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Component 2

Service Improvement Report

**Strengthening Maternity Safety and Clinical Governance: A Service
Improvement Review of the Shrewsbury and Telford Hospital Scandal**

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1. Introduction

The maternity scandal at the Shrewsbury and Telford Hospital NHS Trust is one of the greatest failures in the history of maternity care in the UK, which revealed the systematic problems with leadership, governance, and patient safety (BBC, 2022). The case was directed to the focus of attention after the Ockenden Report (2022) was published, which described the systemic failures in the course of two decades, between 2000 and 2019. The report found that the poor care provision at the Trust resulted in the death and injury of many women and babies, which could have been avoided. The outcry of the scandal brings troubles onto the issue beyond clinical negligence, as it demonstrates the great impact of the organizational culture and misleading leadership, and the collapse of the system of responsibility in healthcare.

Patient safety and the systematic negligence of the concerns brought up by the families and the staff were found to be the main problem in the scandal. There were also critical events, such as the mismanagement of fetal distress, the postponement of the required interventions, and a high incidence of stillbirths and neonatal mortality (Atkins *et al.* 2023). These were not the only problems, but a sign of long-term problems with the Trust's approach to care. The families would always complain of their concerns, but nothing was taken or actioned to help them. Maternity services culture was the culture of un-receptivity towards the raised issues, with employees, who voiced their concerns, usually being muzzled or punished. Insufficient investigations or lessons learned when problems occur were some of the factors that made the problems persist (Dana *et al.* 2021).

The Ockenden Report discovered that the staffing level was poor, equipment was old, and the training level was inadequate, as the major causes of the poor quality of care. Regardless of such warnings, the management of the Trust did not manage to act accordingly, which led to the creation of a situation in which safety and quality are not its priorities (Ongesa *et al.* 2025). The absence of an open and transparent culture was one of the most destructive elements since most staff members were afraid to voice their concerns under the threat of punishment. This culture of intimidation, which was compounded by the fact that there were no systematic checks, gave room to unsafe procedures (Sydorenko and Spindler, 2024).

The extent of this issue was also highlighted by national audits, which included the MBRRACE-UK report, which indicated that the Shrewsbury and Telford Trust had disproportionately high rates of perinatal mortality compared to other NHS Trusts. This problem was a symptom of a larger unsupportive failure in the maternity care within the NHS, indicating the lack of adherence

to the standards of high safety and gaps in the more effective framework of patient safety (Saleh, 2024).

The scandal has been a point of focus towards the need to reform maternity care in the UK, with a focus on the need to have powerful leadership, a sense of accountability, and a learning culture. It is a sharp lesson to learn the significance of quality assurance and the necessity to introduce sustainable changes to healthcare systems.

2. Main Body

2.1 Key Concepts and Theories

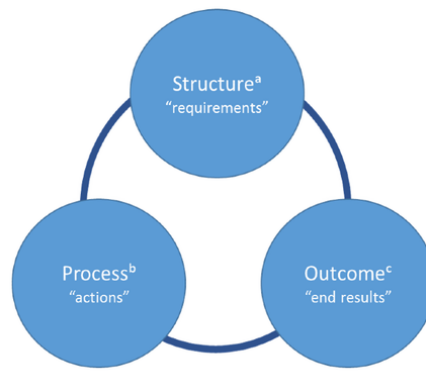
Theoretical models are essential in the examination and resolution of the quality problems in healthcare. Such frameworks provide systematic ways of analysing systemic issues and establishing their root causes. The use of pre-existing theories allows healthcare organizations to identify the presence of flaws in care delivery and make evidence-based plans to enhance the outcomes of their patients.

2.1.1 Fishbone Diagram (Ishikawa)

A Fishbone Diagram, or the Ishikawa Diagram, is a model that is employed in defining the root causes of an issue by classifying the possible contributors to it. It map-graphically represents different aspects that can affect an outcome, which are normally categorized into people, processes, policies, and equipment (Rosa *et al.* 2021). This model is especially applicable in the identification of systemic problems in healthcare because it aids the teams in considering all possible areas of failure. Applied to the situation of the maternity services in GetWell Network Shrewsbury and Telford Trust, the leadership, staffing, inadequate training, and lack of proper policies might be listed among the causes of unsafe practices and poor outcomes, among others.

