



# Shrewsbury and Telford Hospital NHS Trust (UK) Maternity Scandal Issue

Presented by: Muhammad Hamza  
Student ID number: 2515820  
Programme (MSc Public Health and Social Care in Practice)  
Module Code : LCHS7006  
Lecturer's Name: Dr Fahad Khan



# Case Study Overview – Shrewsbury and Telford Maternity Scandal

- Organization: Shrewsbury and Telford Hospital NHS Trust (UK)
- Time period: 1970s – 2019
- Areas of Concern: Serious failures in maternity care services
- Key issue: Unpardonable maternal and neonatal fatalities, stillbirths or other consequences resulting from failures to provide safe care.
- Source Document: Ockenden Review – Final Report (2022)

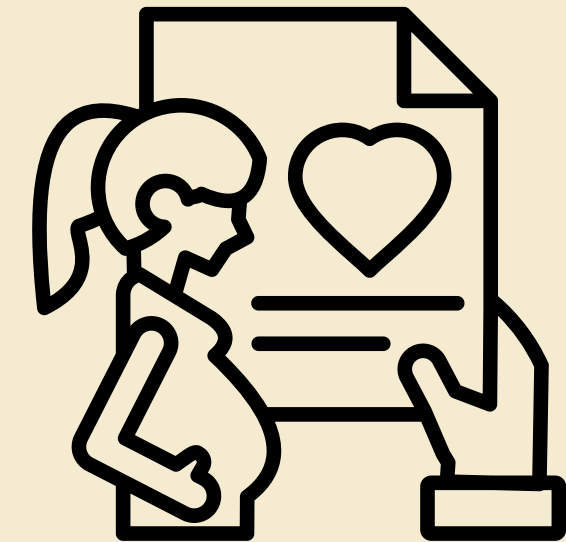
## **Brief context:**

- Hundreds of families that experienced unsafe maternal healthcare practices.
- Frequent systemic deficiencies related to clinical governance, quality of care, leadership and safety culture.
- Failure to identify risks, investigate incidents or enhance care.



# Definition of the Quality Problem

- Core problem: Continual incapability to provide the safest possible, best quality maternal health services.
- Nature of failures:
  - Poor fetal monitoring; poor maternal monitoring
  - Too slow/too few to escalate Urgent Actions.
  - Mismanagement during labour.
- Quality assurance gaps:
  - Poor incident reporting, investigation, and follow up of historical adverse events.
  - Weak clinical governance frameworks.
- Organizational culture:
  - Defensive organization with a blame culture.
  - Concerns raised by the workforce and families dismissed.

