

Systemic Failures in Maternity Quality Assurance

A Critical Analysis of the Shrewsbury and Telford NHS Scandal

Component 1

Individual Presentation

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CONTENTS

- 1.Introduction
- 2.Background
- 3.Problem Statement
- 4.Root Cause Analysis
- 5.Swiss Cheese Model
- 6.Fishbone Diagram
- 7.Donabedian Model
- 8.Systems Theory
- 9.Leadership and Organisational Culture in Healthcare
- 10.Applying Transformational Leadership to Improve Maternity Care
- 11.Workforce Change and Impact (Lewin's Change Model)
- 12.PDSA Cycle
- 13.Barriers to Change
- 14.Kotter's Change Model
- 15.Recommendations
- 16.Conclusion
- 17.References

1. Introduction

The Shrewsbury and Telford maternity scandal represents one of the most significant systemic failures in NHS maternity care, resulting in avoidable deaths and serious harm (Ockenden, 2022).

The case exposed critical weaknesses in patient safety, governance, organisational culture, and accountability (Francis, 2013; Ockenden, 2022).

Failures persisted over several years without effective intervention, highlighting major gaps in oversight and learning systems (Ockenden, 2022).

This demonstrates the importance of robust quality assurance frameworks and continuous improvement in healthcare systems (Donabedian, 1988; Institute of Medicine, 2001).

Key Impact Statistics - 201 avoidable baby deaths
9 maternal deaths
1,486 families affected
Many cases were not investigated (Ockenden, 2022)

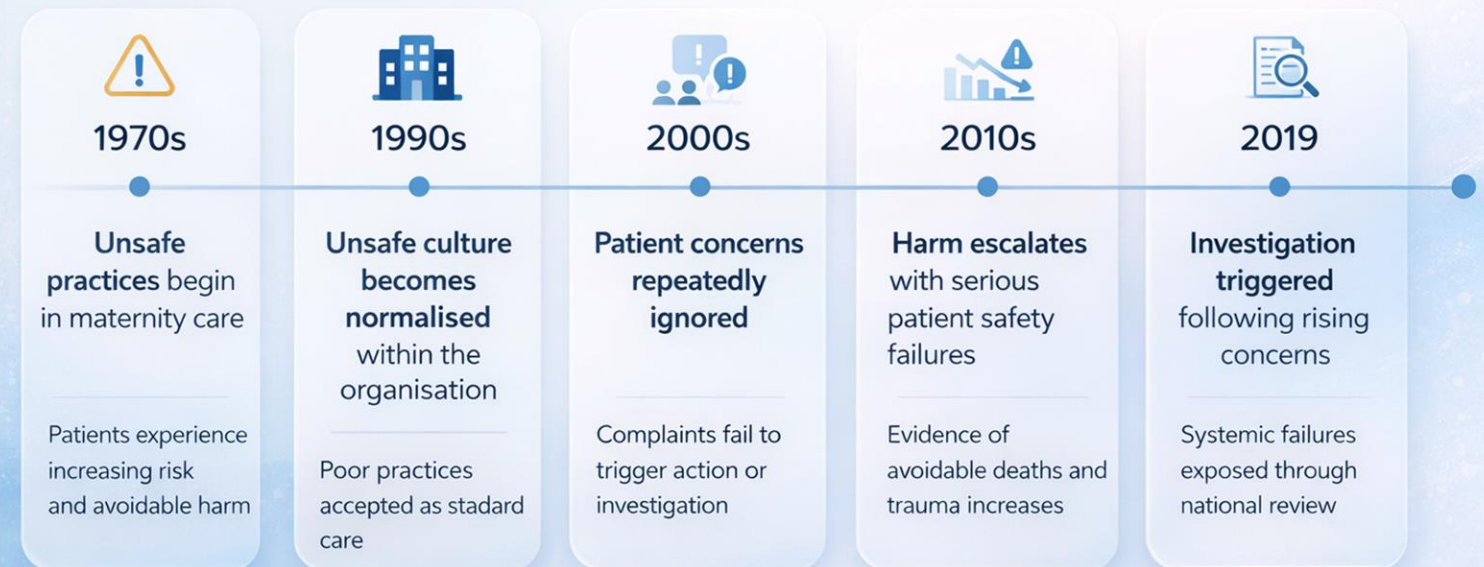
This presentation critically analyses these systemic failures using theoretical models and proposes evidence-based strategies for service improvement.



