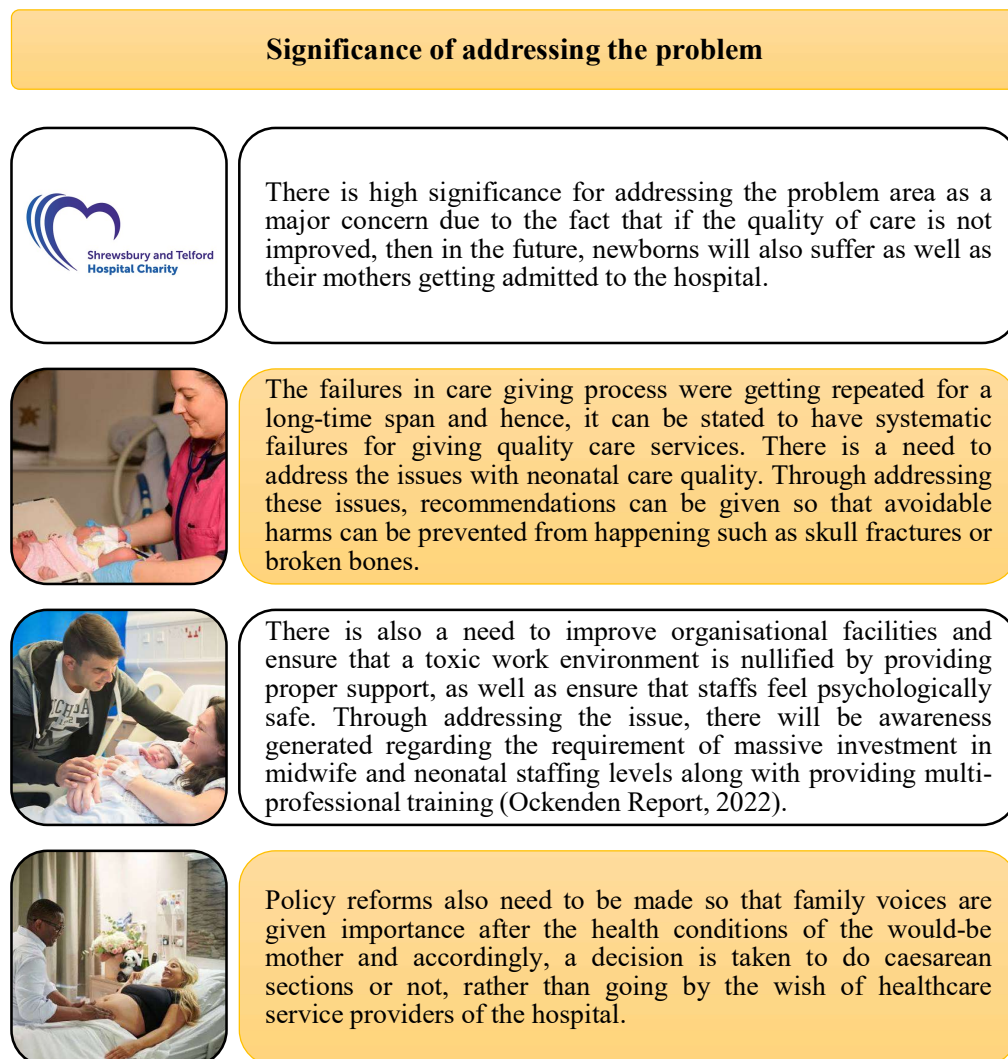


Figure 1: Significance of addressing the issue

(Source: Created by Author)

2. Discussion and Analysis

2.1 Evaluation and analysis of root causes of the issue using relevant models/frameworks

Fishbone Diagram

Fishbone Diagram can be considered as a visual tool which helps in finding root-cause of a problem (Tagaram and Chen, 2024).

