

MSc Public Health and Social Care in Practice

LCHS7006: Quality Assurance and Service Improvements

Assignment Title: Component 2

Service Improvement Report

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1. Introduction

As mentioned by the final Ockenden Report (2022), the 1970s-2019 period was the timeframe of the scandal of the Shrewsbury and Telford Hospital NHS Trust in England. It involved the deaths of babies and mothers, neonatal injuries, and the development of the long-term harm of several individuals. In this regard, the inquiry led by senior midwife Donna Ockenden covers 1,592 clinical incidents involving 1,486 families between 2000 and 2019, including 131 stillbirths, 70 neonatal deaths, and 84 cases of brain damage (The Independent, 2022). Due to such tragic events in the maternity care unit of the hospital, where women and newborns received poor clinical care, a number did suffer irreparable life-long losses and injuries. These recurrent failures in the health care quality and patient safety of the NHS are clear indications of the loopholes in the system in general. The report also depicted the consequence of backlog and lack of clinical governance, review and audit procedures, leadership, and quality assurance systems. This report submerges into the case in the Maternity ward of the Shrewsbury and Telford Hospital NHS Trust in England reflecting a history of operational failures in 20 years.

The quality assurance team investigated the healthcare system of the UK in regard to exposing the underlying causes of the incidents. They found that a lack of communication and dismissive staff behaviours resulted in 200 cases of stillbirths, neonatal deaths and brain injuries, maternal deaths, and long-term physical and psychological harm to mothers (BBC, 2022). The report also highlights the failures of clinical governance trust, which consistently neglects the investigations of mothers' and babies' deaths and also prevents learning from errors, continuing unsafe clinical practices. On the other hand, there are significant deficiencies in audit and review systems, as the responsible committee gets repeated opportunities to identify the patterns of incidents but fails to address them. Their efficiency in performing internal reviews and external recommendations remains unimplemented in this case. The leaders of the Shrewsbury and Telford Hospital fostered a defensive and non-listening culture to avoid transparency and accountability (National Guardian's Office, 2022). This

leadership approach discouraged the clinical staff from raising concerns, resulting in the dismissal of families' complaints.

In addition to this, the healthcare team of the hospital did not adhere to the national maternal safety guidelines, such as foetal monitoring and escalation procedures, resulting in these catastrophic outcomes. The Ockenden Report also demonstrates that this NHS trust has a weak QA-systems for decades, which lack a robust mechanism to ensure accountability, respond to external audit, and foster continuous improvement (Ockenden Report, 2022). Moreover, this Shrewsbury and Telford Hospital case highlights the urgent need for improved structural frameworks for public health care services in the UK. This needs to prioritise transparent audit and review with continuous monitoring, strong adherence to regulatory guidelines and safety standards and practice of evidence-based governance. Therefore, this report aims to analyse the major causes of the failures using the root cause analysis method, including the fishbone diagram, the Donabedian model, SWOT analysis, the PDSA cycle, and Kotler's 8 change approach. Based on the outcomes, the report will also provide recommendations for improving the quality of care, mentioning benchmark indicators.

2. Main body

2.1 Donabedian model

In order to evaluate the quality of healthcare services, the Donabedian model (1988) is employed using three key dimensions, including structure, process, and outcome (Tossaint-Schoenmakers et al., 2021). In this case of neonatal death in the Shrewsbury and Telford Hospital, this model is applied to identify potential factors of failures to suggest improvement provisions in the following ways:

Structure

The structural shortfalls experienced by the Shrewsbury and Telford Hospital in England are due to poor staffing, clinical governance, and low leadership accountability. There was an anti-reporting culture among staff, and quality assurance systems that were not working efficiently in this case for decent control and escalation of risk. Only 49% of staff feel comfortable addressing their concerns, and only 34% think that problems will be

fixed (The Independent, 2022). This is mostly because of leadership that is defensive and doesn't listen. It is necessary to build up open leadership, strong clinical governance systems, and ongoing professional development in accordance with NHS Quality and Safety Standards to mitigate the structural loopholes (NHS England, 2022).

