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Y Drindod Dewi Sant
University of Wales
Trinity Saint David

Programme: MSc Public Health and Social Care in Practice

Module: Quality Assurance and Service Improvements

Module code: LCHS7006

Assignment Title:

Component 2 Service Improvement Report

Shrewsbury and Telford Hospital NHS Trust (UK) -Maternity Scandal

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1. Introduction

1.1 The origin of the problem

The Shrewsbury and Telford maternity scandal is among the largest instances of systemic failure in NHS maternity care in recent decades. The last Ockenden Review found that decades of avoidable maternal and neonatal harm in services that should have safeguarded women and babies was caused by repeated failures in care (Ockenden, 2022). The importance of the case is not merely due to the magnitude of the damage, but as well due to the fact that the failures were not due to isolated incidence, but instead due to systemic and recurrent failure. Staff, women, and families expressed their concerns, but they were not always pursued, whereas the possibility to intervene, learn, and get better opportunities was missed again and again (Ockenden, 2022; Francis, 2013). Consequently, the case offers a valuable example of the ways in which the flaws in governance, patient safety, and organisational culture may disrupt the maternity care.

1.2 Quality and quality assurance in healthcare

Healthcare quality is often defined as the level at which services enhance the probability of desirable health results and align with the existing professional knowledge (Donabedian, 1988). High-quality care entails not just technical effectiveness but also safety, patient-centredness, timeliness, efficiency, and equity (Institute of Medicine, 2001). This is particularly true during maternity care where any delay in the detection or exacerbation of risk can quickly result in severe injury. Quality assurance is defined as systems, standards, monitoring processes and accountability mechanisms that are employed to provide care in a safe and consistent manner. These involve governance provisions, incident reporting, audit, review and organisational learning procedures that help the services to detect risk and act suitably (Vincent, 2010). In addition, effective quality assurance depends on strong leadership, continuous staff training, and the integration of patient feedback into service improvement, ensuring that care delivery remains responsive, transparent, and aligned with evolving clinical standards and patient expectations.

1.3 Significance of continuous quality improvement in social care and health in the community

Continuous quality improvement is directly related to quality assurance, but is more focused on constant learning, reflection, and service redesign. Instead of merely sustaining standards; it aims to enhance systems in the long run by using evidence, feedback, and reaction to the risks that come up (Batalden and Davidoff, 2007). This is particularly vital in maternity care where teamwork, effective communication, timely escalation, and responsive leadership are the key elements that dictate safe outcomes. The Shrewsbury and Telford case explains the impacts of not integrating such improvement processes. The number of incidents and warning signs did not translate into meaningful organisational learning, which implies that the service did not possess the ability and the desire to get better at responding to risk (Ockenden, 2022). It is also a matter of concern to the public health and social care since maternity safety

failures have proven to have an impact on family wellbeing, confidence in the healthcare services, and confidence in broader care systems (Institute of Medicine, 2001; Ockenden, 2022).

1.4 Aim and structure of the report

This report dwells upon the quality assurance deficiencies that led to preventable injuries in maternity care in Shrewsbury and Telford Hospital NHS Trust (Ockenden, 2022). It examines the issue with the help of Fishbone Diagram, 5 Whys, Donabedian Model, and SWOT analysis, and provides evidence-based recommendations backed by the PDSA cycle. In general, the report will demonstrate how better governance, safer organisational culture, and quality improvement that is organised can facilitate safer and more accountable and sustainable maternity, ensuring long-term improvements in patient safety outcomes and service quality across healthcare systems.

Main Body

Background and scope of the problem

2.1 Background and scope of the problem.

Shrewsbury and Telford maternity scandal is one of the huge failures in quality assurance in NHS maternity services. The last Ockenden Review discovered that the recurrence of failures in maternity care took place over many decades, the 1970s to 2019, and led to preventable maternal and neonatal injuries (Ockenden, 2022). The scale of the damage is not the only detrimental aspect of the issue, but the fact that the failures were long-term and recurrent, and integrated into organisational processes, as opposed to episodic causes. Women, families, and staff also raised their concerns that were not always chased and a chance to intervene, learn, and become better was never taken (Ockenden, 2022; Francis, 2013).