2.1.2 Donabedian Model

The Donabedian Model is a model of healthcare quality received by measures the Structure, Process, and Outcome. Structure- Organizational factors, including staffing and resources. Process- The delivery of care, and Outcome- Patient health and satisfaction (Yinusa and Faezipour, 2023). Using this model to the maternity services at Shrewsbury and Telford Trust, highlights the lack of staffing and care delivery, and adverse patient outcomes, which can be used to give a structure on how to identify systemic quality problems.



- a. What an organization needs to have to provide health care
- b. The actions in giving and receiving health care
- c. End results as a consequence of providing care

Figure 01: Donabedian Model

(Source: Tossaint-Schoenmakers et al. 2021)

2.1.3 PESTLE Analysis Introduction

PESTEL analysis measures external forces that affect an organization and analyzes the Political, Economic, Social, Technological, Legal, and Environmental. PESTLE analysis, applied to the Shrewsbury and Telford Trust in this instance, can be used to realize how outside forces, including the policies on healthcare by the government, funding limitations, demanding population, and competitive technology, influence the quality of services in the maternity unit and the organizational setting of providing services.

2.2 Root Cause Analysis

Root cause Analysis (RCA) is an organized technique that is applied in finding the root causes of quality failure or issues in healthcare. RCA will be vital in seeking not only the short-term problems but also the systemic ones behind incidents of poor patient outcomes (Challinor et al. 2025). Identifying root causes, healthcare organizations are able to create specific interventions to avoid the repetitive occurrence, improving patient safety and quality of care.

2.2.1 Root Cause Analysis- Fishbone Diagram.

This is because the Fishbone Diagram (Ishikawa) divides potential causes of a problem and allows them to ensure that they examine all causal agents of a problem. In the case of Shrewsbury and Telford Trust, the Fishbone Diagram indicates the following crucial areas of failure:

- Leadership Problems: Low quality of decision-making, inadequate accountability, and the inability to promote an open culture (Idris *et al.* 2023).
- Policies: The care protocols were outdated or not well-developed to address patient safety.
- Staffing Problems: An understaffing situation has caused the situation of overwork and burnout of staff (Alansari, Omri, and Singh, 2025).
- Training Deficits: The absence of ongoing professional growth, especially in fields such as fetal monitoring.

All these categories are linked, and leadership failures lead to policy gaps, understaffing and staff training. The Fishbone Diagram is a visual way of having the issues synergize to affect the quality of care.

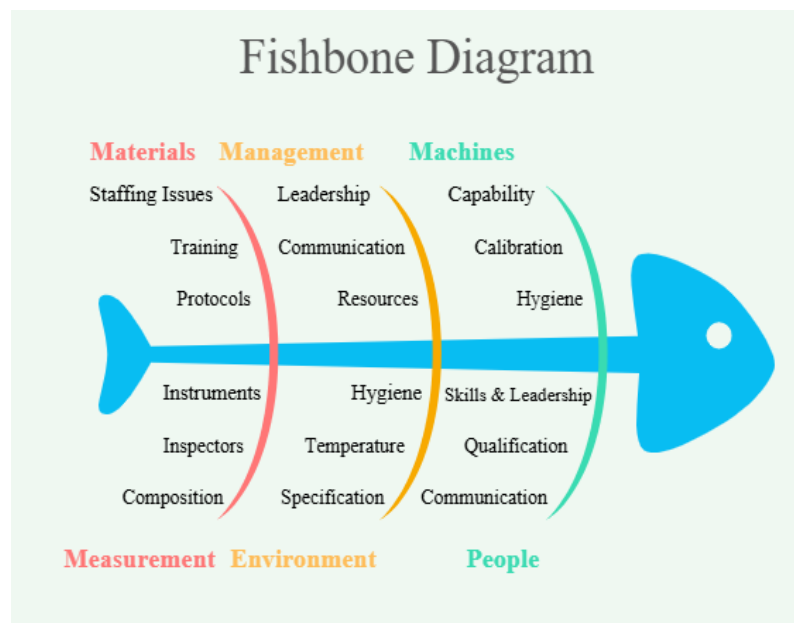


Figure 02: Fishbone Diagram

(Source: Self-made)