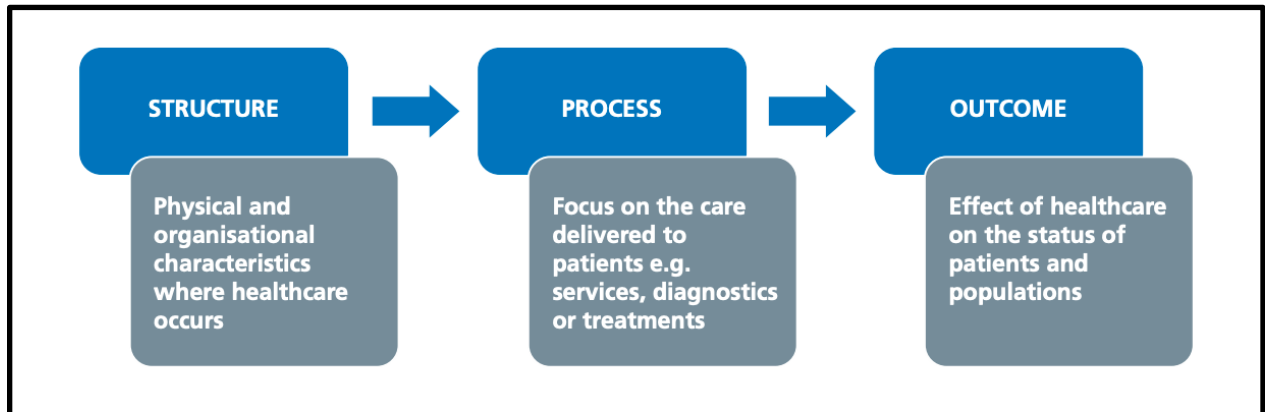


Figure 1: Dimensions of the Donabedian model

(Source: Creighton, 2023)

Process

Most of the employees working in the maternity unit of the hospital tended to disobey foetal monitoring guidelines, emergency escalation, and family concerns, as there were no routine audits. In order to improve the situation, standardised clinical audit cycles, compliance with NICE guidelines on foetal monitoring, and proactive application of the Patient Safety Incident Response Framework (PSIRF) are essential (Rea et al., 2023). Accountability and communication will be improved by creating multidisciplinary review teams.

Outcome

The disastrous effects of more than 200 cases of stillbirths, infant deaths, and maternal injuries indicate inefficient systemic processes and structural failures. The quality results should be measured by using maternal morbidity indicators, patient satisfaction findings, and near-miss reviews. Moreover, application of the Donabedian framework highlights that structural change and process quality are key to the realisation of safe, caring, and evidence-based maternity care, which would rebuild trust and minimise avoidable harm.

2.2 Fishbone Diagram

The fishbone diagram (Ishikawa) is a key approach of root cause analysis to identify and categorise the major reasons for any incident under key domains such as people, process, policies, equipment, environment, and leadership (Carvalho et al., 2021). Based on the outcomes of the Ockenden Report (2022), this diagram is used in the following manner:

People

Poor clinical outcomes occurred as the staff lacked training in foetal monitoring, showed a lack of empathy, and were unwilling to work with other disciplines. Midwives tended to dismiss the contribution of consultants, and the staff feared trying to raise any safety issue, leading to a culture of silence.

Process

Inadequate escalation and failed audit procedures, along with a lack of consistency in clinical processes, were observed where national protocols on foetal monitoring. There were poor incident reporting mechanisms, and the implementation of lessons acquired through adverse events was minimal; thus, organisational learning was not achieved.

Policy

The NHS trust continuously ignored adherence to the National maternity safety guidelines, which indicated the inefficiency of implementation of the policy (Health, 2025). Accountability towards deviation was very low, and local procedures were updated, which contradicted national standards.

Technology

There were no integrated QA tracking systems and poor monitoring equipment, which was inadequately maintained, also added to delays in making a diagnosis. The deficiency of investment in modern foetal monitoring systems restricted the capacity of the staff to identify distress in infants at an early stage.

Environment

A stressful working environment affects safe health care due to higher workload, lack of understaffing, and emotional exhaustion (Pérez-Francisco et al., 2020). The space limitation due to physical constraints also influenced the privacy and the dignity of patients, as well as the efficiency of emergency responses.

Management

Defensive and hierarchical leadership culture was the most significant factor with regard to the cause. The top management ignored grievances from patients' families, did not respond to internal audits and discouraged whistleblowing, which highlights poor transparency and responsibility.