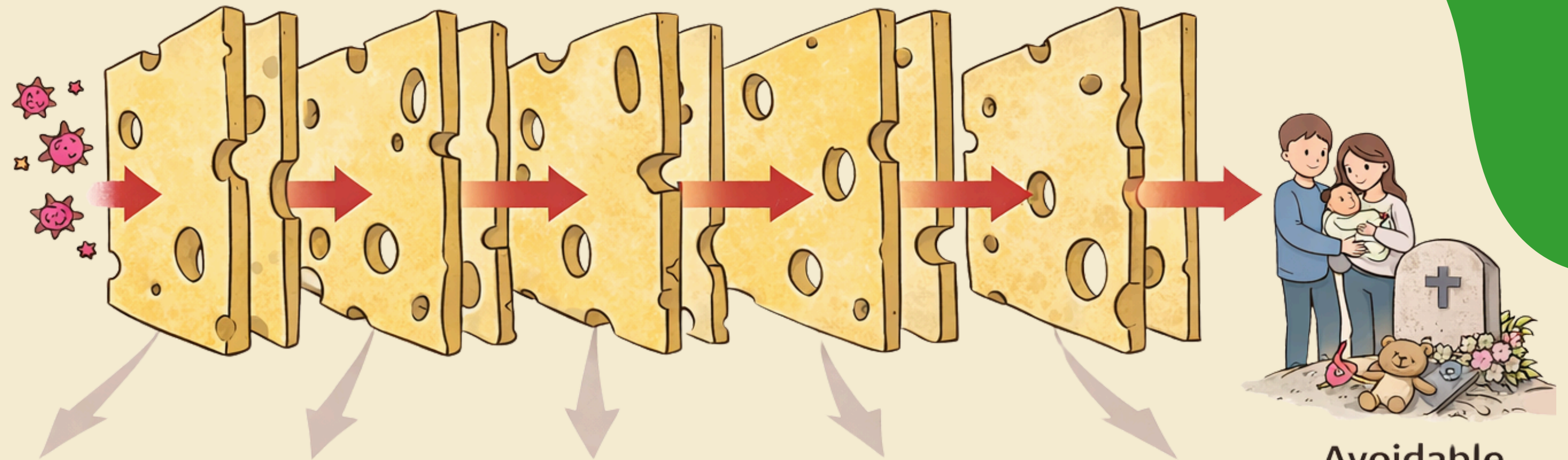


## Why this is a quality issue (not individual error):

- Repeated failures over many decades demonstrates a breakdown of systems, not a series of isolated errors.

# Root Causes of Failures – Swiss Cheese Model

Multiple systemic failures align, resulting in avoidable maternal and neonatal harm



## Organisational Level

- Poor leadership and lack of accountability
- Normalisation of unsafe maternity practices

## Workforce Level

- Inadequate **staffing** and **skill mix**
- Insufficient training in fetal monitoring (CTG interpretation)

## Clinical Processes

- Failure to escalate clinical concerns during labour
- **Delayed** intervention in high-risk cases

## Safety Culture

- **Blame culture** discouraging incident reporting
- **Staff** and families' concerns repeatedly ignored

## Quality Assurance

- **Weak incident investigation** and audits
- **Regulatory** and **supervisory** oversight failures

**Avoidable maternal and neonatal harm**



# Root Causes Using the Swiss Cheese Model

## Swiss Cheese Model (Reason, 2000):

- Patient harm occurs when multiple system failures align

## Key system failures ('holes'):

### Organizational level

- Leadership and accountability do not exist
- Unsafe birth practices are normalized

### Workforce level

- There are not enough personnel to provide care for mothers & children
- Insufficient training on fetal heart rate monitoring (interpreting CTGs)

### Clinical processes

- Do not escalate concerns about labour
- Delayed intervention with high-risk deliveries

### Safety cultures

- A culture of placing blame discourages reporting incidents
- Concerns of staff & families are ignored

### Quality assurance systems

- Poor audit processes do not lead to improvement or learning
- Repeated incidents with no corrective actions are taken