The case is relevant in terms of health and social care as the failures in maternity safety not only impact the clinical outcomes, but also the family wellbeing, trust in healthcare services, and confidence in the broader care systems (Institute of Medicine, 2001; Ockenden, 2022). Maternity care is one of the most dangerous services as an escalation, an insufficiency of communication, and inefficient review systems can easily cause a drastic harm. Consequently, there is a need to have good governance, reporting and learning in organisations. However, the case shows that these mechanisms were not functioning correctly, and the practice of unsafe is normalised with time (Mannion and Davies, 2018, Ockenden, 2022). This highlights the urgent need for system-wide improvement, where learning from past failures is embedded into daily practice, ensuring that similar incidents are prevented and patient safety is consistently prioritised across all levels of care.

2.2 Continuous quality improvement and case.

Quality improvement is a continuous process in healthcare since it concerns continuous learning, reflection, monitoring and redesign as opposed to minimum standards compliance (Batalden and Davidoff, 2007). It is specifically applicable to the environment of maternity care as safe outcomes depend on the ability to timely identify the risks, communicate effectively and multidisciplinarily, have a rapid escalation, and responsive leadership (NHS England, 2019). It is not likely that a service can ensure a repeat failure is avoided unless the negative events and feedback are analyzed and actions taken to respond to the malpractice indicators.

The Shrewsbury and Telford case illustrates the consequences of having a weak or ineffective continuous quality improvement. The Ockenden Review found that repeat incidents, grievances, and issues did not lead to effective organisational learning and long-term corrective intervention (Ockenden, 2022). This means that it was not the poor care as such, but rather that the organisation did not become a better organisation than it used to be as a response to risk. A better culture of operation would be set up by initiating audit, review and follow up action due to recurrence failures. In this case, learning systems were either ineffective, fragmented, or disjointed (Ockenden, 2022; Vincent, 2010).

2.3 Swiss Cheese Model.

The Swiss Cheese Model explicates that damage in complex organisations takes place when several layers of protection go awry concurrently (Reason, 2000). The model shows that organisational protection mechanisms are vulnerable and that they can result in harm when the vulnerabilities are harmonised rather than taking the adverse events as the consequence of a single error made by a particular individual. Examples of such healthcare safety measures may include governance, staffing, reporting, communication protocols, and organisational culture. The model can be applied to the Shrewsbury and Telford scandal as it shows that one mistake did not result in inevitable harm but that there are errors that pass through the system.

Governance and oversight was one of such significant defense lines. Good governance should be in a position to create awareness of safety risk at the board level, accountability of repeated failures and response to risk pattern. Nevertheless, very serious problems of supervision and response to the ongoing maternity safety concerns were revealed by the Ockenden Review (Ockenden, 2022; Francis, 2013). Incident reporting and investigation was a second layer. Repeated incidents in safe systems should result in organisational learning and improvement of services. Here, research was not necessarily timely and efficient and education was not necessarily translated into practice change (Ockenden, 2022; Vincent, 2010).

Communication and escalation was a third layer. Maternity care needs to be safe by ensuring timely dissemination of information, joint decision making and raising of concern. Failure to establish communication may slow down the risk identification process and may be the immediate cause of damage (Vincent, 2010). Organisational culture was a fourth layer. The

employees must be allowed to raise issues, raise concerns on unsafe practices and report without intimidation. A defensive culture can be observed in this instance as it seems to have suppressed openness and undermined effective challenge (Mannion and Davies, 2018; Ockenden, 2022). This system thinking can be furthered to say that the scandal was systemic and not due to isolated clinical errors.

Swiss Cheese Model (Reason's Model)

