



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

Systemic Failure in Maternity Care

A Service Improvement Report on the Shrewsbury and Telford Hospital
NHS Trust Maternity Failure

Presented by: Md Shamim Osman

Student number: 2503961

Module: LCHS7006, Quality Assurance and Service Improvements

Lecturers: Dilhara Mampitiya and Christopher Mafuva

Assignment: Component 2, Service Improvement Report

Table Of Contents

Table of Contents

1. Introduction-----	3
2. Root Cause Analysis and Application of Theory-----	5
2.1 Root Cause Analysis Using the Fishbone Diagram-----	5
2.2 The Donabedian Model, From Structure to Process to Outcome-----	7
2.3 SWOT Analysis of NHS Maternity Services-----	8
2.4 Linking Root Causes to the National Picture -----	10
3. Recommendations and Implementation Strategy-----	11
3.1 A Plan Do Study Act Approach to Reducing Escalation Failures-----	11
3.2 Reducing Waste in Incident Investigation Using Lean Thinking-----	12
3.3 Practical Implementation Steps-----	13
4. Conclusion-----	13
References-----	15

1. Introduction:

The Shrewsbury and Telford Hospital NHS Trust are an example of what can happen when warning signs are repeatedly ignored and is one of the clearest examples of what happens when safety warnings are not acted upon, leading to maternity safety failure in the NHS. In Component 1, the Ockenden review of 1486 families and 1592 incidents between 2000-2019 was introduced, and it was found that potentially 201 babies and nine mothers could or would have survived with better care at the trust (Ockenden, 2022; Shrewsbury and Telford Hospital NHS Trust, 2022). In this essay, we shall investigate this and analyse the case as part of a more general fault than one individual incident specific to the Shrewsbury and Telford Hospital NHS Trust but reflecting structural problems across the NHS, making it a matter of quality instead.

Another review supports these findings. East Kent Hospitals University NHS Foundation Trust had their cases from 2009 to 2020 reviewed by Kirkup (2022), and she included 202 cases between these 11 years. They found that out of 65 baby deaths examined, if national standard care was applied, 45 of these babies might have had their outcome altered. The review in discussion was conducted on fewer people, as we can see with Figure 1 showing smaller numbers for East Kent; nonetheless, a severe amount of avoidable damage was found again in East Kent, with only around half of the examined cases in which better care could have aided changes to the outcome (Kirkup, 2022). Both these reviews, only months apart, were found to have similar reasons for the tragedies - a bullying tribunal staff culture which left out the family from being involved in cases, not to mention a slow-to-act management that failed to react to continuous warnings that were given.

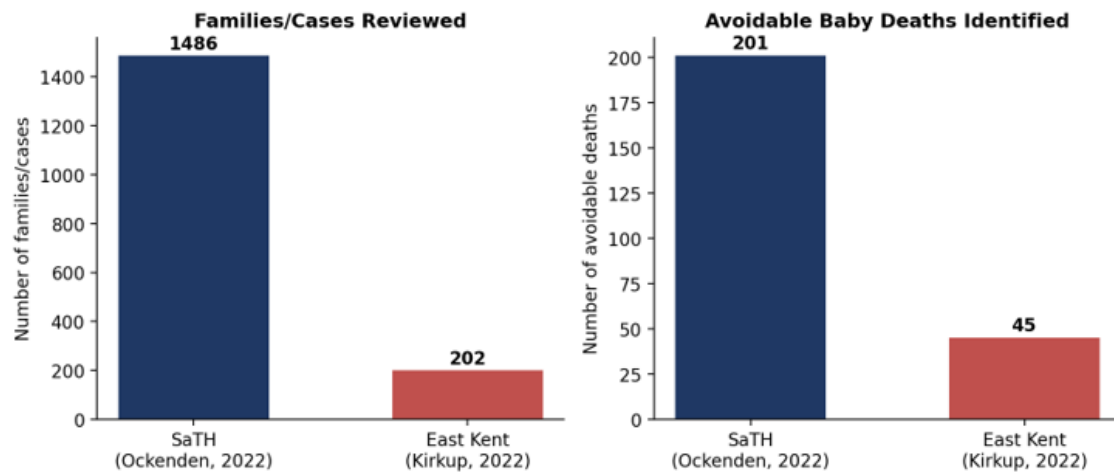


Figure 1. Comparison of families/cases reviewed and avoidable baby deaths identified at SaTH and East Kent (Ockenden, 2022; Kirkup, 2022)

The report now references both SaTH and East Kent throughout, not in replacement of other similar trusts but with the purpose of demonstrating that this type of failure may be systemic, not one-off. It is an important perspective shift where previously (component 1) SaTH has been considered largely to be a one off failure of an organization whose case report was provided, yet now it is becoming clear that cases with a similar set of roots are occurring in organizations with different staffing, management structures which point clearly to gaps in national management/manpower initiatives/workforce development and patient safety culture within the UK system than purely some failure of local Trusts.