### Outcome:

- Alignment of failures → avoidable maternal and neonatal harm



# Policy Issues Contributing to the Failures

## Not following national guidelines

- Not following NICE maternity care and fetal monitoring guidelines

## Absence of clinical governance

- Inadequate safety measures
- Lack of Trust leadership and regulatory oversight

## Whistleblower protections are ineffective

- Staff are discouraged to speak up
- Families' concerns ignored

## Inadequate accountability

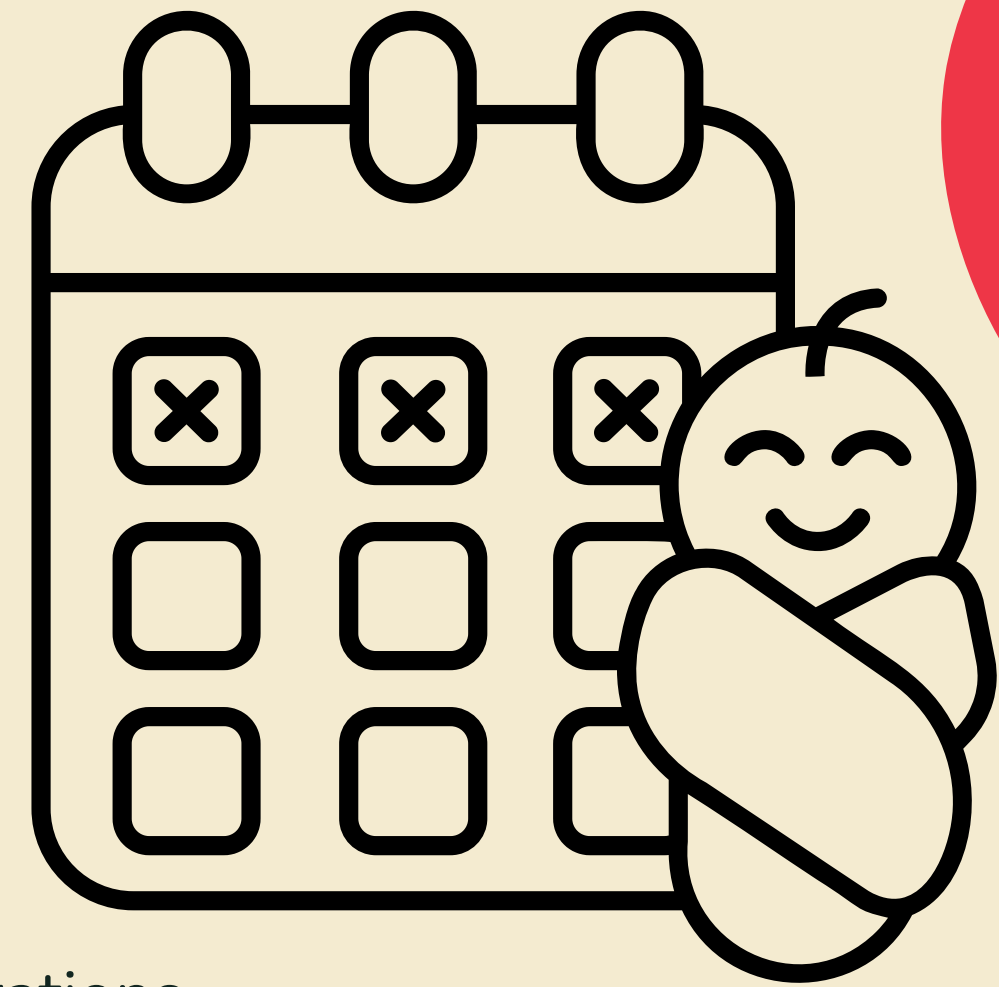
- External reviews are not conducted in a timely manner
- Regulatory gaps and persistent problems

## Mismatch between policy and practice

- Safety policies were developed but not practiced in day-to-day clinical operations

## Key point

- The regulatory failure was not an absence of regulations, but an absence of implementation and enforcement.



# Impact on Service Provision



## Influence on Quality

- Unsafe maternity care and avoidable injury
- Lack of compliance with minimal standards for patient safety
- Deterioration in trust between patients and caregivers