2.2.2 5 Whys Technique

The 5 Whys methodology assists in investigating a particular problem to the best of the knowledge by constantly asking why in order to figure out the roots. As an illustration, as to why fetal distress was not intensified:

- What was the reason that fetal distress was not scaled high?

These were missed appropriately by the staff.

- Why did the staff miss the signs?

They were not well-trained to detect fetal distress.

- Why has there not been proper training?

The professional development program was not ongoing.

- Why was there no program?

The Trust did not provide enough resources for training.

- Why were the resources allocated?

The management was not ready to lay emphasis on staff development.

2.2.3 Donabedian Model Application.

The Donabedian Model measures Structure, Process, and Outcome. The issues revealed in the Trust, Structure have young personnel, Process failures are observed through the absence of proper monitoring, and the Outcomes provided are high stillbirth rates, which indicate where quality care failed (Gondwe *et al.* 2022).

Combining the Fishbone Diagram, 5 Whys, and Donabedian Model helps to uncover that leadership failure, poor policies, staffing weaknesses, and lack of training were major factors of systemic failures at Shrewsbury and Telford Trust.

2.3 Strategic Planning

The tools of strategic planning play a crucial role in healthcare organizations to determine the major issues, priorities, and effective solutions. They assist in enhancing quality, patient safety, and allocating resources in a better way so that organizations can create sustainable circles of ongoing enhancement in care provision.

2.3.1 PESTLE Analysis for Strategic Planning

Political: Shrewsbury and Telford Trust maternity services are strongly dependent on the political aspects. The resource distribution, the staffing, and the quality of care are directly influenced by governmental policies and resource limitations (Chen *et al.* 2023). The pressure on the Trust to achieve better care is placed by national priorities like maternity safety reforms, which were caused by the Ockenden Report. The emphasis of the government on the systematic breakdown of the maternity services affects the business of the Trust and the urgency to introduce the changes to the rates of national safety.

Economic: The quality of care is largely influenced by economic pressures, such as the budget cuts in the NHS. Lack of sufficient finances limits personnel, equipment, and training. Staffing Shrewsbury and Telford Trust, experiencing financial restraint, had problems with understaffing and inadequate resources, which resulted in work overloads and burnout in employees (Udushirinwa *et al.* 2022). This economic burden compromised the quality and safety of care and led to patients having bad outcomes.

Social: The Trust activities are impacted by social factors, e.g., increased people awareness and expectations about maternity care. The need to be more transparent, safer, and participative in care decisions is increasing. Shrewsbury and Telford Trust could not live up to these expectations of society, leading to an outburst by the people. The Trust has to consider these issues by promoting the culture of patient-centred care and the state of communicating with families (Hansson and Fröding, 2021).

Technological: The use of technology is critical in enhancing care, in the case of digital health records and advanced fetal monitoring systems (Mohamed *et al.* 2025). The failure of Shrewsbury and Telford Trust to use the latest technology in its operation also led to poor monitoring and delayed actions to fetal distress, which explains why the Trust was in need of modern healthcare technologies.

Legal: The compliance of the Trust is influenced by legal factors such as healthcare regulations and patient safety laws. The fact that these legal standards were not adhered to and remained revealed in the Ockenden Report is among the reasons that led to the systemic failures in maternity care, and it, therefore, needs to be corrected immediately.

Environmental: The quality of care also depends on such environmental factors as the infrastructure of hospitals and the staff members' conditions, and the lack of resources influences the quality of maternity care (Karlton *et al.* 2020).