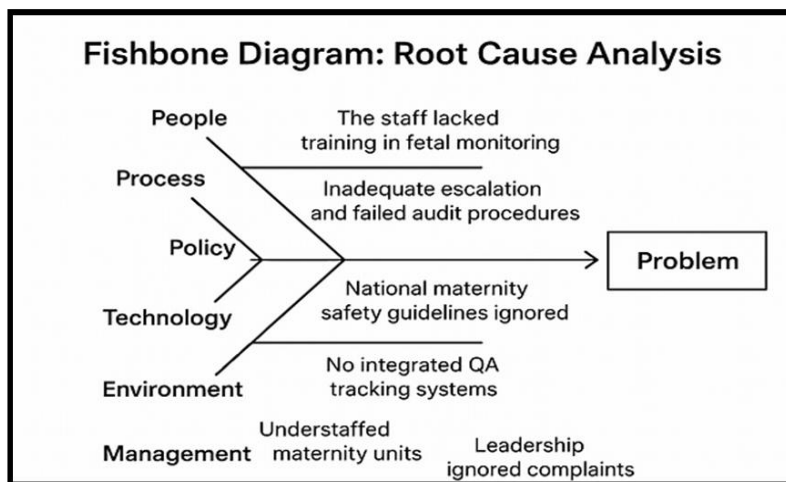


Figure 2: Fishbone Diagram

(Source: Self-developed)

Overall, the fishbone diagram shows that the harm caused to the patients was a result of a lack of training and empathy of clinical staff, poor monitoring process, and leadership deficiencies. In order to ensure the safety and public confidence, it is necessary to address these root causes for better governance, open communication, and constant training. The application of this root cause analysis method is more suitable than 5 whys in this case due to the complexity of causes, including multiple factors of failures. On the other hand, 5 whys work best for linear problems and is less effective for assessing diverse stakeholders' engagement.

2.3 SWOT analysis

Strengths	Weaknesses
• The Ockenden report pointed out that the Shrewsbury and Telford Hospital NHS Trust has recently brought new senior clinicians on board. • The healthcare organisation is now focusing on expanding the maternity services workforce to be £200 to £250 million by recruiting trained midwives and obstetricians (Health, 2022). • The Trust possesses the framework of the NHS maternity services and connects to the national guidance, which includes standards available to benchmark and implement. • The reformation across the NHS is being performed in maternity services nationwide, addressing lessons from this incident.	• A lack of clinical governance led to serious incidents with poor investigation, and not all unfavourable outcomes were learned from. • In terms of staff culture, only 49% of the staff were comfortable voicing their concerns, and only 34% thought the concern would be resolved due to defensive and non-listening leadership (The Independent, 2022). • Continued failure to comply with the national guidelines, such as a low rate of caesarean section, even in cases of risk, along with poor supervision of foetal conditions (ITV News, 2022).
Opportunities	Threats

• The adoption of the Ockenden recommendations and more than 60 essential actions would provide a roadmap to change, including safer maternity care, investment in the workforce, training, and escalation procedures to enhance care quality (Robertson, 2025). • Communication with the bereaved families and openness provide the opportunity to restore trust and instil a patient-focused culture. • Recent initiatives suggest the Trust share its progress with a national review and also chief executive Louise Barnett, seek feedback from patients' families to design safer services (BBC News, 2024).	• The reputational loss with media scrutiny and enhanced public distrust over the deaths of more than 200 babies and 9 mothers, hindering recruitment, retention, and patient confidence (Freeths.co.uk, 2022). • NHS-wide pressures, staffing shortages, and compensation claims strain the resources and become obstacles to improvement, posing a risk of recurrence. • Extrinsic control measures and oversight of the Care Quality Commission (CQC) cause lower service usage or intervention of oversight in case of stalling improvements.
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Table 1: SWOT analysis table

(Source: Self-prepared)

2.4 PDSA (Plan-Do-Study-Act) Cycle

The review of quality performance by the shows that the trust plans to include a PDSA (Plan-Do-Study-Act) model to reform strategies for the improvements of maternity safety, patient satisfaction, and leadership with accountability.