## Influence on Efficiency

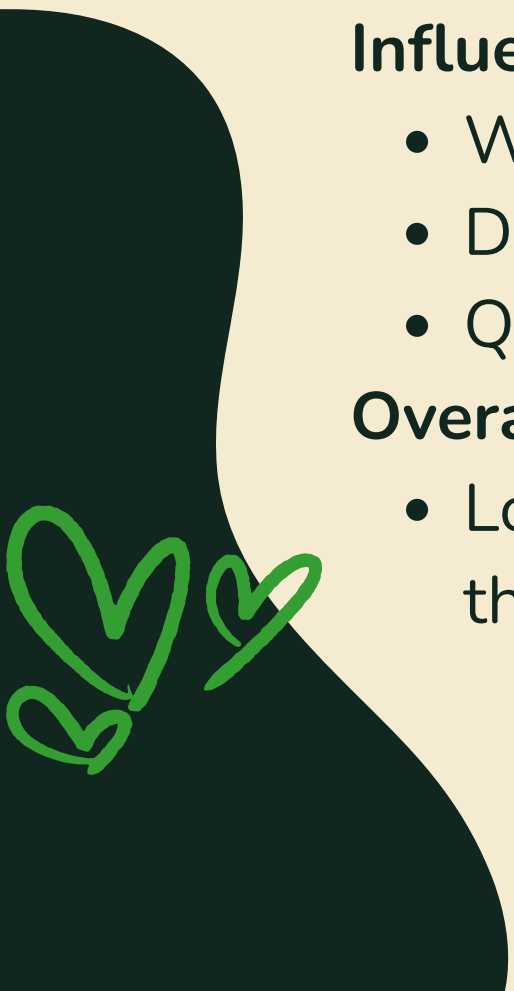
- Extra litigation and reimbursements create large financial burdens
- Recurrent instances of injury lead to more work and strain on resources
- Reactive instead of preventative care leads to ineffective utilization of employee time

## Influence on Equity

- Women and families' concerns have been downplayed or dismissed
- Differences in quality of care provided to various types of patients
- Quality of care is still less than ideal for many vulnerable women

## Overall consequence:

- Long term erosion of trust in the service will ultimately lead to diminished credibility and viability of the services being delivered.(Halligan & Zecevic, 2011)



# Benchmarking Gaps

| National Standard (Benchmark)                                                                                                                     | Expected Function                                               | Practice in Other NHS Trusts<br>(National Comparison)                                | Practice in Other NHS Trusts<br>(National Comparison)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Whistleblowing: Staff feel safe levitating concerns within a culture of psychological safety.<br>(West,M et al., 2019 ; NHS England, 2022)        | Staff feel safe raising concerns (Griffiths et al., 2020)       | Staff feared speaking up; concerns ignored (Ockenden, 2022)                          | The Freedom to Speak Up Guardians role established across Non-Hospital Trusts and the majority (71%) of staff felt confident in raising any concerns; however, there continues to be variations in confidence levels (NHS Staff Survey 2022, NHS England 2022).<br><br>Most NHS Trusts have formal systems to manage the transfer of care or handovers between teams when a patient is transferred or escalated within a Trust; however, inconsistencies in communication between teams continue to exist in multi-disciplinary areas within some maternity Units (CQC 2023).<br><br>With significant shortages in the NHS workforce, the majority of NHS Trusts have developed and implemented workforce planning tools/methodologies and risk escalation systems that are consistent with National Guidance on staffing (NHS England 2023).<br><br>Use of the MBRRACE-UK Perinatal Mortality Review Tool (PMRT) is widespread within NHS Trusts. The PMRT has a clear process for conducting structured case reviews and shared learning (MBRRACE-UK 2023).<br><br>CQC's 2023 Single Assessment Framework found governance systems operational in most trusts, although culture ratings varied between “Good” and “Requires Improvement” (CQC, 2023). |
| Communication Standards: Support clear communication and well-timed risk escalation to prevent harm.<br>(Wood, 2025; CQC, 2016)                   | Clear handovers and escalation (CQC, 2016)                      | Poor multidisciplinary communication; failure to escalate risks (Ockenden, 2022)     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Safe Staffing: Maintain adequate midwife-to-birth ratios to ensure safe, continuous maternity care.(NICE, 2015 ; NHS, 2023)                       | Adequate midwife-to-birth ratios (NICE, 2015)                   | Chronic staff shortages affecting patient monitoring (Mid Staffordshire & NHS, 2013) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Mortality Reviews: Conduct mandatory, systematic reviews of maternal and neonatal deaths to learn and prevent recurrence.<br>(MBRRACE-UK, 2022)   | Mandatory review of maternal/neonatal deaths (MBRRACE-UK, 2022) | Deaths not consistently reviewed; missed learning opportunities (Ockenden, 2022)     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Leadership & Culture: Substitute transparent, accountable leadership that maintains just culture and quality improvement. (CQC, 2016 ; NHS, 2019) | Open, transparent governance (NHS, 2019)                        | Defensive leadership and resistance to scrutiny (Mid Staffordshire & NHS, 2013)      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