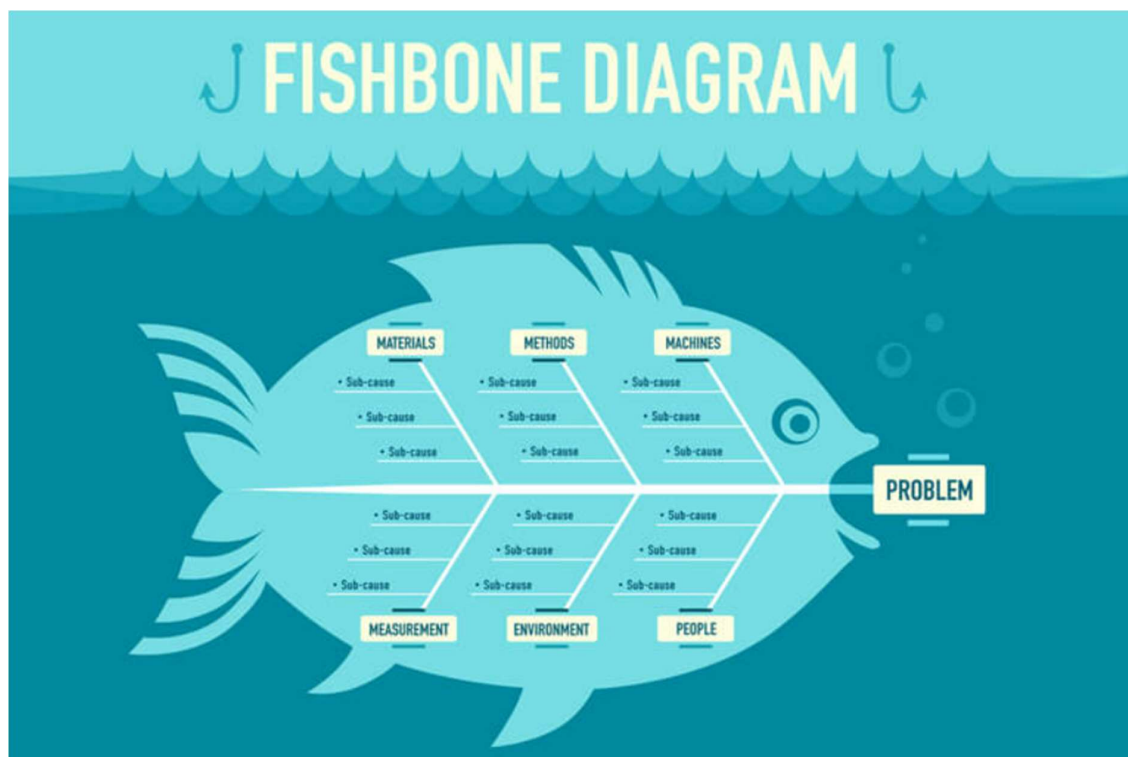


Figure 2: Fishbone Diagram

(Source: 6sigma, 2026)

In this case, the fishbone diagram presenting the root cause of the low-quality maternity health care services at Shrewsbury and Telford Hospital (SaTH) NHS Trust are as follows:

