



The Shrewsbury and Telford Maternity Scandal

Examining root causes and policy failures in NHS maternity safety through Root Cause Analysis

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Introduction

In recent history, the Shrewsbury and Telford Hospital NHS Trust (SaTH) maternity scandal has become an NHS failure widely seen to be one of the most serious breaches of quality it could experience. Between the years 1979 and 2019, the Trust frequently operated cases with standards of care that fell short of what is deemed to be acceptable (Ockenden, 2022). Mothers and babies suffered as a result of these low standards, with preventable deaths in many cases. 1,592 clinical incidents were reviewed in the Final Ockenden Report, and it found that insufficient care was in place in 201 cases and that death could have been prevented as a result, whilst mothers died due to the same reason. As a consequence of these findings, SaTH were consequently embroiled in a long conversation with the rest of the nation about the safety of NHS maternity units, with half of those it now inspects still rated as needing improvement for their levels of safety or indeed inadequate, a debate and concern that is now set to continue further into 2026 (Care Quality Commission, 2024).

Drawing on Component 1, this report summarises how failures of staffing, supervision, culture and external oversight aligned and combined (following the Swiss Cheese Model of organisational accidents) to allow cases of harm to go unchallenged for nearly 20 years (Reason, 2000; Rutherford, Sperandeo and Bishop, 2021). Drawing primarily on the fishbone diagram and Donabedian model to explore causes of the harm and SWOT and PESTLE to investigate whether the company's ability to instigate change is backed up by its current circumstances and environment, the report aims to provide a structured service improvement report. No single model was considered sufficient, meaning that whilst the fishbone diagram (Institute for Healthcare Improvement, n.d (Donabedian, 1988) diagnosed the causes behind the harm and Donabedian explained how these transferred into outcome, the SWOT and PESTLE analysed how its current situation supported change being able to be made sustainable (van Wijngaarden, Scholten and van Wijk, 2012).

The quality concern is the failure of maternity governance to detect, investigate and act on warning signs of unsafe care and a culture where targets prioritised normal birth over a detailed individual clinical assessment of risks. This is not just a problem in one Trust, but national reviews highlight understaffing, poor incident investigation and poor outcomes for women from black and brown BAME backgrounds, as a concern found in NHS maternity care (Care Quality Commission, 2024; MBRRACE-UK, 2025). Inquiries which took place years before SaTH was publicly investigated and published findings such as the Morecambe Bay inquiry, demonstrated exactly similar patterns in outcomes, again indicating a culture not an isolated event (Kirkup, 2015).

The primary section of this project utilises root cause analysis tools that include fishbone diagram, donabedian model, SWOT and PESTLE analysis, supporting them with literature from peer-reviewed studies and pieces of work surrounding national policy. The recommendations are further used to apply the above into a phased Plan-Do-Study-Act (PDSA) cycle-based approach that also implements lean working. The concluding part of the project then summarises the most important recommendations and lessons learnt for quality assurance in maternity and the wider social care services alike.

Main Body

Applying the Fishbone Diagram

The Fishbone or Ishikawa Diagram maps factors that have contributed to one adverse outcome and stores them in groups, as a team might find a range of separate weaknesses come together to combine and cause harm. Used commonly in manufacturing, it has become a standard in healthcare Root Causes Analysis simply because it does not aim to identify single causes to fault but to accept that the problem is rooted in a chain of failures (StatPearls Publishing, 2024).

When a Fishbone Diagram is applied at SaTH, the effect explored was preventable harm to mothers and babies for 20 years. The cause of such harm can be divided into five broad classes. Under people, chronic midwifery and obstetric vacancies led to units becoming reliant on junior staff being adequately supported by seniors (Royal College of Midwives, 2024). Under methods, there was a trust-wide emphasis on reducing caesarean section rates, which overrode individualised clinical risk assessment. Under environment - defensive leadership of the hospital closed down loops which may have helped intervene, and under measurement - no mechanism in place allowed escalating a pattern of harm to external scrutiny (House of Commons Library, 2026). Thus, early warning signs continued to accumulate for many years under that radar.