This seems to be part of a bigger picture. Of the 131 maternity locations which the CQC (2024) (Care Quality Commission (2024)) have reviewed between 2022 and 2024, only 4% received a safety rating of outstanding and nearly half were rated as requires improvement or inadequate. The CQC have cautioned that risks may become normalised. Disparities in equity exacerbate the issue, with the CQC finding that women from an ethnic minority background and those residing in the most deprived areas are still less likely to have sought care or receive good-quality communication and their concerns continue to be dismissed. This pattern can be observed as part of the Ockenden and Kirkup findings. A mother and infant relationship that deserves the protection which safe and attentive care is expected to give is represented by the statistics in Figure 1, as Figure 2 illustrates.



Figure 2. A mother and newborn in the immediate postnatal period, reflecting the relationship that safe maternity care is intended to protect

The following pages use Fishbone diagram and the Donabedian model to explore causes of SaTH failure, and SWOT analysis is applied to investigate external and internal factors concerning the wider maternity system, where the national East Kent trust will be occasionally referred to complement the facts when the argument of the essay expands. The approaches which have been used are literature-reviewed with evidence to support all models from government reports and peer-reviewed articles. Therefore, cases of harm related to local trusts and higher government decision-making processes about national policy can be explored side by side and not just as a coincidence. Based on findings from these analyses, recommendations are then developed, using the Plan-Do-Study-Act cycle coupled with Lean thinking, on how a trust may attempt to reform its internal structure and how the board of care should supervise and manage improvement-based projects with East Kent where necessary to illustrate the slow rate of change.

Main Body:

2. Root Cause Analysis and Application of Theory:

2.1 Root Cause Analysis Using the Fishbone Diagram

The Fishbone or Ishikawa diagram sorts the contributing factors behind a quality failure into distinct categories, so that isolated incidents can be read as a recurring

pattern rather than individual error (Ishikawa, 1976; Advancing Quality Alliance, 2023). Applying this model to SaTH separates the causes of preventable harm into four groups, people, process, policy and management, shown in Table 1.

Category	Contributing factor identified at SaTH
People	Fear of escalation and a bullying, hierarchical culture among clinical staff (Wiegmann et al., 2022)
Process	Substandard investigation of serious incidents and exclusion of families from reviews (Ockenden, 2022)
Policy	Inconsistent compliance with national fetal monitoring guidance (Ockenden, 2022)
Management	Leadership culture that prioritised targets over safety and responded defensively to concerns (Association for Improvements in the Maternity Services, 2022)

Table 1. Fishbone categorisation of contributing factors at SaTH (Ishikawa, 1976)

In relation to 'people', Ockenden (2022) described a culture where some midwives and junior doctors were worried about scaling issues as consultant colleagues responded aggressively to concerns raised, rather than in a supportive manner. Multiple observers have described this as a toxic hierarchy, whereby challenging a consultant's decision took a personal-level heavy toll on junior staff (Wiegmann et al., 2022). In terms of 'process', some investigations into severe incidents did not exceed standards of a healthcare organisation (Ockenden, 2022). Families were banned from getting into reviews of their own care. For 'policy', there was a national guideline on continuous fetal monitoring during the period under review (Ockenden, 2022). It was not yet followed, causing the missed or incorrect interpretation of fetal stress signs. Under 'management', trust leadership paid more attention to meeting waiting time and cost targets than considering the concerns raised by families and staff (Association for Improvements in the Maternity Services, 2022). Complaints were dealt with through a defensive rather than curious attitude.

The weight of those failures did not fall equally on every family (2024). Minoritised women from areas with high levels of deprivation still report being treated by CQC poorly and dismissal of their worries, which brings in an issue of equity within the

category of people that would not be recognised in other narratives examining this particular catastrophe.