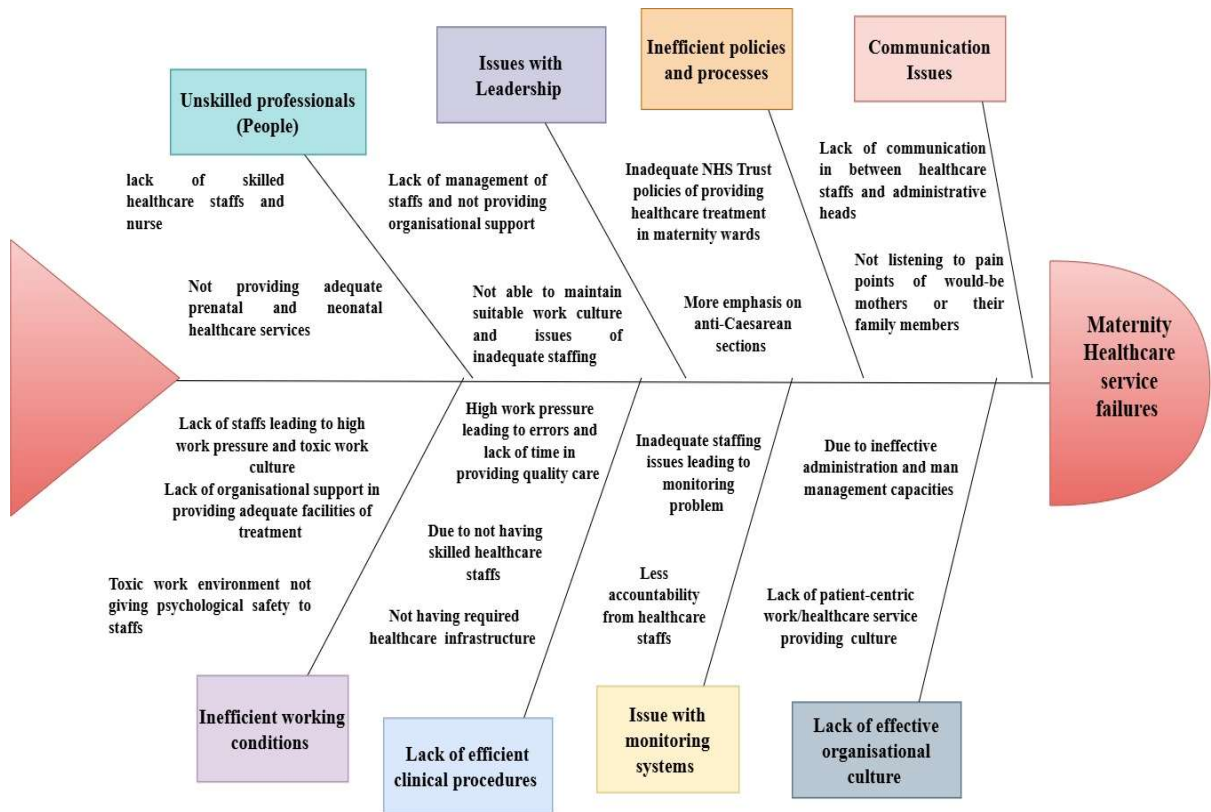


Figure 3: Fishbone Diagram

(Source: Created by Author)

Analysis of the root-cause of the issue as identified from Fishbone Diagram

From the Fishbone diagram, it can be stated that the reasons for maternity healthcare service failures are the lack of skilled professionals providing routine care and inefficient clinical procedures due to a lack of proper healthcare infrastructure at the hospital (BBC, 2022a). There has been lack of multi-disciplinary infrastructure and due to lack of required skill sets, staffs aggressively promoted natural, unassisted vaginal births. It has resulted in many harms which can otherwise be avoidable and led to stillborn babies as well as many suffering from neurological injuries and brain damage. Moreover, due to a lack of adequate staffing, the time and quality of care required were not given, as there was high work pressure on the staffs (Ockenden Report, 2022). It led to mental fatigue and, at times, frustration, which led to deterioration of the caregiving process. Continuous failures in the provision of maternity care are also attributed to a lack of administrative and situational leadership skill sets, which allowed clinical errors to occur without any initiatives to train staff (Lakasing, 2025). Moreover, it is evaluated that midwives and doctors at SaTH did not take responsibility of doing surgical

intervention and for this reason, ignored fetal distress intentionally. It has also happened due to lack of proper monitoring of healthcare giving process to admitted world-be mothers at SaTH.