When the causes are arranged in the Fishbone structure, it can be seen that no single cause would result in harm on this scale. It is the combination and reinforcing of causes from all categories that ensures the pattern does not stop (Reason, 2000). This concurs with the application of Swiss cheese in component 1 and generally within the literature on analysing the causes of adverse events (Patient Safety Learning, 2020). Adverse incidents are nearly always multifactorial

Applying the Donabedian Model

In the Donabedian Model, the quality of care can be analysed under three headings. Structure refers to the resources and organisational conditions within which care is delivered. Process refers to the interactions and clinical decisions between staff and patients. Outcome refers to the effect on patient health (Donabedian, 1988). This Model remains popular because it provides scope to assess healthcare quality at the origin of a quality-compromising problem, rather than where harm is evident in retrospect (De Rosis et al., 2024). Newer examples of the model have illustrated the enduring nature of its applicability.

From a structural perspective, a fundamental input failure emerged from chronic understaffing and the reliance placed upon temporary or inexperienced cover. The national guidance on safe midwifery staffing was not enforced; thus, the Trust had consistently operated at levels well below the resourcing threshold for safe care in the absence of all clinical decision-making (National Institute for Health and Care Excellence, 2015). At process level, delayed escalation of high-risk labours and pressure placed upon clinicians to maintain attempts at vaginal delivery when risk factors arose reflect an erosion of the interprofessional boundaries which are supposed to protect mothers and babies. Ineffectual clinical governance rendered the organisation unable to learn effectively from incidents- an inability which ultimately resulted in avoidable neonatal and maternal deaths and subsequent measurable decline in public trust and was evident at outcome (Care Quality Commission, 2024).

Failure of structure was not merely a background event, but an agent of poor process and consequently, poor outcome. This suggests the usefulness of the Donabedian framework here. An intervention that seeks to heal outcome alone, such as additional support provided to families after incidents, would not repair the underlying structural and process inefficiencies that caused the outcome to happen in the first place, thus requiring reform across all three dimensions for a lasting change to be possible (De Rosis et al., 2024).

SWOT and PESTLE Analysis

Internal Strengths, Weaknesses, external Opportunities, Threats - The humble SWOT analysis is ubiquitous in healthcare, and yet uncritical use of it has been cited as a weakness of healthcare strategy itself. In one study of four Dutch health organisations (by Van Wijngaarden, Scholten and van Wijk (2012)), the classic model SWOT, 'developed for closed-hierarchy single establishments', jars with providers which are part of networks of independent professional and regulatory bodies, not closed systems. This has consequences for SaTH. A Trust-bounded, classical SWOT risks taking factors at the network or 'national body' governance level (commissioner oversight, regulatory scrutiny, coronial referral, etc.) not as

inherent features of the system the Trust is accountable to, but exogenous threats instead, that need to be reacted against. The SWOT below is then conducted under this caveat against misinterpreting these as solely existential threats rather than fundamental aspects of the trust's operating environment. Its findings are therefore to be read as interim rather than comprehensive.

Against that background, strengths include well-established evidence base nationally about maternity failures and a new national safety investigation function. Strong evidence suggests midwifery continuity of carer can reduce risk of preterm birth & increase spontaneous vaginal birth by proper resourcing (Sandall et al., 2016). Weaknesses include the same issues continue to be found within other Trusts even after national reviews show lessons are learnt but perhaps not fully embedded across organisations (Care Quality Commission, 2024). Recruitment into midwifery continues to fall short of required levels (Royal College of Midwives, 2024). Tension therefore than settled picture, the results for the latest full evaluation by Resolution about Maternity Incentive Scheme in 2024/25 saw 102 trusts comply fully with National Safety Standards since starting the Scheme as the highest number (NHS Resolution, 2025). CQC are still flagging Maternity as a high-risk area for trusts, concern where the risk of preventable harm for patients becomes normal (Care Quality Commission, 2024, 2025). Thus, compliance might not necessarily mean that lived safety has improved for the population and following a regime primarily focusing on meeting the compliance target risks repeating the former approach of SaTH only to achieve targets whilst not reducing risk.