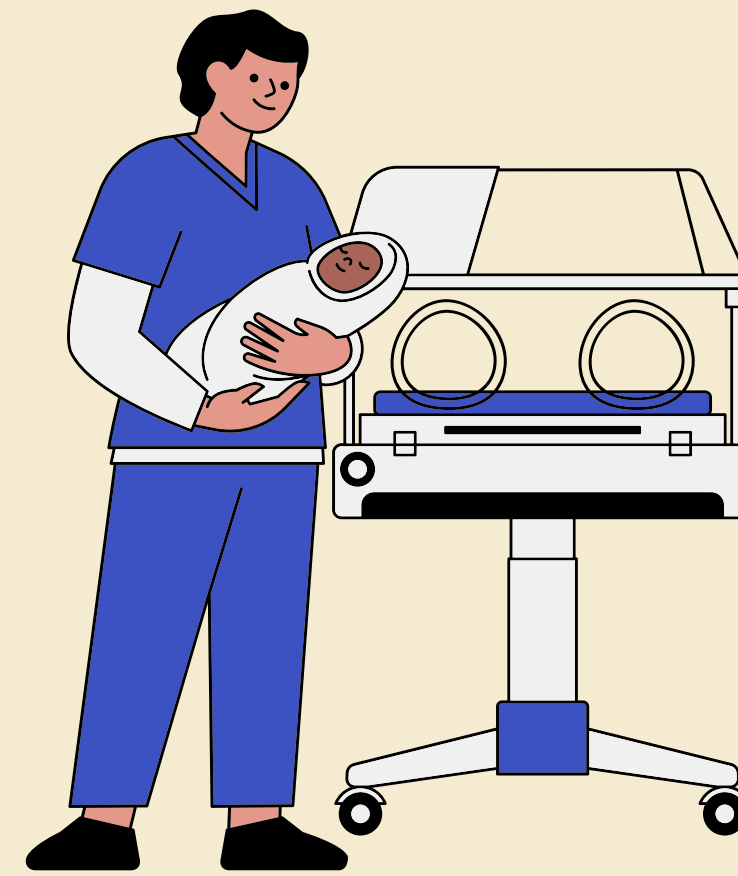
# Component 2 Report

- **Introduction & Background of Telford and Shrewsbury Maternity:**  
Overview of the Telford and Shrewsbury maternity disaster, its association with quality control, and why safe practice for patients is not being met.
- **Models & Frameworks:** Use of Donabedian model Fishbone diagram and 5 Whys to investigate structural deficiencies, process deficiencies, and outcome deficiencies.
- **Analysis of Root Cause & Benchmarking:** This involves discussing the organizational deficiencies, workforce deficiencies, cultural deficiencies, and governance deficiencies in relation to national standards and benchmarks.
- **Policy & Regulatory Context:** This involves reviewing the policies/standards of NICE, CQC, NHS England, & MBRRACE-UK and the lack of implementation.
- **Impact and Recommendations:** Analysis of effects on quality, efficiency, and equity, followed by evidence-based quality improvement strategies.