One disadvantage of the Fishbone approach is that, as it relies on pre-selected categories, it can lead investigators into trying to fit evidence into boxes rather than exploring alternative, less obvious reasons for failures in care (Anderson, 2016). On its own, it does not explain why the same failings went uncorrected for so many years, for which reason it has been used here in conjunction with and not in lieu of the Donabedian model. The advantage of using both in combination is that no single box by itself is to blame for the failure: A lone, overworked midwife or one lone missed guideline or defensive manager should not lead to harm on the scale that Ockenden described. It was the combination and persistence of weaknesses in all four areas which caused repeated, preventable harm (Reason, 2000).

2.2 The Donabedian Model, From Structure to Process to Outcome

Donabedian provided us with a different way of charting how weaknesses within the building blocks of a service eventually turn into harm, setting out cause-and-effect down a chain from the structure of the care to process and outcome (Donabedian, 1966, reprinted 2005; Ayanian and Markel, 2016). Figure 1 plots this chain in SaTH.

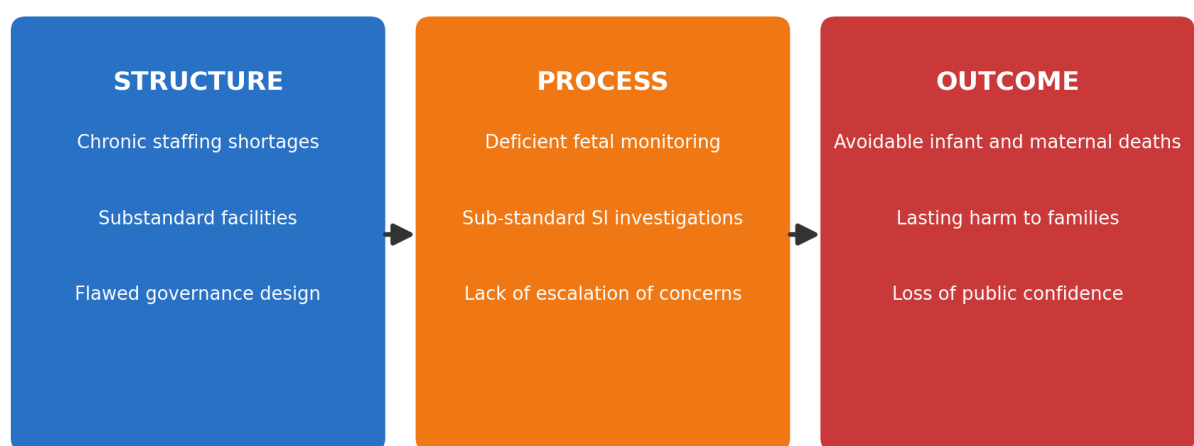


Figure 1. The Donabedian structure, process and outcome chain applied to SaTH (Donabedian, 1966, reprinted 2005)

At the top level, structurally, the trust was short-staffed, heavily relying on locum and agency staff less familiar with local protocols and had amenities as well as a

structure of governance that were not fit to support safe birthing (Ockenden, 2022). These structural issues then shaped the processes that emerged: fetal monitors were used inconsistently, serious accident investigations were of an unacceptably low quality, and staff had inadequate means by which they could have raised concerns before harm had already occurred (Ockenden, 2022). Crucially, De Rosis et al. (2024) discuss this as the manner in which the Donabedian model should in actual fact be read, as not being three measures which allow independent assessments of care but as a chain in which weak structure inevitably implies weak process, which at SaTH led to avoidable deaths in cases of birthing mothers and babies, serious injury or psychological harm that has in cases persisted years after the incidents (Ockenden, 2022).

Donabedian's own later work accepted that structure, process and outcome are not always neatly sequential, since poor outcomes can also expose hidden structural weaknesses that were not visible until harm had already happened. Similarly, what was happening at SaTH was a weakness in governance (in process) which remained uncovered until data on outcomes and the testimonials of the families of the victims were looked into (De Rosis et al., 2024). A strength of the model is that it forces attention to move upstream, to search for those structural conditions under which poor governance of process almost made it a matter of fate that there would be some adverse outcomes (Ayanian and Markel, 2016).

This kind of scrutiny can also come at a cost to staff. Plachouri et al. (2025) saw that during the OCKENDEN Review, midwives feared low morale and as such, reminded midwives that reform needs to involve supporting as well as holding health professionals to account, as a punitive culture might simply replace one of defence.