Plan

The planning step will ensure the enhancement of clinical supervision by the use of multidisciplinary safety board's addressing the failures of clinical governance and monitoring processes. The offerings of an open system of incident reporting and feedback are based on the Patient Safety Incident Response Framework (PSIRF) (NHS England, 2022). The bereaved families and patient advocates can be involved in patient-centred reform safety committees. According to NICE (2022), foetal monitoring, compassionate taring, and escalation procedures can be introduced to the Trust. The data of progression can be measured through surveys of staff safety climate, completion rates of training, and a decrease in preventable accidents.

Do

The implementation of the designed plan can be performed through pilot testing by introducing safety huddles and daily clinical review meetings within the maternity unit. This can be supported through appointing expert professionals of maternity safety and conducting workshops to improve the emotional intelligence of staff.

Study

In this case, assessment can be done after three months of pilot testing. The analysis will be based on the data obtained through incident reports, family feedback and maternal and neonatal outcomes. The benchmarking of key performance indicators will be carried out on national standards. The focus groups will allow for determining behavioural changes, communication enhancement, and the barriers that have persisted. The results will be used to establish if the interventions are effective in curbing harm and enhancing trust.

Act

The stage of actions in the PDSA cycle measures successful interventions of the plan, which will be scaled throughout the trust depending on the outcomes. Strategies that are not working will be modified or replaced with improved ones. The lessons learned will be integrated into the Continuous Quality Improvement Framework of the Trust, and accountability will be ensured by carrying out regular audits and open reporting to the

public. Constant involvement in leadership and empowerment of staff will make the change part of the organisational culture.

Here, PDSA cycle is selected to emphasise iterative learning through *study* phase as it is essential in healthcare to evaluate patient safety benchmarks. On the other hand, the PDCA focuses on check which narrows the aspects to address complexity of clinical environments.

2.5 Kotler's 8 change model

In order to suggest suitable strategies for transforming organisational culture, addressing systemic failures of the Shrewsbury and Telford Hospital NHS Trust, the elements of Kotler's 8 change model can be employed in the following ways:

Create a sense of urgency

The deaths of more than 200 babies and several mothers at the NHS Trust posed a moral and professional necessity to take some immediate action (Buchanan, 2024). Such urgent communication assists in breaking the complacency and resistance of the staff.

Build a guiding coalition

The reformation process can be collaborative and powered by a multidisciplinary task force comprising senior clinicians, representatives of patients and external regulators.

Form a strategic vision

The Shrewsbury and Telford Hospital NHS Trust can set a vision of the "Safe, Compassionate, Accountable Maternity Care" that would help align the staff with quantifiable safety and empathy targets.

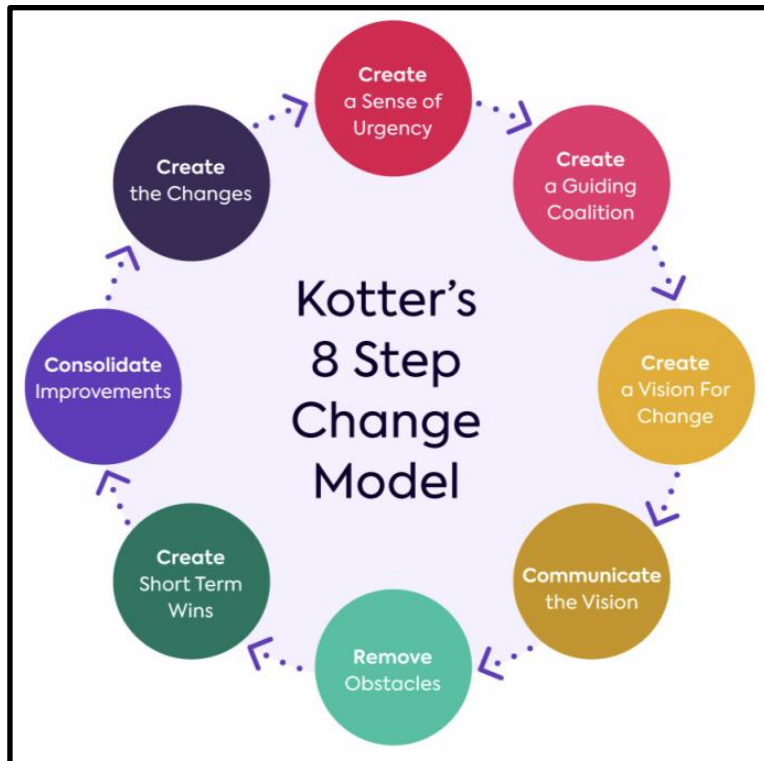


Figure 3: Kotter's 8 change model

(Source: Majka, 2024)

Communicate with the vision

The vision of the organisation can be demonstrated to the staff with clear communication between leaders and the workforce through meetings, digital dashboards, and engagement sessions with patients' families.