There has been lack of efficient clinical procedures as junior midwives failed to escalate high-risk cases to consultant obstetricians. Staffs also lacked adequate training for managing complex cases such as fetal heart failures. Lack of funds led to inadequate staffing, and organisational culture deteriorated due to not having the accountability to provide patient-centric care services (Badshah, 2022). In addition to this, without a proper governance framework in place due to leadership failure, families are not listened to and hence, patient-centric care services are not provided (BBC, 2022a). It has led to doing of more normal vaginal birth and complicated the health outcomes of new born babies. The culture within SaTH was not smooth for doing teamwork as due to lack of clarity of roles and responsibilities, healthcare staffs blamed each other. No clear policies are set out to communicate with patient family and know about their preferences or discuss to provide holistic care approach. There were no corrective actions taken in the course of 19 years, which led to repeated mistakes, followed by allowing a culture of bullying, anxiety, and fear of speaking to prevail, which made staff less accountable for providing quality maternity care services. Staff's pain points are also not listened to, and no initiative was taken by the NHS trust to improve the quality of care-giving process.

The 5 Whys

The 5 Whys method is an iterative and simple technique developed to identify root cause of an issue by asking questions (Majka, 2024).



Figure 4: 5 Whys Technique

(Source: Majka, 2024)

It is used for identifying the root cause of the maternity care giving issues that happened in Shrewsbury and Telford Hospital NHS Trust from 2000 to 2019:

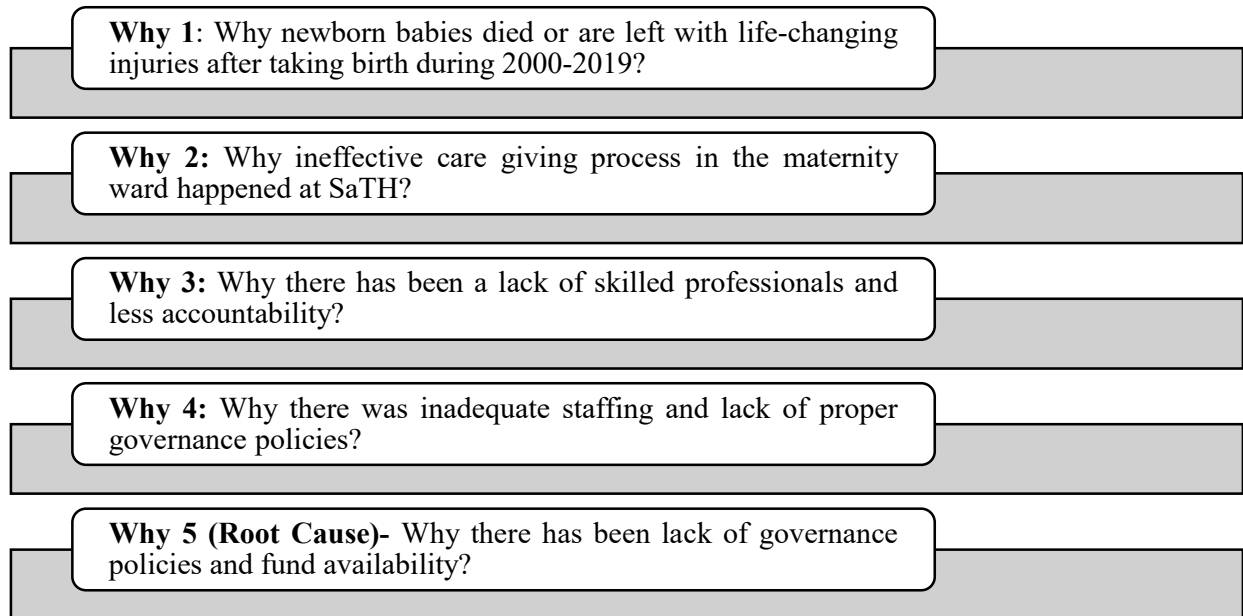


Figure 5: 5 Whys

(Source: Created by Author)

Analysis of 5 Whys Framework

The first question is raised to identify the basic reason behind death of newborn babies at SaTH during 2000-2019. It happened due to repeated failures in the caregiving process at SaTH during the prenatal and neonatal stages. Ineffective monitoring of foetal growth and a lack of effort or reluctance to perform Caesarean sections (BBC, 2022b; BBC, 2022a). This led to issue of brain damage and neurological injuries which could otherwise be avoided. The second question deep down to one more layer and tends to identify the reason behind ineffective care process. It happened due to lack of skilled staffs and healthcare professionals not taking accountability of the care given or making it a necessary to ensure sound health of newborn and their mothers (Ockenden Report, 2022). Lack of accountability from healthcare staffs happened due to ineffective governance and healthcare leaders at SaTH not setting the right organisational culture.