2.3 SWOT Analysis of NHS Maternity Services

Internal and external factors shaping success or failure of reform are summed up in another retrospective technique, a SWOT analysis which supplements the root cause tools. Initially a business planning exercise, SWOT is widely implemented for the purpose of pinpointing the strengths, weaknesses, possibilities and challenges which a healthcare organisation faces in preparation for the improvement of services

[Agency for Healthcare Research and Quality, no date]. NHS maternity is presented to SWOT in 2 after the Ockenden and Kirkup reviews.

Strengths	Weaknesses
Skilled and committed midwifery and obstetric workforce, and detailed independently verified evidence of what went wrong (Ockenden, 2022)	Chronic understaffing, a hierarchical culture that discourages escalation, and inconsistent application of national guidance across trusts (Care Quality Commission, 2024)
Opportunities	Threats
National Three-Year Delivery Plan, new digital monitoring tools, stronger focus on family voice, and a continued long term decline in perinatal mortality (NHS England, 2023; Draper, Gallimore and Smith, 2023)	Continued midwifery shortages, funding pressure, and inconsistent reform between trusts allowing failures to recur, as seen at East Kent (Kirkup, 2022)

Table 2. SWOT analysis of NHS maternity services following Ockenden and Kirkup

Strengths - skilled and dedicated midwifery and obstetric workforce, detailed and independently verified evidence about what went wrong to give reformers credibility to the evidence that is available (Ockenden, 2022). Weaknesses - chronic understaffing, hierarchical culture where things do not get escalated and trusts applying and not applying the same national guidance (Care Quality Commission, 2024). Opportunities - national Three-Year Delivery Plan for maternity and neonatal Services, newer devices for remote monitoring and listening to families, the fall in the perinatal mortality rate has continued to fall slowly, a long-term trend which shows that consistent national effort could be made (NHS England, 2023; Draper, Gallimore and Smith, 2023).

Threats to the continued improvement include ongoing workforce shortages faced nationwide in midwifery and funding pressure limiting their capacity to invest in staff and estate (Kirkup, 2022). Uneven distribution of this pressure, resulting in inadequate staff and overstretched resources in one trust compared to another, could lead to issues similar to the East Kent incident re-emerging unexpectedly. These are important factors to consider, as workforce and similar funding issues

could result in future stagnation of the current improvements, should they not be addressed.

There is too a limitation to the SWOT analysis. It is a static snap-shot analysis of a fast-moving situation and may underplay the speed at which opportunities and threats can change, which mirrors criticism that some responses by policy after the report have been created fast and without an accurate evidence base (de Jonge, De Vries and Declercq, 2022). Any strategy drawn upon the above SWOT information should be reviewed frequently to fix.