2. Background

- Failures occurred over several decades (1970s–2019) (Ockenden, 2022)
- Unsafe maternity practices became normalised within the organisation
- Women and families were frequently ignored when raising concerns (CQC, 2019)
- A “normal birth” approach was prioritised over clinical safety (Ockenden, 2022)
- Multiple opportunities for intervention were repeatedly missed (Francis, 2013; NHS Resolution, 2022)

Timeline of Systemic Failure in Maternity Services



(Ockenden, 2022; Francis, 2013; CQC, 2019)

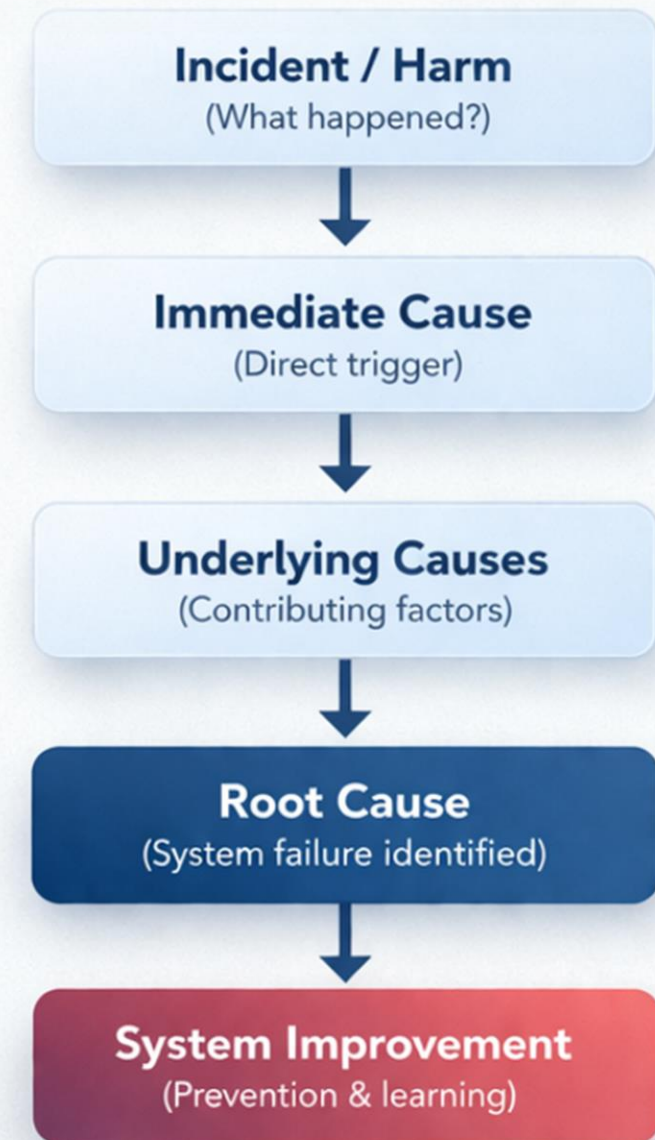
3. Problem Statement

- The core issue was a **systemic failure of quality assurance** (Ockenden, 2022)
- Governance and board oversight were ineffective (Francis, 2013)
- Incident reporting and learning systems failed (Vincent, 2010)
- Organisational culture discouraged openness and accountability (Mannion and Davies, 2018)
- These failures resulted in **avoidable harm and loss of life** (Ockenden, 2022)



4. Root Cause Analysis

- Root Cause Analysis (RCA) identifies **underlying system failures** (Reason, 2000)
- Healthcare harm results from **multiple interacting factors** (Carayon et al., 2014)
- Focus is on **systems rather than individual blame** (Ockenden, 2022)
- RCA supports **learning, prevention, and service improvement** (Vincent, 2010)



This demonstrates that failures were systemic rather than individual errors.(Reason, 2000; Vincent, 2010; Carayon et al., 2014)

5. Swiss Cheese Model

- The Swiss Cheese Model explains how harm occurs when multiple system defences fail (Reason, 2000)
- Each layer of defence contains weaknesses or “holes”
- Harm occurs when these weaknesses align across multiple system levels
- In the Shrewsbury and Telford case, failures occurred across governance, staffing, communication, and clinical practice (Ockenden, 2022)
- This demonstrates cumulative system failure rather than isolated error (Vincent, 2010)



This demonstrates how multiple system failures aligned to cause harm.