A range of opportunities exists to enhance maternity services. A National Maternity Review of safer, more personalised and more family-centred care occurred in 2016 (NHS England, 2016), and this was complemented by a Three-Year Delivery Plan for Maternity and Neonatal Services (NHS England, 2023). Furthermore, the framework on Patient Safety Incident Response supports a flexible, compassionate, system-focused approach to learning (NHS England, 2022). There are, however, threats that must not go amiss. Negligence is a major issue in maternity care (House of Lords Library, 2021; NHS Resolution, 2023a). It has long been the largest area of claims in the NHS for negligence. Inequalities in maternal outcomes for black and Asian women must also still be addressed. Little progress has been made for over two decades despite regular nationwide attention (MBRRACE-UK, 2025).

A lightning PESTLE analysis gives wider context. It is an evidence-based tool for structuring analysis of the macro-environment in health care settings: on the Political side, successive governments have committed to decreasing maternal and neonatal harm (Mwogosi and Mambile, 2025), but MBRRACE-UK (2025) confirms ambitions will not be met on current trends. From an Economic point of view, litigation attached to maternity care is growing to a

scale that makes a financial, not just ethical, argument for investment in prevention (NHS Resolution, 2023a). In Legal terms, all providers must comply with the Patient Safety Incident Response Framework under the NHS Standard Contract, so an overhaul of investigations is not elective (NHS England, 2022).

All three frames must be used critically and not be used as neutral checklists. The Fishbone identifies numerous causes of failure but fails to show their relative importance; some being minor factors, may be of minor impact unless supplemented by a prioritisation tool such as Pareto (Institute for Healthcare Improvement, n.d., 2026). Secondly, the Donabedian model understates patient-side factors like the patient's underlying history, such as the health inequalities she sustained over time in life, oversimplifying the connection between structure, process and outcomes (De Rosis et al., 2024). Thirdly, the conflict between individual accountability and system-based analysis is relevant here, diffusing responsibility although the decision might have been taken by individual leaders. Instead, this analysis treats the two as compatible, as root-cause analysis is being initiated with tools including fishbone and Donabedian, and responsibility of parties that are involved right up to the Trust, commissioners, and regulators will be defined in the context through SWOT analysis rather than merely attributing cause and effect to the overall "system".

The above frameworks help to show that resources and policy opportunities for meaningful change are now available at a national level, that these opportunities are not always transferred into effective local-level practice and whether services are becoming safer may not be truly represented from compliance data alone. This is the rationale behind the following recommendations.

Recommendations

The proposals below address the root causes of the problem in fish bone and Donabedian models with use of PDSA cycles that follow principles of improvement approach, one of the tools recommended for NHS use, to implement changes on a smaller scale to begin with, so that they can be assessed and if satisfactory put in place on a larger scale (NHS England and NHS Improvement, 2022; Agency for Healthcare Research and Quality, n.d.). Lean approach was used for few solutions that addressed repetition and delay in an incident investigation (Proudlove, Moxham and Boaden, 2008). Some recommendations have been suggested out of interest to develop a further investigation after the solutions are put in place (McGowan et al., 2023); these may be considered ideas of developing a further intervention after this, especially as studies show some maternity improvement tools were not assessed that did allow for further change to occur that could be measured accurately with appropriate time.

Cycle One: Safe Staffing Escalation

First Cycle: The first cycle addresses the structural root cause of chronic understaffing. Under a new protocol, a mandatory 'trust-wide escalation' mechanism operates, initiating a review by executive members whenever midwifery staffing drops below a national guidance ratio threshold for a defined number of shifts within a rolling four-week period (National Institute for Health and Care Excellence, 2015). During a three-month pilot phase at two hospital units, the changes would be measured using the occurrences of escalations and responses. They would be evaluated by comparing incident numbers and staff confidence levels before & after implementation. Subsequently, if an improvement in response times should occur, the protocol can thus be refined & extended 'trust-wide', which would also serve the greater purpose of promoting the staffing guidelines from being merely an advisory role to an active governance role.

Cycle Two: Standardised, Independent Incident Investigation

The second cycle combats weaknesses in investigations as uncovered by both analyses. Building on the shift to the Response Framework, it first Lean maps the investigatory pathway, removing superfluous duplicative steps, followed by a standardised template whereby family and staff must be involved (NHS England, 2022). Since McGowan et al. (2023) find that initiatives aimed to improve maternity rarely involve rigorous evaluation, the cycle uses outcome measurements as opposed to storytelling. The do stage would see the pathway trial run over a course of six months on incidents categorised locally as meeting safety priorities. Outcome measurements will be around investigatory completion times as well as family satisfaction in involvement; whether or not the proportion of investigations leading to a monitored action as opposed to reports left filed away is measured. Act would standardise all successful steps of the do stage and discontinue any that were found not to be of any value.