The third question tend to identify the reason behind lack of skilled healthcare staffs. Healthcare professionals are not governed by a strict governance team, and it led to getting diverged from providing patient-centric care (Ockenden Report, 2022). Not having the required medical/healthcare infrastructure facilities to provide adequate care led to less accountability, as the needs are also not listened to. It led to less willingness to opt for safer option of doing Caesarean section and hence, the avoidable risks to health of newborns babies are not avoided. It led to complications after birth and lack of skills to manage them resulted in deaths of new born babies.

The question has helped in understanding the reason of inadequate staffing and not having proper governance policies. Inadequate staffing happened due to a lack of funds, and a lack of governance policies also happened due to inefficient administration. Inefficient governance policies such as not listening to family members of patient or patient themselves of whether they want to do Caesarean section has led to avoidance of providing holistic care. Lack of funds also led to not having proper healthcare infrastructure required for providing maternity care (Ockenden Report, 2022). The main reason of inadequate staffing and lack of funds for arranging training sessions or healthcare infrastructure at SaTH to do Caesarean sections is due to not having equity-based funding. Not having equity-based funding policies of NHS Trust and also lack of effective leadership at the top led to ineffective man management. Furthermore, not been able to set culture of providing patient-centric care giving process at maternity ward of SaTH (Webber, 2022; Barcan Kirby, 2022)

The Donabedian Model

The Donabedian Model is considered as a conceptual framework developed for evaluating quality of medical care (Tossaint-Schoenmakers *et al.*, 2021). Health systems are assessed based on three linked categories- structure, process and outcomes. The model is applied for SaTH in following manner:

Structure	• Lack of funding has led to a smaller number of staff, which has deteriorated the quality of care given to would-be mothers or during neonatal stages (Ockenden Report, 2022; Badshah, 2022)
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	• Inefficient training programs led to a lack of skill sets in providing adequate quality of care required at the maternity ward • Lack of proper governance structure and monitoring process made junior staff take less accountability (BBC, 2020) • Flawed structure in providing healthcare services to would-be mothers as a patient-centric process was not followed (Badshah. 2022) • More emphasis or bias towards natural, vaginal births at any clinical cost than doing Caesarean sections • Toxic workplace culture led to a lack of growth-oriented mindset, and management did not take any corrective actions (BBC, 2020) • Normalisation of acceptance of substandard care that led to organisational abuse in the long run
Process	• Aversion to Caesarean sections, as the trust believed in maintaining abnormally low caesarean rates. It led to discouragement of surgical interventions even if it was clinically necessary. This caused to direct contribution to preventable intrapartum deaths and stillbirths (BBC, 2022a) • Failure of staff to monitor fetal heart rates during labour and it caused a lack of clear warnings of fetal growth restriction or maternal distress • Poor management of complications due to a lack of skilled staff led to high-risk conditions such as pre-eclampsia, as well as abnormal placenta presentations, being ignored (BBC, 2022a; Ockenden Report, 2022) • Critical errors occurred during physical resuscitation and stabilisation of newborns on an instant basis following delivery

	• Lack of process of doing investigation and also engaging in blaming families rather than taking corrective actions (Ockenden Report, 2022)
Outcomes	• Outcomes were severe as it resulted in catastrophic failures and caused deaths of almost 200 babies, nine mothers and also left infants with life changing injuries • 201 babies could have survived if SaTH provided better care related to 131 cases of babies who were still born and another 70 neonatal cases of deaths (BBC, 2022a) • There were 29 cases where babies were born with severe brain injuries as well as another 65 incidents of cerebral palsy • In between 2011-2019, 40% of still births and 435 of neonatal deaths did not undergo any investigation (BBC, 2022a)