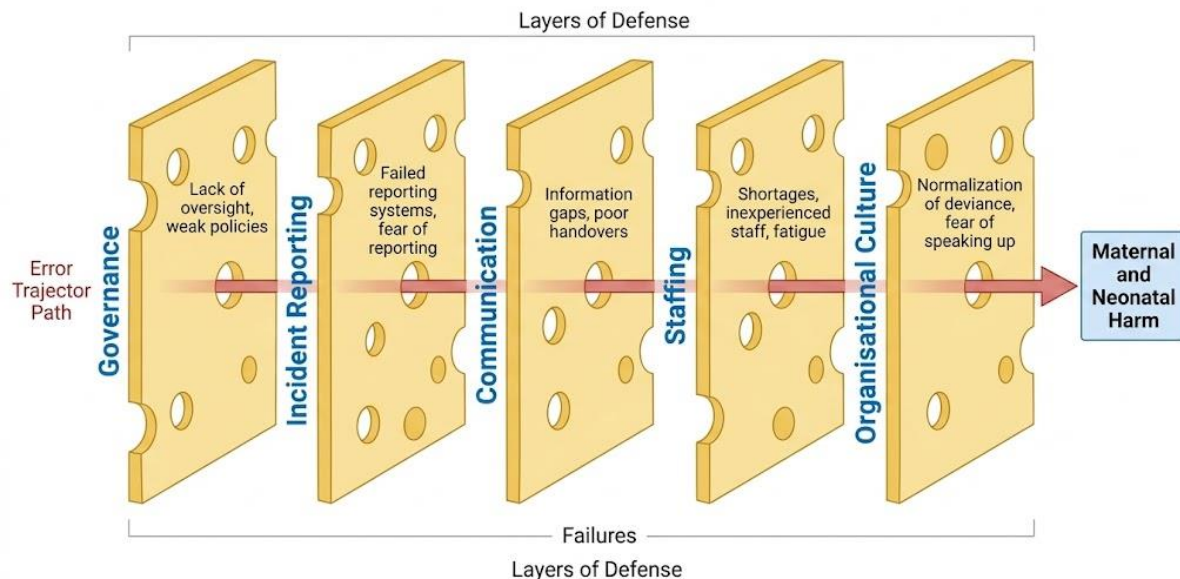


Figure 1: Swiss Cheese Model illustrating system failure in maternity care (Reason, 2000).

(Source: Self-created using design tools)

2.4 Root cause analysis with Fishbone Diagram and 5 Whys.

Root cause analysis is a systematic approach which assists in identifying the root cause of failure rather than focusing on the visible mistakes or on the immediate outcomes (Vincent, 2010). The Fishbone Diagram is apt in this report because it is flexible, the categories can be customized to the case and it is appropriate to complex healthcare failures that have a number of interacting causes (Ishikawa, 1986).

5 Whys:

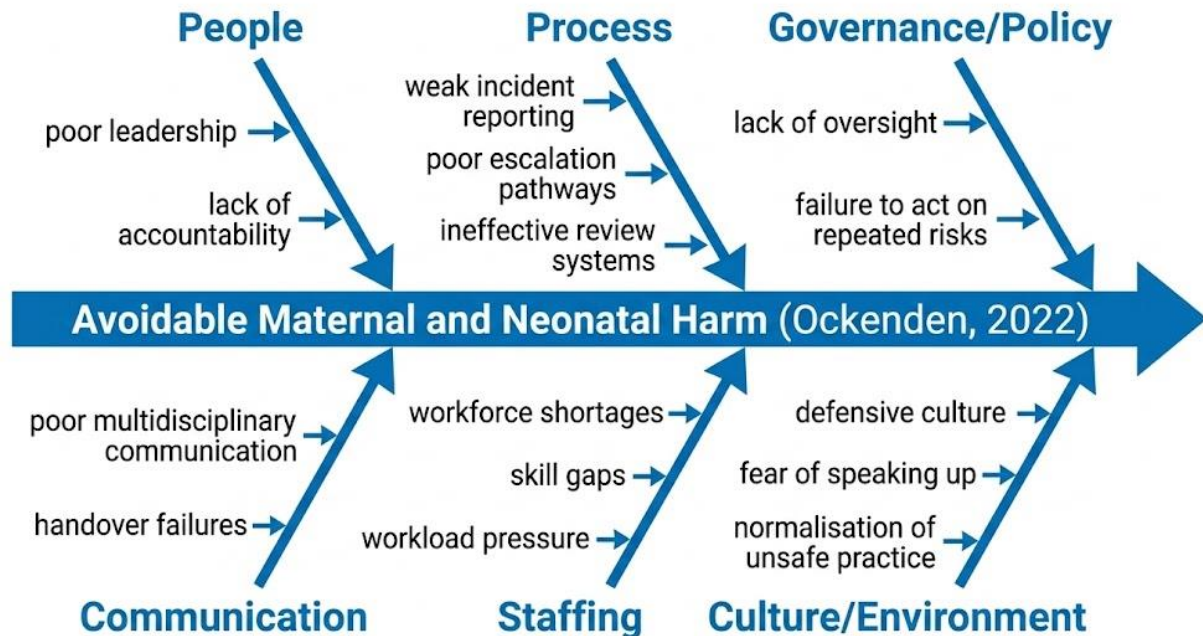
What are the causes of preventable deaths? Due to lack of timely interventions.