2.4 Linking Root Causes to the National Picture

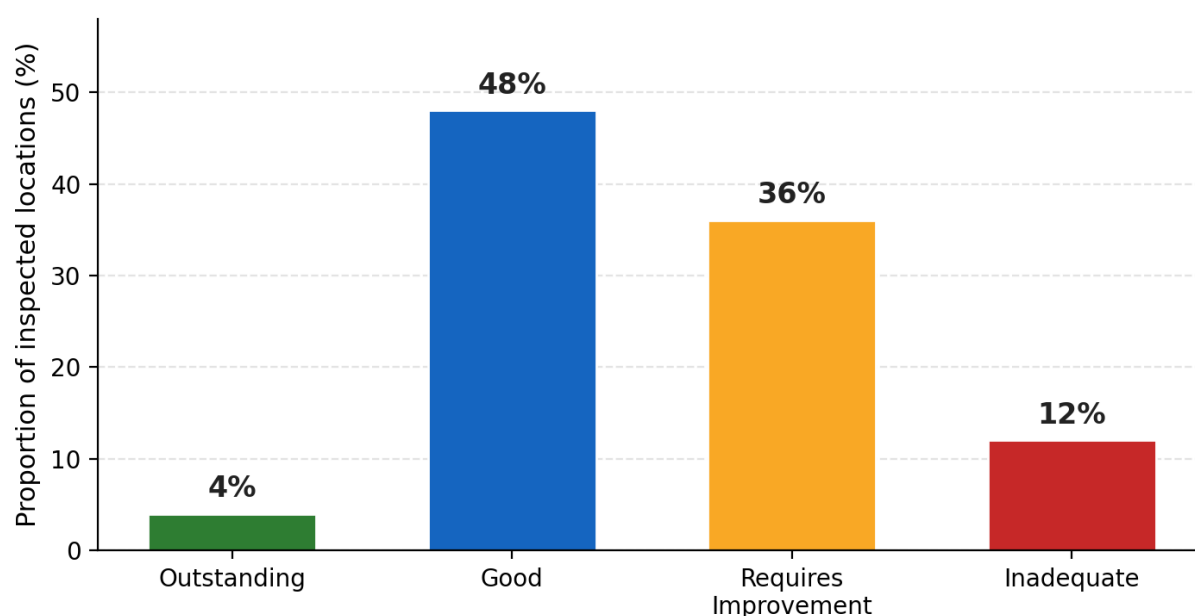


Figure 2. CQC ratings of NHS maternity services in England, 2022 to 2024 (Care Quality Commission, 2024)

The Care Quality Commission (2023) had already warned of a decline in the quality of maternity, mental health and ambulance services across England and its dedicated maternity review a year later confirmed that the decline was severe and persistent. Of the locations inspected, 47% were rated as requiring improvement for safety and 18% were rated inadequate, and no service was rated outstanding for safety (Care Quality Commission, 2024). Staffing shortfalls were named as a key driver of these ratings, in some cases leading to the closure of birthing suites (Care Quality Commission, 2024). Patient Safety Learning (2022) welcomed the detail in

the Ockenden report but warned at the time that publishing findings is not the same as acting on them, and the CQC data above suggests that warning has held up. This national picture backs up the conclusion drawn from the Fishbone and Donabedian analyses above, that the SaTH failure was not an anomaly but an extreme version of weaknesses that remain widespread across NHS maternity services.

3. Recommendations and Implementation Strategy

3.1 A Plan Do Study Act Approach to Reducing Escalation Failures

Escalation failure: this was one of the clearest causes found in the root cause investigation so this would be the first point addressed. Redesign and begin testing a new escalation pathway using the Plan-Do-Study-Act cycle, used in healthcare across the UK for example, to test change on a small scale before wider roll-out (Langley, Nolan and Nolan, 1996; Agency for Healthcare Research and Quality, 2024). The cycle used by a maternity unit is shown below (Figure 3).

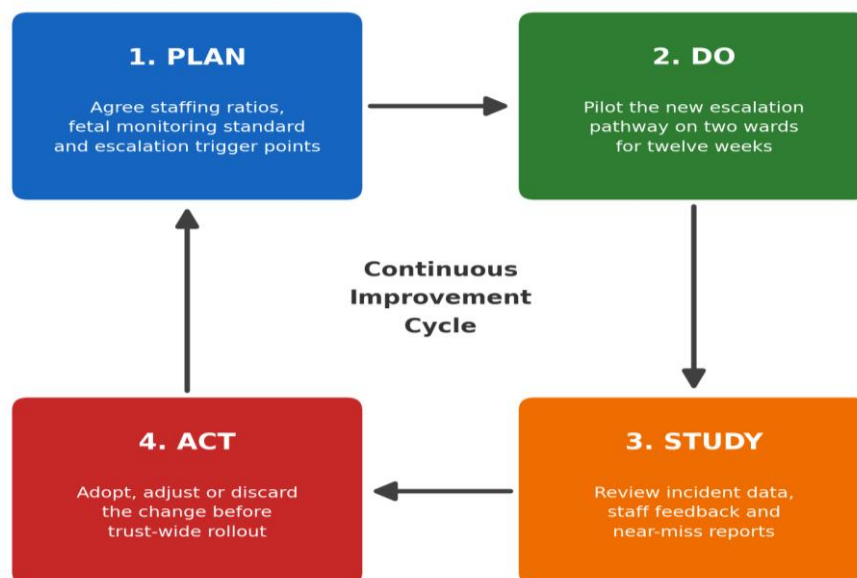


Figure 3. Proposed PDSA cycle for redesigning the maternity escalation pathway (Langley, Nolan and Nolan, 1996)

The plan phase has a team of midwives, obstetricians and neonatal staff agree clear, written trigger points for escalating concerns about fetal monitoring or maternal deterioration, so they were no longer reliant on individual judgement that Ockenden (2022) found was the cause of warning signs to be dismissed. Ockenden wrote about cases where midwives' concerns were dismissed: "it was assumed that midwives who raised these concerns lacked faith or confidence to support physiological labour without intervention". A Freedom to Speak up guardian supports staff to enable them to report concerns that may arise in the do stage when piloting the pathway on two wards for a set period of time, without fears of response to raising concerns noted by SaTH (Francis, 2013; National Guardian's Office, 2022). Studies have found that an increase in reporting of safety concerns is associated with a Freedom to Speak up Guardian in Trusts where the Guardian has enough funds to develop an effective Guardian service. An increase in incident reports may seem like a negative outcome, but they highlight issues within the staff that, when improved, prevent adverse safety and death.