Table 1: Application of the Donabedian Model

(Source: Created by Author)

2.2 Strategic Planning through application of SWOT analytical tool

Strengths	Weaknesses
• Operates through two main general hospital sites and ensures wide geographic coverage in terms of providing healthcare services (Jobs SaTH, 2026) • Delivers essential acute provisions, which include 24/7 accident and emergency as well as critical care services • Specialises in children's and women's services	• Lack of patient-centric care giving approaches as family members and would-be mothers' pain points are not listened • Lack of skilled healthcare professionals (HCPs) and staffs in maternity care unit (BBC, 2022a) • Lack of funds leading to inadequate infrastructure and low number of staffs causing high workload on remaining HCPs. It leads to deterioration of care giving process

• Large workforce of 7,000 to 8,000 staff (Shropshire Telford and Wrekin, 2026) • Teaching hospital status through having a partnership with medical schools and universities (The NHS Alliance, 2026) • Formal alliance and group structure with Shropshire Community Health NHS Trust for boosting organisational resilience as well as improving care pathways	(Devon Shires Claims, 2026; Murray, 2021) • Large number of staffs are present, however, no governance policies or training programs causing them to have less accountability as well as gap in care giving process
Threats • Threat of receiving backlash from the public due to two decade long catastrophic failing of providing required maternity care (BBC, 2022a) • Police inquiries were launched to determine the reasons for negligence that led to manslaughter for so many years • Clinical negligence claims amounting to multi-million pounds and further threat of facing such allegations in future if the maternity ward care services are not improved (Ockenden Report, 2022) • Regulatory sanctions by the General Medical Council (GMC) over	Opportunities • Opportunity to improve the skill set of staff through continuous training so that maternity care services can be improved • Gain funds and improve healthcare infrastructure so that avoidable harms can be prevented from happening, thereby making newborns go through the neonatal stage safely • Opportunity to have more maternity care wards developed to have caesarean sections if clinical complications make it important to be done • Improve the workplace environment and apply situational leadership skills to ensure that proper governance policies are in place, thereby

failures of staff members to report poor care-giving norms • It threatened individual medical licenses if found guilty and can cause suspensions or striking off professional registers	monitoring the performance of staff with a 360-degree view • Increase staff numbers in the hospital units as per requirement and address pain points of staff by nullifying cases of workplace bullying
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Table 2: SWOT Analysis

(Source: Created by Author)

2.3 Evidence from previous research works and real-world examples

Flawed care-giving policies and chronic understaffing has led to inefficient care services along with giving rise to a toxic blame culture. It happened due to lack of willingness to take accountability of providing safe care services and resulted in development of toxic blame culture in NHS maternity wards. Empirical evidence showed that it has resulted in preventable stillbirths and also caused neonatal brain injuries as well as maternal deaths. Examples similar to that of SaTH where mothers and newborn babies have suffered from avoidable harm due to inefficient quality of care. The Nottingham Review as per Ockenden Report, 2026 reviewed 2,500 families at Nottingham University Hospitals NHS trust and it was identified that 520 mothers and babies suffered avoidable harm (Osbornes Law, 2026). It includes 162 deaths out of which 94 are stillborn, 62 are neonatal deaths and 6 cases of maternal deaths (Osbornes Law, 2026). Similar, to SaTH, there were dysfunctional unit cultures and poor risk assessments done that led to deaths of 1 mother and 11 babies at Furness General Hospital which can be otherwise avoided if timely care was given (Murray, 2021).