6. Fishbone Diagram (Root Cause Analysis)

The Fishbone (Ishikawa) diagram categorises root causes of system failure across key domains (Ishikawa, 1986).

People

- Weak leadership and fear culture (Ockenden, 2022)

Process

- Poor investigation and escalation systems (Ockenden, 2022)

Policy

- Failure to implement national guidance (Francis, 2013)

Environment

- Organisational pressure and defensive culture (Mannion and Davies, 2018)

Communication & Staffing

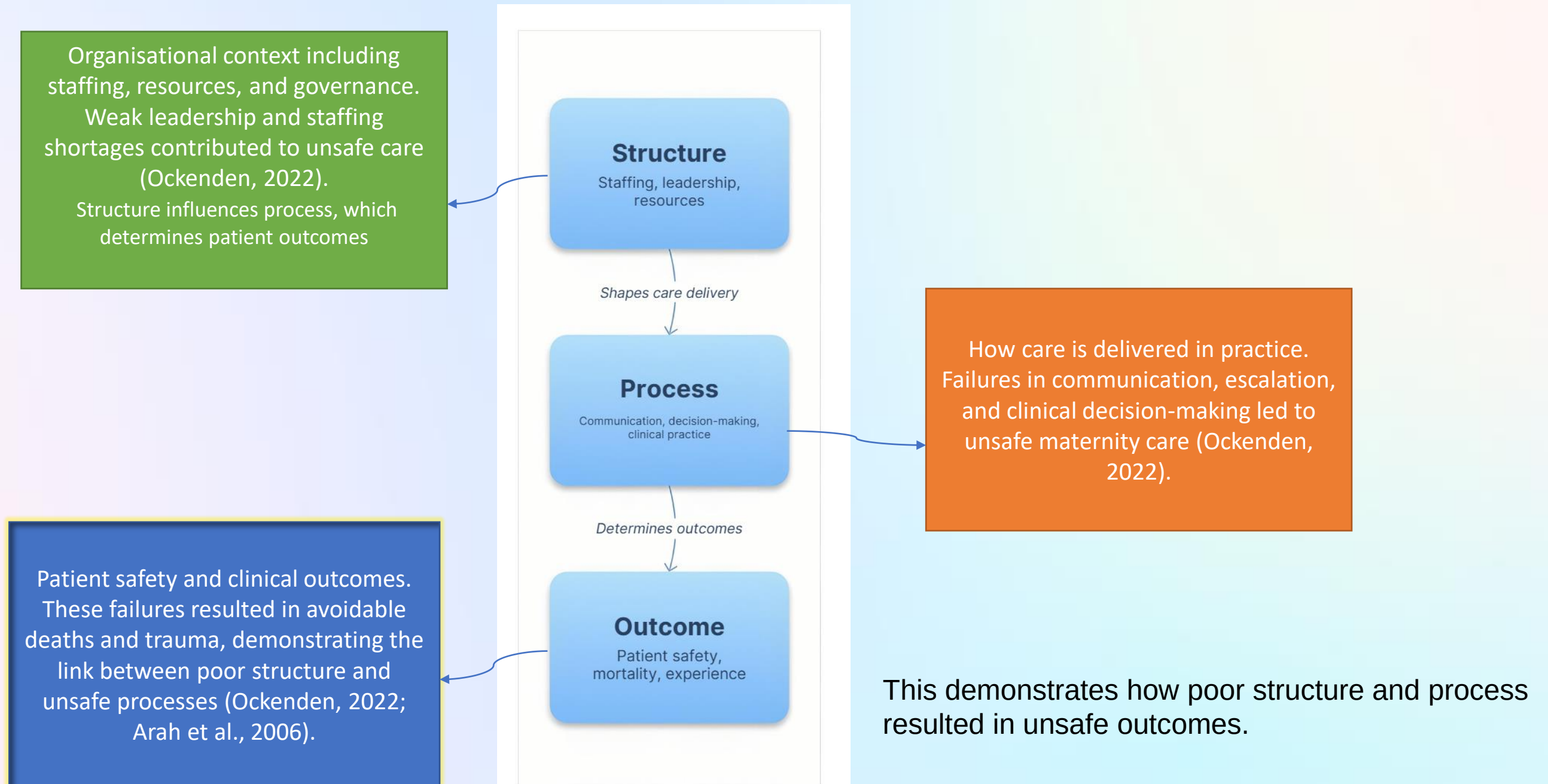
- Poor communication and workforce shortages (NHS England, 2019)



This highlights how multiple organisational factors contributed to system failure. (Ishikawa, 1986; Ockenden, 2022; NHS England, 2019)

7. Donabedian Model

The Donabedian Model evaluates healthcare quality through three interrelated components: structure, process, and outcome (Donabedian, 1988).