Figure 03: PESTEL Analysis

(Source: Segura *et al.* 2023)

2.3.2 Strategic Interventions Based on PESTLE

According to the PESTLE analysis, strategic actions to be taken concerning the Shrewsbury and Telford Trust are reducing leadership responsibility, creating a culture of openness, and training staff to overcome the problem of staff shortage and guarantee quality care. It is important to invest in the current technology, including advanced fetal monitoring and digital health records that help enhance patient safety and care delivery. The model of patient-centred care should be the priority of the policy reforms, and sufficient resources will aid in the long run (Gagliardi *et al.* 2020). The success in the long term depends on the continuous development of the staff, leadership, and new technologies.

2.4 Integration of Key Concepts and Strategic Recommendations

The combination of the Fishbone Diagram, Donabedian Model, and PESTLE analysis offers a holistic picture of the aspects of quality of maternity care at Shrewsbury and Telford Trust that cause its problems and external forces that cause them. The Fishbone Diagram reveals structural problems, such as the problem of leadership failure, staff shortage, and old policies. The Donabedian Model exposes structural (e.g., insufficient staffing), process (e.g., lack of communication), and outcome (e.g., high stillbirth rates) gaps. The external forces affecting the

operations of the Trusts, as indicated in PESTLE analysis, include political changes, economic factors, and technological factors that have influenced the Trusts' operations (Bruijl, 2025). The combination of these frameworks results in strategic resolutions to enhance the fit between leadership accountability, safety, and transparency culture, staff continuous training, and investing in modern technologies (Balogun and Zaghmout, 2024). These interventions will mitigate the discussed root causes and facilitate sustainable changes in the processes of care delivery that will guarantee a quality improvement in the long term.

3.Recommendations

In the recommendations section, clear action steps, which can be taken to develop maternity care at Shrewsbury and Telford Trust have been provided. These are recommendations that can be made on the basis of root causes spotted during the Fishbone Diagram, Donabedian Model, and PESTLE analysis to ensure that the systemic problems had been resolved and that patient safety and quality of care were improved.

3.1 Use of Quality Improvement Tools

PDSA (Plan-Do-Study-Act) can help to test either small-scale care delivery change by addressing such areas as employee training or communication guidelines. Plan: Identify areas for improvement. Do: Implement a pilot program. Trial: Assess outcomes like reduced incidents. Act: Standardize successful interventions.

PDCA (Plan-Do-Check-Act) makes constant improvement occur by performing ongoing review of processes in a systematic manner (Arredondo-Soto *et al.* 2021). Plan: Work out a plan to enhance the level of staff engagement. Do: Work out the plan with effective guidelines. Check: Surveillance of effect using audits. Act: Policy optimisation.

Lean is concerned with the minimisation of waste and streamlining. The delays and possible bottlenecks can also be reduced by implementing the principles of Lean in the management of patient flows and enhancing efficiency (Daly *et al.* 2021).

The objective of Six Sigma is to minimize variability and faults. Through the Six Sigma tools, the Trust will have an opportunity to examine the organisational maternity care defects and apply the data-based interventions to enhance consistency and quality.

3.1.1 Practical Steps for Implementation

Leadership and Governance

In order to enhance leadership responsibility, roles and responsibilities should be defined in every level of the organisation. Leaders must be given the mandate to make swift decisions on matters and instill a culture where employees are not afraid to bring about issues without any threat of reprisal. Leadership training programs should be regularly done with an aim of improving decision-making, communication, and responsiveness to challenges (Dirani *et al.* 2020). The transparency and openness is encouraged by leadership, and the characteristics of fearing errors and addressing them as a learning opportunity are created. This would not only enhance leadership but it would also lead to a more responsive, safer organisational culture.

Staff Training and Development

There should be continuous and organised training, which is based on the core competencies like fetal monitoring, emergency procedure, as well as communication skills (Musie *et al.* 2025). The training modules in question must be created relying on the PDSA cycle, which also enables pilot testing and modifications on the basis of feedback. Every staff member should also have clear competence goals at which progress should be assessed regularly. Continuous change will guarantee that the employees are trained to deal with high-stress scenarios and guarantee improved patient outcomes. This will also contribute to the development of a safety and preparedness culture in the maternity unit.