Policies are not made adequately that reviews the staffing requirements in maternity wards and also no provision for continuous skill or expertise development has led to gap in getting quality care services from NHS run hospitals (Matneoinv, 2026). There were also communication issues as national data showed that 27% of the obstetrics and gynaecology trainees feel hesitant to escalate the serious patient safety concerns to senior supervisors. It leads to delay in giving required care services. There have happened operational slacks in case of SaTH and other NHS Trust led maternity care giving process as emergency complications are left unattended properly due to staffing issues. Haemorrhages and surgical site deteriorations has led to

misidentified or delayed treatment leading to fatal incidents which could otherwise be addressed (Npeu, 2025; Matneoinv, 2026). On overall basis, there has been lack of board-level oversight and weak governance structures that gives rise to bullying work culture (Health–Europe, 2025). In such work culture, junior HCPs and staffs are made to work for longer durations that led to fatigue as well as frustration in providing required care (Open Access Government, 2026).

Empirical reports suggested that the slow organisational learning has made staff feeling ignored or dismissed during escalated clinical risks. It happened due to lack of transformational leadership within healthcare units such as that of SaTH as staffs are not taken through intellectual stimulations to improve care giving process during critical scenarios of prenatal or neonatal care (Timothy, Lloyd and Bradshaw, 2025; BBC, 2022a). It has led to less accountability and also gave rise to blame culture on each other as well as on parents. Care Quality Commission (CQC) Ratings were poor for almost half of NHS maternity units that included SaTH also as it required more strict governance so that staffs take accountability and develop their expertise level to provide maternity care in crisis situations (Care Quality Commission, 2024; Care Quality Commission, 2025). More reluctance towards Caesarean section has happened due to chronic underfunding in dedicated obstetric theatres and also not having specialised triage staffs or 24/7 consultant-led labour ward coverage (Dixon-Woods, 2022; BBC, 2022a). Hierarchical divided in between midwives and obstetricians led to creation of them and us division that led to discouragement for staffs from raising safety concerns (Picken and Summers, 2025). It might have happened within SaTH also giving rise to blame culture and lack of accountability. Situational leadership attributes were lacking as enough monitoring was not done to know pain points of staffs and also funding deficits has led to poor healthcare infrastructure required for efficient maternity ward care services.

3. Recommendation

Plan	• There is a need to identify the total number of staffs required to ensure that the understaffing issue is nullified in maternity wards of SaTH. Accordingly, the NHS Trust needs to be pitched to recruit staffs and also develop training programs so that skill sets can be improved. It will help in taking necessary steps during emergency cases or clinical complications (BBC, 2020; BBC, 2022b) • Need to identify the healthcare infrastructure and training required so that preventable harm such as cerebral palsy, skull fractures, or brain damage can be prevented for newborns • Pitch for the need of fund to develop operation theatres and have the required facilities at SaTH so that more caesarean sections can be done to ensure clinical complications are avoided
Do	• Provide the required training programs to existing staff and also recruit more skilled healthcare professionals, as well as a 24/7 consultant required for effective labour support/process • Ensure that there is prevalence of transformational and situational leadership along with development of proper governance policies • Ensure that through transformational leadership equal opportunities for skill development are given to all staff, as well as encourage them to report issues faced during providing care in maternity wards related to lack of healthcare infrastructure or bullying from seniors (Brown-Deveaux <i>et al.</i>, 2022; Picken and Summers, 2025) • Situational leadership will be required in providing training and also in identifying the reasons for gaps in providing standard quality services • Need to establish governance policies and implement them by appointing a team looking after performance of HCPs, staff allocated in each shift • Governance policies need to be in place so that there is maintenance of clear communication with family members of would-be mothers and the would-be mothers (Andrzejczak, Jones and Nye, 2024)