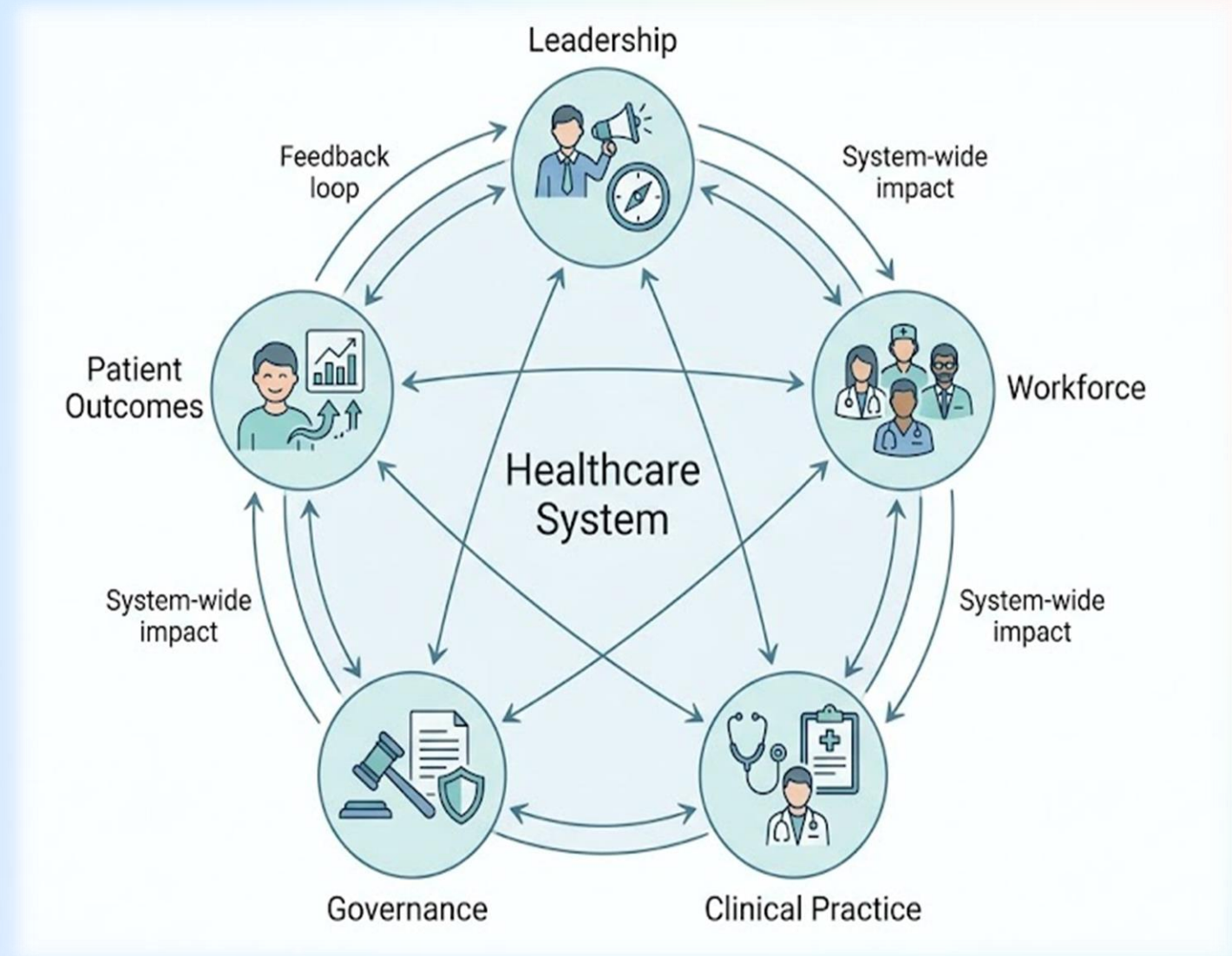


8. Systems Theory

Systems Theory views healthcare as a complex, interconnected system where changes in one area affect the whole (Senge, 1990; Von Bertalanffy, 1968).