In the study stage, the incident data, near miss forms and staff feedback would be reviewed to see if escalation occurs sooner and if the outcomes improve. In the act stage, the pathway would then either be employed in the rest of the hospital and adapted or dropped if there have been no positive changes, and then the cycle is repeated (Institute for Healthcare Improvement, 2023).

Small repeated PDSA cycles are better than one large-scale change, as problems tend to surface early, the staff takes greater ownership of the change, which the literature states is important for making improvement sustainable, so that once people have become familiar with changes, old ways of working do not return (Deming, 1986).

3.2 Reducing Waste in Incident Investigation Using Lean Thinking

The second recommendation addresses the weaknesses during the process stage that were suggested by the Donabedian analysis: substandard investigation of serious incidents. The concept of Lean thinking is from manufacturing and means removing the steps in any process that cause delay & waste and do not add value to the patient or family involved (Toussaint and Berry, 2013; George, 2003; Nicolay et

al., 2012). Applied to investigation, it would mean mapping out the current path from the incident to a report arriving at the family, spotting where there is wasteful duplication or delay and setting a standard of how soon a serious incident review should be completed and shared with the family. A shortened standard investigative process would appeal to the theme coming through again and again in this report, i.e. that families were being left waiting for answers (Ockenden, 2022). Families had no part in reviews of their care.

3.3 Practical Implementation Steps

Trust boards should take up the national perinatal culture and leadership programme in full, because leadership behaviour has come up throughout this analysis as central to whether staff feel safe in reporting concerns (NHS England, 2023). Third, there should be a requirement through the Maternity Incentive Scheme to adopt a single national incident reporting standard for all maternity services (NHS Resolution, 2022), because this addresses the national policing gap identified earlier and because it will be tougher for a trust to under-report harm without being noticed. Fourth, family voice should not only be brought in when a crisis hits but should sit inside governance through a body representing family voice sitting alongside the trust-safety committee, e.g., in a maternity and neonatal voices partnership, especially with the equity concern raised by the report (NHS England, 2023).

These recommendations are meant to be modest and testable rather than sweeping. That reflects a core lesson of PDSA methodology, that small, well-evaluated changes are more likely to stick than large reforms announced from the top down (Langley, Nolan and Nolan, 1996).

4. Conclusion

This analysis has demonstrated that the maternity failures at Shrewsbury and Telford were not due to one poor decision or one negligent person (Reason, 2000; Ockenden, 2022), but weak links in people, procedure, policy and management

which accumulated over the decades. The Fishbone diagram showed how fear of escalation, substandard investigation, uneven policy compliance and defensive leadership interlinked to cause four harms (Donabedian, 1966, reprinted 2005), whereas by the Donabedian model structural weaknesses in staffing and governance linked to poor process and preventable death and injury.

The SWOT analysis showed that the evidence base behind reform and the political will to pursue it are stronger than they were before in 2022, but that the weaknesses of workforce and culture which caused the original failure remained only partly resolved in the wider system (Care Quality Commission, 2024). That is why the recommendations presented above - a tested escalation pathway developed through PDSA cycles, Lean-based reform of the way incidents are investigated, and permanent representation of families at the table - deliberately consist of practical incremental steps rather than one massive transformation, thereby preserving the core meaning and details of the initial statement.

The disasters and tragedies discussed here make me reflect on the effectiveness of national reviews commissioned by the government. Although they hold the government to account to an extent, a series of further such reports is not going to improve maternity care in the U.K (Kirkup, 2022). We should hope instead that trusts themselves cultivate an open culture where listening to patients, family concerns and staff's reports of understaffing is practised regularly. By using these insights in conjunction with the tools mentioned, such as the Lean method and PDSA cycles, to carry out change that works, improvements can be observed. Until this sort of safe culture is embedded in all of trusts, the risk of preventable harm for trusts, which was highlighted in this analysis, remains a serious matter in NHS maternity services (Care Quality Commission, 2024).