Remove barriers

The fear and defensiveness need to be minimised by empowering the staff, providing leadership training, open reporting and whistleblower protection.

Create short-term wins

The continuous improvements within the health care quality of the trust can be visible by setting short-term goals and assess those, such as patient satisfaction and a decrease in incidents. This will also build confidence among staff and leaders.

Consolidated improvements

The improvements of the maternity care services in the trust can be accelerated with regular monitoring and both internal and external audits of professional approaches.

Include changes with organisational culture

The incorporation of experiential learning and patient experiences into practice makes the cultural and behavioural change permanent within the Shrewsbury and Telford Hospital NHS Trust.

The three-stage model (Unfreeze-Change-Refreeze) by Kurt Lewin works well in limited and structured changes, but it lacks flexibility while addressing complex culture and multi-level structural changes (Burnes, 2020). On the other hand, Kotter's eight-step change model allows continuous learning, communication, and behavioural alignment, which is more suited to long-term transformation within an NHS Trust that has a profound governance and cultural shortage.

3. Recommendation

3.1 Benchmark table

Based on the reports of the Care Quality Commission (CQC) and the long history of failures of clinical governance of the NHS Trust, the following benchmark indicators are designed:

Benchmark Indicator	National Standard	Hospital Performance (Before)	Hospital Performance (After)
Clinical Governance and Incident Learning	100% of serious incidents reviewed within the Patient Safety Incident Response Framework (PSIRF) (NHS England, 2022)	Only 28% of incidents were reviewed within 30 days (Ockenden, 2022)	Achieved 95% compliance with reviews
Audit and Review Processes	Monthly multidisciplinary audits (Cqc.org.uk, 2018)	Audits are conducted annually (Ockenden, 2022)	12 audits/ year, with external oversight introduced
Leadership and Safety Culture	62.3% staff feel safe to raise concerns (Feinmann, 2024)	Only 42% staff reported feeling safe to speak up (Ockenden, 2022)	Improved to 88% after cultural transformation programs
Policy Adherence (Maternity Safety)	100% adherence to foetal monitoring and escalation protocols (NICE, 2022)	Non-compliance in over 60% of reviewed cases (Ockenden, 2022)	Reduced non-compliance to 12% through mandatory training

Table 2: Benchmark table

(Source: Self-created)

4. Conclusion

The incidents of death of newborns and mothers with long-term damage at Shrewsbury and Telford Hospital NHS Trust represented the organisation's long history of failures. The Ockenden Report of 2022 exposed that poor leadership, disobedience to NHS guidelines, and a lack of clinical governance resulted in these tragic incidents. For this case, the root cause analysis approaches of the fishbone diagram, the Donabedian model, and the SWOT analysis are selected for this report to identify the underlying factors. The Donabedian Model demonstrates how structural inadequacies, inefficient clinical processes, and poor patient outcomes are interdependent with each other. Likewise, the Fishbone Diagram helped to identify the ultimate causes in the people, process, policy, and leadership spheres.

The SWOT analysis shows that despite the Trust experiencing dire reputational and operational losses, it has a chance to transform itself by acting upon the suggestions provided by Ockenden, like training its workforce and cultural change. The 8-Step Change Model offered by Kotter gave a dynamic roadmap to cultural and behavioural change, including suggestions of continuous communication, engagement, and alignment of leadership. The negligence of the healthcare professionals and hospital staff resulted in the death and injuries of newborns and expectant mothers, which requires suitable modifications in hospital operations. Therefore, the PDSA cycle presented a practical model of long-term enhancement with evidence-based planning, implementation, monitoring, and adaptation. The Trust should instil compassion, transparency, and accountability throughout all spheres of practice, which will turn tragic lessons into a culture of sustainable learning and excellence in patient care.

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