Failures in maternity care were not isolated but influenced multiple system components. The organisation failed to respond to feedback and early warning signs (Ockenden, 2022).

Effective improvement therefore requires coordinated, whole-system change rather than isolated interventions (Weick and Sutcliffe, 2007).



This highlights the interconnected nature of healthcare system failures.(Senge, 1990; Von Bertalanffy, 1968; Weick and Sutcliffe, 2007; Ockenden, 2022)

9. Leadership and Organisational Culture in Healthcare

Leadership

- Transformational Leadership promotes cultural change, staff engagement, and psychological safety (West et al., 2014; West et al., 2017)

Culture

- Encourages openness, speaking up, and learning from errors, contrasting with the blame culture identified in the Shrewsbury and Telford maternity scandal (Ockenden, 2022)

Behaviour

- Improves teamwork, communication, and staff empowerment, which are essential for safe care delivery

Safety Outcomes

- Leaders must drive system-wide learning and continuous improvement



This demonstrates how leadership influences culture and patient safety outcomes.(West et al., 2014; Mannion and Davies, 2018; Ockenden, 2022)

10. Applying Transformational Leadership to Improve Maternity Care

Transformational Leadership Approach

- Transformational leadership is most appropriate as the case required **cultural and behavioural change**, not only procedural correction (*West et al., 2014*)
- It promotes **shared vision, trust, openness, staff engagement, and collective accountability** (*West et al., 2014*)
- This is critical in environments where **fear, silence, and defensive culture** are normalised (*Francis, 2013; Ockenden, 2022*)
- Transactional leadership may improve **short-term compliance**, but is less effective in addressing **deep cultural failures** (*West et al., 2014*)
- Therefore, transformational leadership supports **speaking-up culture, organisational learning, and safer maternity care** (*West et al., 2014; Ockenden, 2022*)



This highlights the importance of leadership in driving cultural and system change.

11. Workforce Change & Impact (Lewin's Change Model)

Lewin's Change Model explains how organisations implement sustainable change (Lewin, 1947; Burnes, 2004)

Lewin's Model

Unfreeze:

Recognition of unsafe maternity practices and a system failure (Ockenden, 2022)

Change:

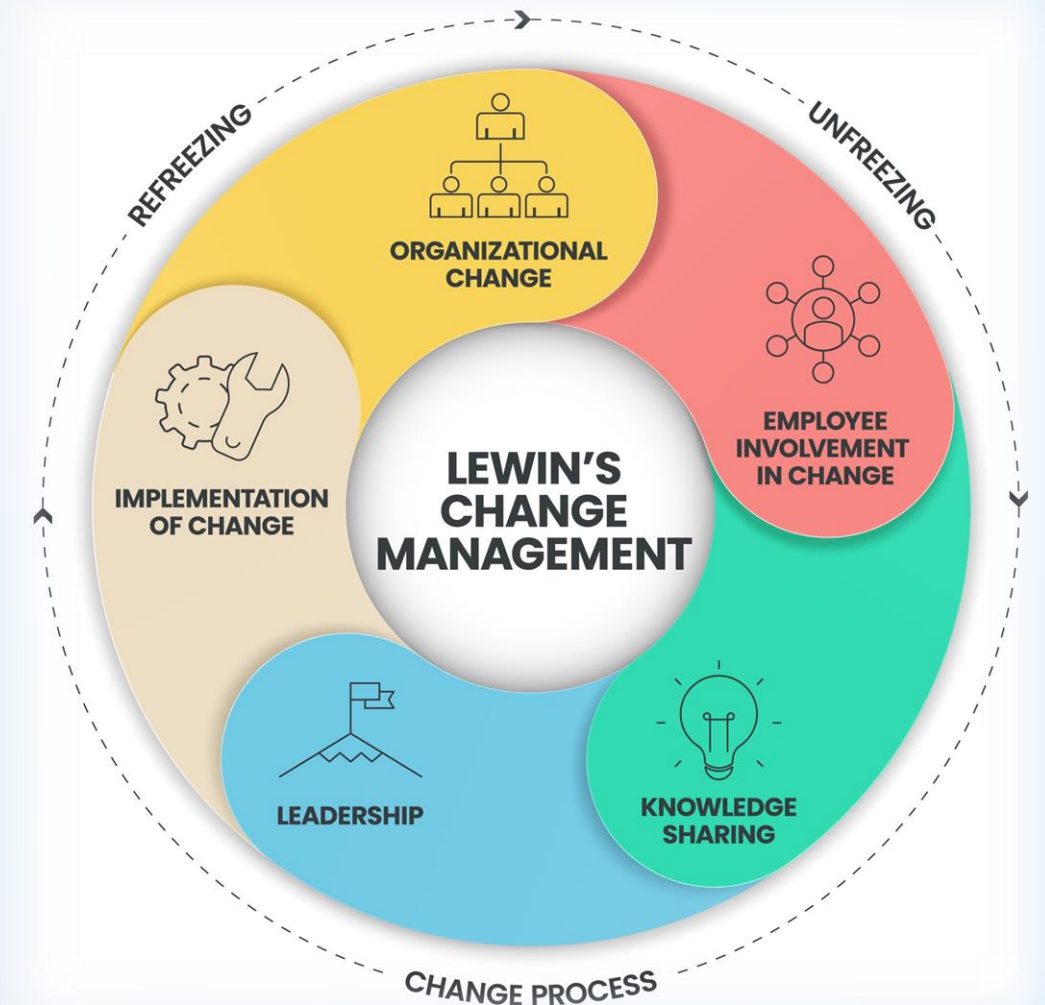
Implementation of safer systems, improved communication, and governance reform