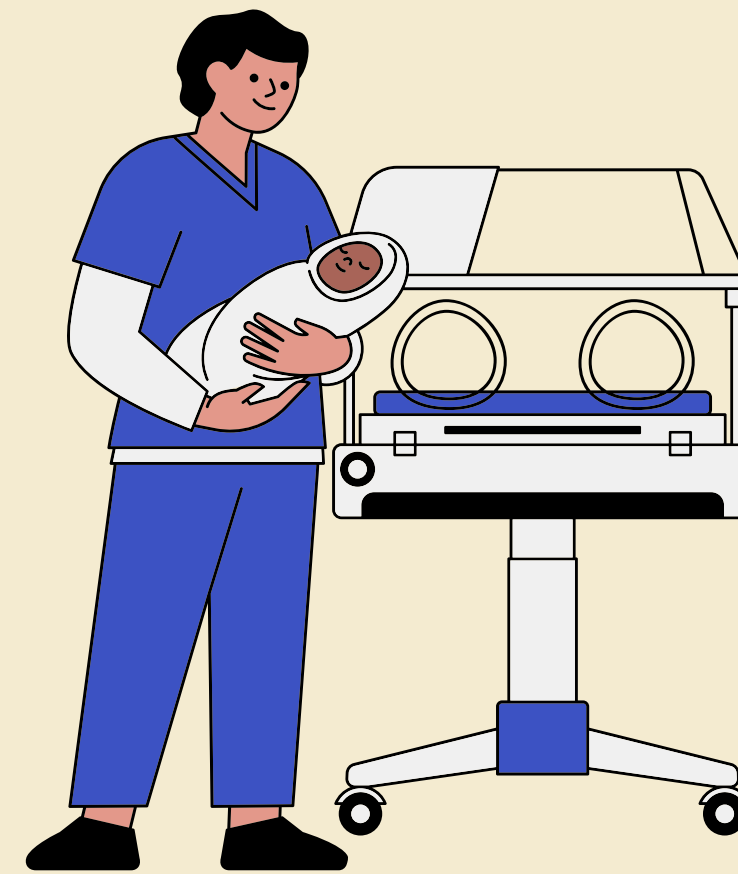
# Conclusion

- The Shrewsbury case is a direct result of extensive systemic failings not just isolated clinician error as had been previously suggested.
- Numerous levels of “organizational defense” failed all at the same time.
- While national standards and guidelines exist, there has been no effective implementation of such.
- The cultural silence surrounding the management and use of poor benchmarking along with weak governance allowed for unnecessary harm to occur.
- To have quality improvement become permanent requires changes to structure, accountability and continuous oversight.



# References

1. Care Quality Commission (CQC) (2022) Maternity services inspection framework. London: CQC
2. England, N.H.S. and Improvement, N.H.S., 2019. The NHS patient safety strategy. Safer culture, safer systems, safer patients.
3. England, N.H.S., 2023. NHS long term workforce plan.
4. Foley, C., McCourt, C. and Yuill, C., 2025. An exploration of midwives' perceptions of the Ockenden review: a qualitative study. *Sexual & Reproductive Healthcare*, p.101166.
5. Griffiths, P., Maruotti, A., Saucedo, A.R., Redfern, O.C., Ball, J.E., Briggs, J., Dall'Ora, C., Schmidt, P.E. and Smith, G.B., 2019. Nurse staffing, nursing assistants and hospital mortality: retrospective longitudinal cohort study. *BMJ quality & safety*, 28(8), pp.609-617.
6. Halligan, M. and Zecevic, A., 2011. Safety culture in healthcare: a review of concepts, dimensions, measures and progress. *BMJ quality & safety*, 20(4), pp.338-343.
7. MBRRACE-UK (2022) Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care. Oxford: National Perinatal Epidemiology Unit, University of Oxford.
8. Mid Staffordshire, N.H.S., 2013. Report of the Mid Staffordshire NHS foundation trust public inquiry. Stationery Office.
9. National Institute for Health and Care Excellence (NICE) (2015) Safe midwifery staffing for maternity settings (NG4). London: NICE.
10. National Institute for Health and Care Excellence (NICE) (2015) Safe midwifery staffing for maternity settings (NG4). London: NICE.
11. NHS England (2022) Freedom to Speak Up: Raising concerns (whistleblowing) policy for the NHS. London: NHS England.
12. Reason, J., 2000. Human error: models and management. *Bmj*, 320(7237), pp.768-770.
13. West, M. and Coia, D., 2019. Caring for doctors, caring for patients. General Medical Council.



Thank You