References

1. Advancing Quality Alliance (2023) Quality, Service Improvement and Redesign Tools, Cause and Effect (Fishbone). NHS England.
2. Agency for Healthcare Research and Quality (2024) The Improvement Cycle, Plan-Do-Study-Act. Rockville, AHRQ.
3. Agency for Healthcare Research and Quality (no date) Strength, Weakness, Opportunities, and Threats Analysis. Rockville, AHRQ Digital Healthcare Research.
4. Anderson, B.R. (2016) 'Improving healthcare by embracing systems theory', *Journal of Thoracic and Cardiovascular Surgery*, 152(2), pp. 593 to 594.
5. Association for Improvements in the Maternity Services (2022) AIMS critique of the Ockenden Report. AIMS Journal.
6. Ayanian, J.Z. and Markel, H. (2016) 'Donabedian's lasting framework for health care quality', *New England Journal of Medicine*, 375, pp. 205 to 207.
7. Care Quality Commission (2023) State of Care 2022 to 2023. London, Care Quality Commission.
8. Care Quality Commission (2024) National Review of Maternity Services in England 2022 to 2024. Newcastle upon Tyne, Care Quality Commission.
9. de Jonge, A., De Vries, R. and Declercq, E. (2022) 'Where the Ockenden review goes wrong, let us keep calm and follow the evidence', *BJOG*, 130(1), pp. 11 to 14.
10. De Rosis, S. et al. (2024) 'Performance measurement and user centeredness in the healthcare sector, opening the black box adapting the framework of Donabedian', *International Journal of Health Planning and Management*.
11. Deming, W.E. (1986) *Out of the Crisis*. Cambridge, MIT Press.
12. Donabedian, A. (1966, reprinted 2005) 'Evaluating the quality of medical care', *Milbank Quarterly*, 83(4), pp. 691 to 729.

13. Draper, E.S., Gallimore, I.D. and Smith, L.K. et al. (2023) MBRRACE-UK Perinatal Mortality Surveillance, UK Perinatal Deaths for Births from January to December 2021, State of the Nation Report. Leicester, University of Leicester.
14. Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London, The Stationery Office.
15. George, M.L. (2003) Lean Six Sigma for Service. New York, McGraw-Hill.
16. Institute for Healthcare Improvement (2023) Science of Improvement, How to Improve. Boston, Institute for Healthcare Improvement.
17. Ishikawa, K. (1976) Guide to Quality Control. Tokyo, Asian Productivity Organization.
18. Kirkup, B. (2022) Reading the Signals, Maternity and Neonatal Services in East Kent, the Report of the Independent Investigation. London, Crown Copyright.
19. Langley, G.J., Nolan, K.M. and Nolan, T.W. (1996) The Improvement Guide, A Practical Approach to Enhancing Organizational Performance. San Francisco, Jossey Bass.
20. National Guardian's Office (2022) Freedom to Speak Up, Annual Report. London, National Guardian's Office.
21. NHS England (2023) Three Year Delivery Plan for Maternity and Neonatal Services. London, NHS England.
22. NHS Resolution (2022) Clinical Negligence Scheme for Trusts, Maternity Incentive Scheme. London, NHS Resolution.
23. Nicolay, C.R. et al. (2012) 'Systematic review of the application of quality improvement methodologies from the manufacturing industry to surgical healthcare', British Journal of Surgery, 99(3), pp. 324 to 335.
24. Ockenden, D. (2022) Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. London, Crown Copyright.
25. Patient Safety Learning (2022) Initial Response to the Publication of the Ockenden Review. London, Patient Safety Learning.

26. Plachouri, K. et al. (2025) 'An exploration of midwives' perceptions of the Ockenden review, a qualitative study', *Midwifery*.
27. Reason, J. (2000) 'Human error, models and management', *BMJ*, 320(7237), pp. 768 to 770.
28. Shrewsbury and Telford Hospital NHS Trust (2022) Annual Report 2021 to 2022. Shrewsbury, SaTH.
29. Toussaint, J.S. and Berry, L.L. (2013) 'The promise of Lean in health care', *Mayo Clinic Proceedings*, 88(1), pp. 74 to 82.
30. Wiegmann, D.A., Wood, L.J., Cohen, T.N. and Shappell, S.A. (2022) 'Understanding the Swiss Cheese Model and its application to patient safety', *Journal of Patient Safety*, 18(2), pp. 119 to 123.