Refreeze:

Embedding improvements in routine practice and organisational culture (Burnes, 2004)

Impact on Workforce & Services

- Avoidable deaths and trauma occurred due to delayed change (Ockenden, 2022)
- Loss of trust in maternity services (WHO, 2020)
- Staff morale, confidence, and psychological safety were negatively affected (Mannion and Davies, 2018)



(Lewin, 1947; Burnes, 2004; Ockenden, 2022; WHO, 2020)

12. PDSA Cycle

Plan–Do–Study–Act supports continuous improvement (Deming, 1986; Langley et al., 2009).

Strengths:

Iterative and evidence-based (NHS England, 2019).

Limitations:

May be ineffective without leadership and culture change (Reed and Card, 2016). Effective PDSA implementation requires strong leadership and organisational culture to sustain improvement

Plan: Identify problems and design evidence-based interventions

Study: analyse data and evaluate outcomes

Do: implement changes and collect data

Act: refine, standardise, and implement improvements



This demonstrates the importance of continuous improvement in healthcare systems.(Deming, 1986; Langley et al., 2009; NHS England, 2019; Reed and Card, 2016)

13. Barriers to Change

Barriers to Change in Healthcare

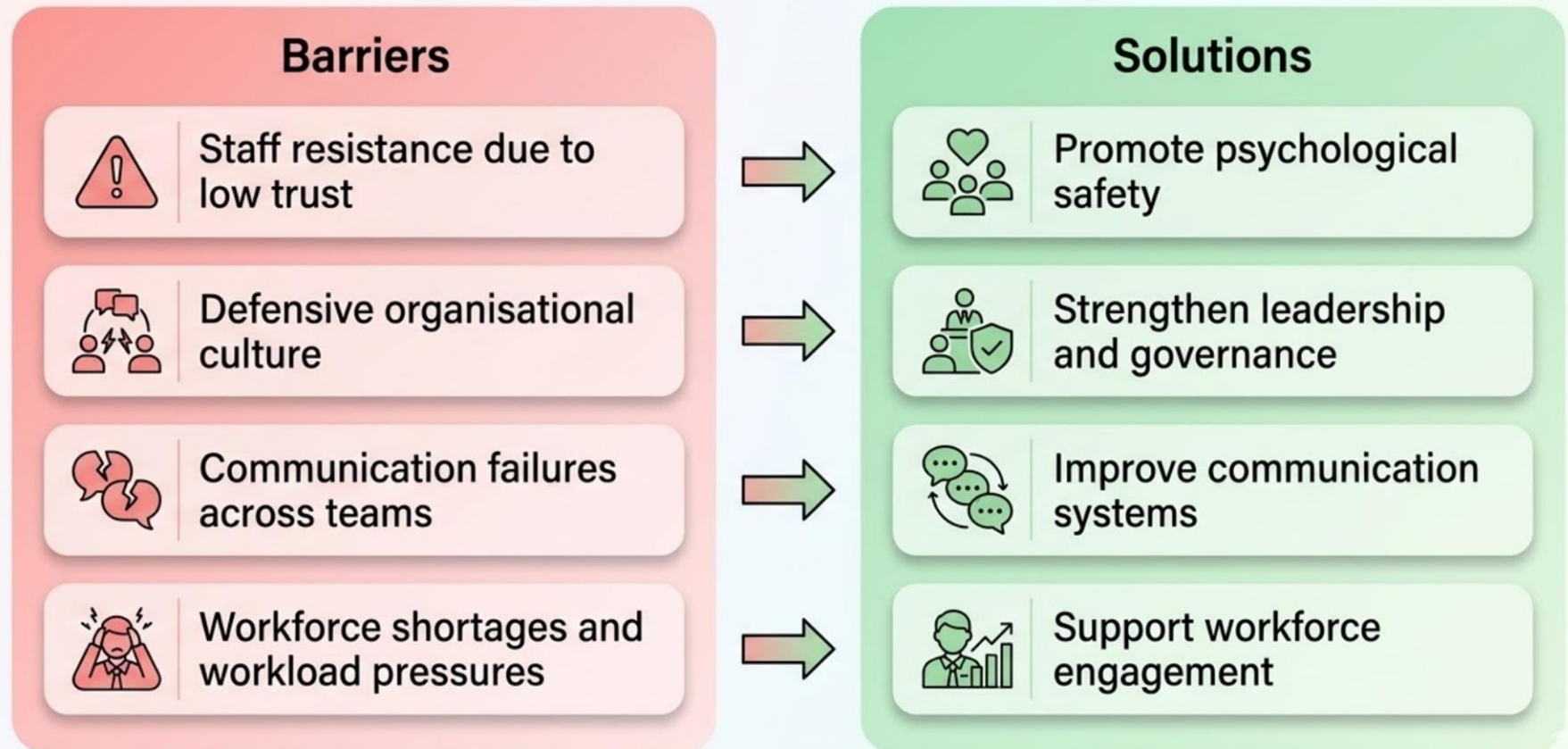
Barriers to change in healthcare systems often arise from organisational culture, workforce challenges, and communication failures.

Low levels of trust contribute to staff resistance, while defensive cultures discourage openness and learning (Mannion and Davies, 2018).

In addition, poor communication across teams and staffing shortages create significant pressure, reducing the ability to implement safe and effective care (NHS England, 2019; Ockenden, 2022).

Addressing these barriers requires strong leadership, psychological safety, and system-wide engagement to support sustainable improvement (Kotter, 1996).

Barriers to Change in Healthcare



(Mannion and Davies, 2018; NHS England, 2019; Ockenden, 2022; Kotter, 1996)

14. Kotter Model

Kotter's model supports implementation (Kotter, 1996):

Kotter's 8-Step Model provides a structured approach to implementing sustainable organisational change (Kotter, 1996). The model emphasises leadership, clear vision, and staff engagement as key drivers of successful change. In the context of maternity care failures, the absence of urgency, weak leadership, and poor communication limited effective implementation of improvements (Ockenden, 2022). Applying Kotter's model supports cultural transformation, staff empowerment, and long-term sustainability of patient safety improvements.