Cycle Three: Embedding a Just and Listening Culture

The final PDSA cycle is around tackling the cultural root cause, namely an organisational culture amongst leaders of defensive dismissal of issues of concern raised by families and their staff, which is what happened across multiple maternity units over 20 years (Kirkup, 2015; Francis, 2013). Culture is here not a case of something tone at the top. The plan looks at where culture comes from based on ethnographic research on safer units (Liberati et al., 2021), which found safety is derived from structural features, not culture policy (e.g. multi-disciplinary team-working, staff can raise concerns without fear of blame). These would be tested starting with structural change, namely protected listening sessions between senior leaders and frontline staff, and that a family liaison role is attached to investigations of serious

incidents from opening (NHS Resolution, 2023b), which is in line with national guidance on safety culture and being fair (NHS England, n.d.). The do stage would see this implemented within one directorate, which would be studied as staff survey and family feedback would indicate whether concerns are being raised and investigated rather than blamed. The act stage will involve spreading through all directorates if there are significant early positives through this work.

Cycle Four: Closing the Equity Gap

Cycle four relates to the consistently worsened outcomes of Black and Asian women, being more likely to die or suffer severe complications than other women despite this being a nationally noted fact for twenty years (MBRRACE-UK, 2025). This plan introduces mandatory ethnicity-disaggregated auditing of triage response time, access to pain relief and escalation decisions modelled similarly to the one suggested in the CQC national review in the two units tested under Cycle One, with response time compared against staffing (Care Quality Commission, 2024). The audit would initially look into whether there exists a linkage between disparity and certain points in the pathway and focus training or process change on those points rather than general equality training, which is not tethered to measures for practice.

Sustaining Improvement

All cycles are deliberately scaled to be manageable in current resources before systemwide (NHS England and NHS Improvement, 2022). It is fundamental principle of PDSA to learn small before changing a system. This approach coincides with international opinion (World Health Organisation- Patient safety action plan 2021-25) that eliminating avoidable harm requires integrated, high-reliability complex systems to remove siloed efforts to improve patient safety (World Health Organisation, 2021). To ensure sustainability, the Trust Board has to oversee, via a single consolidated quality dashboard, all four cycles, whereas previously the data had resided independently without the need for a coordinated response across 4 organisational silos. If a cycle shows measurable improvement, then a time-limited project, it can then be formally adopted as part of the trust's Plan-Do-Check-Act quality management system.

Conclusion

In this report, the Fishbone Diagram, Donabedian Model and SWOT & PESTLE analysis are used to identify the root causes of the SaTH maternity scandal, starting with the systems-

based approach of component 1. The analysis confirmed the harm cannot be put down to one failing alone but the alignment of structural understaffing, defective clinical and governance processes, a defensive organisation culture and an absence of external scrutiny for over 20 years. The Donabedian model demonstrates these were related failures of structure, process and outcome, so improvement should address all.

The national policy environment provides both more resources and more structural opportunity for change now than it did during the period under review (NHS England, 2022; 2023). The SWOT and PESTLE analysis refer specifically to the opportunity of the Three-Year Delivery Plan and the Patient Safety Incident Response Framework. While meeting compliance figures has narrowed some of the gap identified by CQC, it is the clearest evidence that opportunity at a national level does not guarantee local change (Care Quality Commission, 2024). Turning policy commitment to embedded practice rather than simply compliance figures may prove to be the biggest challenge facing NHS maternity services.

The proposed four PDSA cycles address each of the four root causes identified using the Fishbone and Donabedian models, i.e., staffing escalation, independent investigation, cultural listening and equity of outcome. Each cycle would be tested on a small-scale before wider delivery, reflecting the wider lesson that untested organisation-wide change motivated by targets as opposed to evidence can again lead to additional issues. Staffing at adequately resourced levels, honest investigations into incidents, a non-defensive culture of listening to patient needs, and an explicit commitment to closing inequalities in outcome form the foundation for delivery of sustainable quality assurance within the health and social care sector, well beyond just in terms of maternity services but in quality assurance practice as a whole.

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