Staffing and Resource Allocation

Targeted recruiting and retention should be addressed as a way of addressing staffing shortages. The strategies ought to make sure that the staffing level matches the demand of patient care, especially at the peak time. The resources should be optimised using lean principles that minimise wastage of resources and make the available equipment and people work to their best. The Trust can optimise the process of care delivery and reduce delays by optimising their workflows and patient flow.

Technology Integration

It is vital to invest in current technology. Introduction of superior fetal monitoring systems and electronic health records will be used to promote the accuracy of data and the safety of patients. With Six Sigma techniques, the Trust will be able to simplify the process of technology integration

and reduce the number of system errors (Pongboonchai-Empl *et al.* 2024). Test these technological changes through the PDCA model to determine efficacy and further optimise the system prior to using the method in a large scale.

Policy and Procedure Improvements

The current practice of maternity care provision must be changed to encompass the best practices as well as adhere to the current practice of national standards of care safety (Eppes *et al.* 2021). The PDSA model may be applied to pilot new policies and improve them in accordance with the initial results so that the changes have a beneficial effect on patient outcomes.

3.1.2 Sustained Improvement

Continuous Monitoring and Feedback

Monitoring mechanisms must be put in place continuously to determine the performance of the changes undertaken. PDCA cycles allow reviewing the processes on a regular basis and correcting them according to real-time feedback (Gong *et al.* 2024). They should establish a strong feedback loop; they must include the staff as well as the patients and the stakeholders to make sure that there is continuous innovation in the maternity services. This will be used as feedback to pinpoint areas that can be further improved, as well as to ensure high standards of care.

Long-Term Sustainability

To make it sustainable in the long term, a culture of continuous improvement should be promoted, where the quality improvement initiatives will be incorporated into the daily practice. Continuous training and development needs to be offered in order to ensure that the staff skills are upgraded to current best practices (Yertas, 2024). Moreover, one should form a special quality assurance team that would monitor the progress, guarantee the preservation of the improvements, and discover new prospects for additional improvement over a period of time.

To sum up, the proposed measures are designed to correct the root causes observed during the analysis since stronger leadership, more appropriate staff training, technology implementation, workforce optimisation, and revised policies will all help address the root causes of the current issues. Such tactics will result in sustainable changes in the quality and the safety of maternity care at Shrewsbury and Telford Trust.

4. Conclusion

This report has critically sought to identify systemic failure in maternity care in Shrewsbury and Telford Trust and established the root causes of the problem using such frameworks as the Fishbone Diagram, the Donabedian Model, and PESTLE analysis. The major findings are leadership breakdowns, under staffing, deficient training, obsolete policies, and ineffective communication, which have led to unsafe practices and unfavorable results in maternity care. The external conditions like the economic pressures, political changes and the technological limitation also contributed a lot towards the worsening of these problems.

Actionable recommendations based on these findings were given with the focus being placed on enhancing leadership accountability and the culture of safety, staff training, and modern technology adoption. Quality improvement tools, including PDSA, PDCA, Lean, and Six Sigma will be used to ensure these changes are implemented and perfected in a systematically maintained way that will ultimately bring long-term changes. Also, continuity of feedback and long-term maintenance operations, such as the culture of constant improvement and continuous employee development, were also highlighted as a key factor in keeping improvement afloat.

When considering the points of these insights, it is evident that the multifaceted approach that would need to be taken to resolve the root cause of quality failures encompass leadership, staff engagement, policy changes, and technological investment. The Trust should focus on a holistic approach that would result in intended safe and open culture allow its staff to provide a high-quality patient-centered care. By introducing these changes into ordinary practice and creating a culture of learning and accountability, Shrewsbury and Telford Trust could make sure that such failures do not recur, and the final result would be the following: patient outcomes would be improved, and the level of trust would be increased.

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