	• There is a need to set protocols in which clinical complications will be discussed, followed by listening to the wishes of the family regarding doing a caesarean section or not, and then following the step that is necessary • Setting governance policies for continuous monitoring of the care-giving process so that any gaps identified can be given feedback by the senior HCPs working at SaTH
Check	• After implementation of the new governance policies and way of providing care at maternity ward, there is need of checking whether a smooth workflow is maintained or not • Feedback needs to be taken from the HCPs, nurses, staffs, midwiferies and obstetricians to understand whether they are given equal opportunities to develop skills as well as are not bestowed with inhumane work pressure (Peter <i>et al.</i>, 2026) • Check for the quality gap in care giving process by discussing the care received by the would-be mother and giving feedback to improve upon those reported complaints on immediate basis (BBC, 2022a) • Development of the operation theatres for doing caesarean section in phased manner and check whether the standard healthcare equipment is provided or not
Act	• SaTH need to act upon the set governance policies and assure that patient-centric care services are taken at every stage • Need to discuss the clinical complications and know the wish of the family members before taking any further steps • Always monitor the health condition in the prenatal and neonatal stage along with continuous development of healthcare infrastructure so that quality care can be given

Table 3: PDCA Cycle

(Source: Created by Author)



Figure 6: PDCA Cycle

(Source: Rittberger and Schneider, 2018)

The change process within SaTH to have better maternity ward care services can be implemented following Kotter's 8-Step change model in following manner:

Kotter's 8-Step change



Step 1- Creating Urgency- There is need of creating an urgency by the leadership group of SaTH. It can be done through issuing an announcement through governing NHS Trust Board members and calling for senior healthcare professionals, nurses, staffs to reflect on the maternity ward healthcare service providing issue as well as discuss solutions. Threats on cancellation of individual practice license can be shown as a reason of urgency and also to improve upon the maternity care services provided (BBC, 2022b)



Step 2- Building a Coalition- A coalition can be formed by involving the senior healthcare professionals, representative of nurse and midwifery department along with one representative of obstetricians. It will help in understanding the issues faced in providing quality care services in the maternity units and solutions can be brainstormed accordingly (Mistry, *et al.*, 2025)



Step 3- Creating a Vision- There can be creation of vision such as to have zero cases of child and maternal deaths along with improving the healthcare infrastructure within the maternity ward to ensure clinical complications can be addressed effectively.



Step 4- Communicating the Vision- The vision is required to be communicated through the entire team of healthcare staffs and can be done by informing about its importance to the coalition team formed. Any queries can be resolved on 1:1 basis.



Step 5- Empowering Others- There is need of empowering the obstetricians, nurses and midwiferies, healthcare professionals to speak up and report cases of negligence they observe instantly so that avoidable harms can be prevented from happening (Lakasing, 2025). There is also need of encouraging the healthcare unit to engage in skill and knowledge development practice on continuous basis so that best care services can be given (Dixon-Woods, 2022)



Step 6- Creating Quick Wins- Need to create quick wins by setting manageable milestones as it helps in encouraging the staffs to work with more effort. In this case, the quick wins can be that of having development of new operation theatres to execute caesarean sections and to have all clinical complications addressed with zero complaints from family of patients.



Step 7- Building on the Change- There is need of building upon the change process of working and have monthly review meetings as well as upgradation of the healthcare infrastructure as per requirement through having equity-based funding from NHS Trust. Need to make the staffs grow in terms of experience and skills by organising training provisions on mandatory basis (Lakasing, 2025)



Step 8- Embedding the Change- Need to embed in the change process of working and normalise it through ensuring that right governance policies are in place (Lakasing, 2025). 360-degree feedback and reviewing process will make the staffs to automatically work according to the patient-centric manner and take complete responsibilities of providing quality care in the maternity units of SaTH.

Figure 7: Kotter's 8-Step Model

(Source: Created by Author)

4. Conclusion

From the study done, it can be concluded that within SaTH, there has been issue with providing quality maternity care services that has resulted in over 200 cases of deaths of children (newborns) in neonatal stage and mothers. It needs to be improved through having proper governance policies and ensure that toxic work culture is nullified that has been leading to less accountability for providing efficient maternal care services. There is need of making sure that the staff numbers are increased in maternal care service unit and for that there is need of adapting equity-based funding policies. The staffs need to be upskilled and also healthcare infrastructure need to be developed so that more caesarean sections can be done and patient-centric care services are provided. It will help in decreasing the clinical complications and will nullify the risk of newborns facing fatal ends.

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