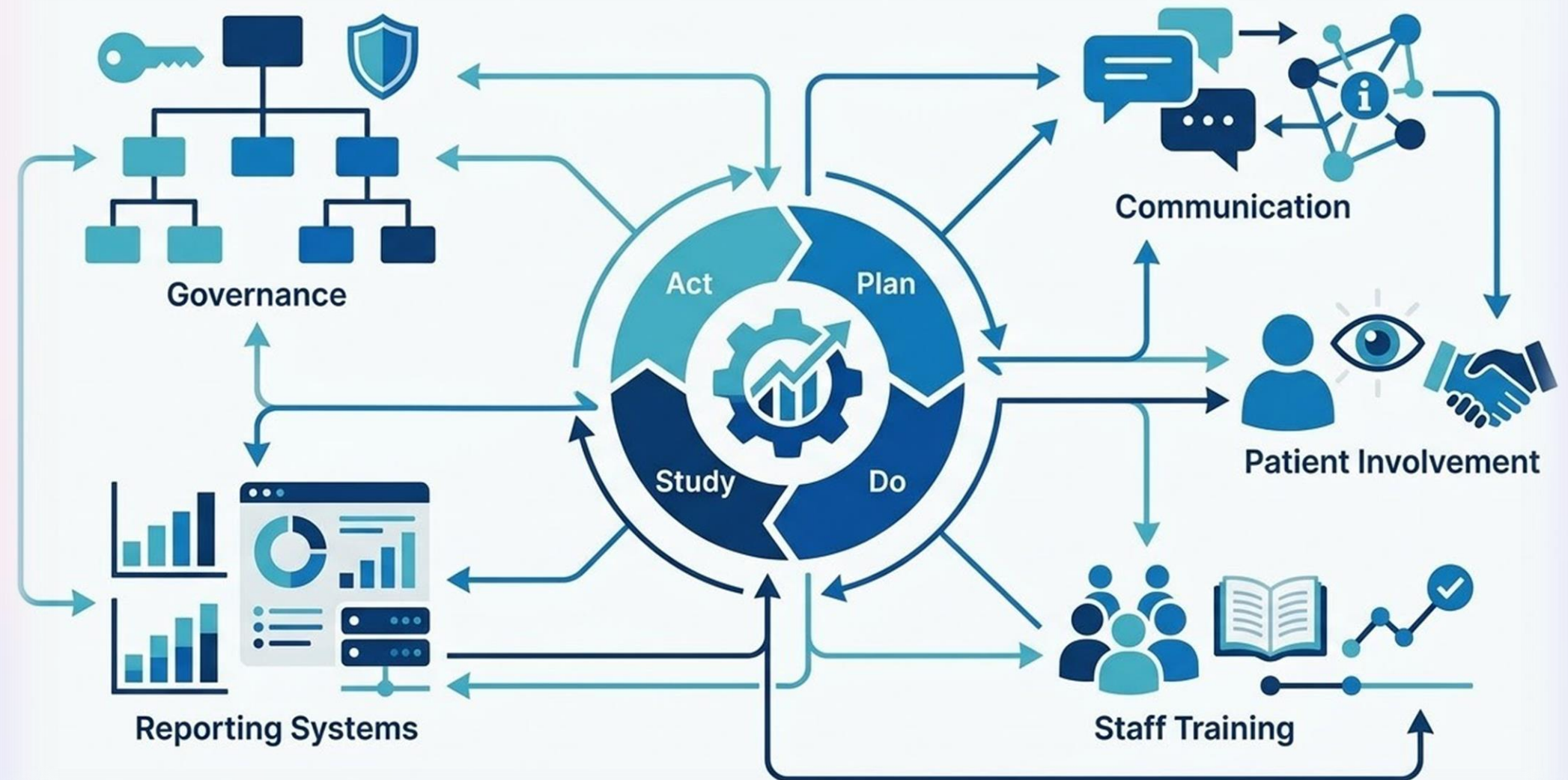


This demonstrates how structured change management supports sustainable improvement.(Kotter, 1996; Ockenden, 2022)

15. Recommendations for Improving Maternity Care Quality

Key Recommendations

- Strengthen governance and accountability systems
(Francis, 2013)
- Enhance incident reporting and learning systems
(Vincent, 2010)
- Implement continuous audit and PDSA cycles
(Langley et al., 2009)
- Improve staff training and multidisciplinary collaboration
(NHS England, 2019)
- Embed Duty of Candour and open communication
(CQC, 2015)
- Involve families in safety monitoring and feedback
(Ockenden, 2022)



16. Conclusion

- The Shrewsbury and Telford scandal represents a **systemic failure of quality assurance** (*Ockenden, 2022*)
- Failures in **governance, leadership, and organisational culture** led to avoidable harm (*Francis, 2013*)
- Theoretical frameworks, including the **Swiss Cheese Model** and **Donabedian Model**, explain how these failures occurred (*Reason, 2000; Donabedian, 1988*)
- Effective improvement requires **integrated systems, strong leadership, and a learning culture** (*WHO, 2020*)
- Sustained patient safety depends on **continuous improvement, transparency, and accountability**
- (*Ockenden, 2022; Francis, 2013; Reason, 2000; Donabedian, 1988; WHO, 2020*)

“Learning from failure is essential to ensuring safer maternity care for future generations.”



17. References

Image Credits

- All diagrams (Swiss Cheese Model, Fishbone Diagram, Donabedian Model, Systems Theory, Lewin Model, PDSA Cycle, Kotter Model) were **adapted and designed by the author using Microsoft PowerPoint, Adobe Photoshop and Canva design tools.**
- Conceptual models are based on published frameworks including Reason (2000), Donabedian (1988), Lewin (1947), and Kotter (1996)

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Thank You