Why? Normal birth was the priority of staff.

Why? Escalation was discouraged.

Why? Leadership ignored concerns.

Why? Unsafe maternity practices had been practiced over the years due to weak governance and lack of accountability.



(Diagram Source: Self-created using design tools)

Figure 2: Fishbone Diagram of the Causes of the Shrewsbury and Telford Maternity Scandal. Outcome: Avertable maternal and neonatal injury (Ockenden, 2022) Types: People; Process; Governance/Policy; Communication; Staffing; Culture/Environment. Source: Author's own adaptation based on Ishikawa (1986), Ockenden (2022), Francis (2013), Vincent (2010), West et al. (2014), Leonard, Graham and Bonacum (2004), and Mannion and Davies (2018).

2.5. Usage of Donabedian Model.

The convenience of Donabedian StructureProcessOutcome model is that it provides a connection between the situation in an organisation to delivery of care and patient outcomes (Donabedian, 1988). In Shrewsbury and Telford case, structure involved governance, leadership, staffing and quality assurance systems. They were feeble, especially when it comes to oversight, accountability, and organisational learning (Ockenden, 2022). It involved bad communication, lack of good escalation, ineffective incident review, and coordinated decision-making failures (Ockenden, 2022; Vincent, 2010). These unjust procedures were a direct contributor to the outcomes, such as preventable maternal and neonatal injuries, trauma, and loss of trust (Ockenden, 2022).

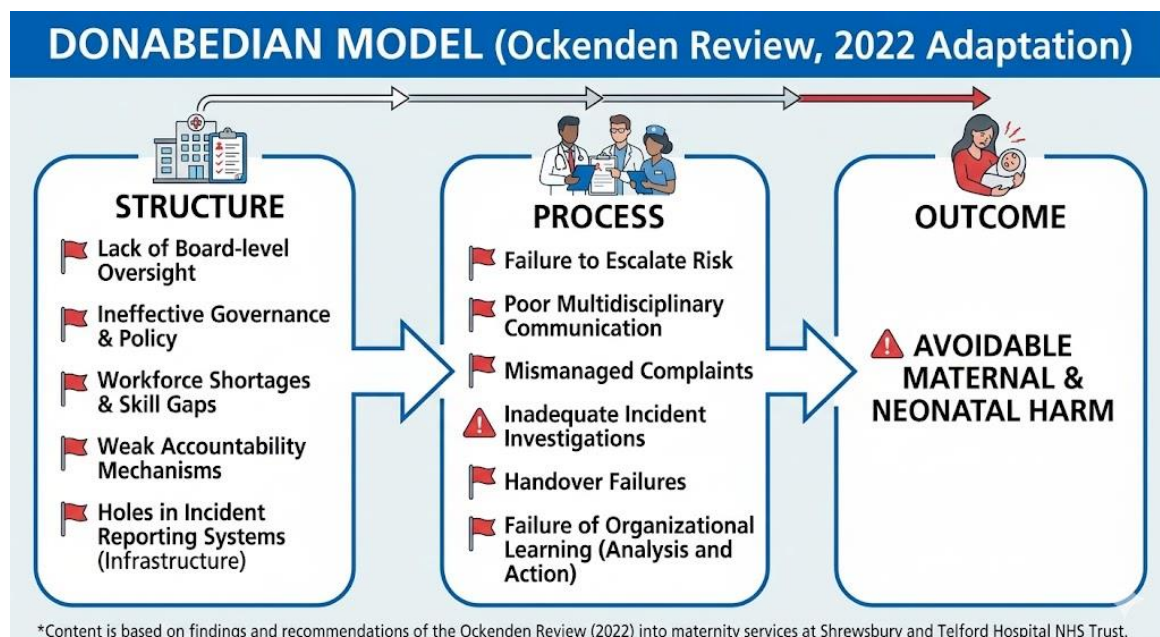


Figure 4: Donabedian Structure–Process–Outcome Model applied to maternity care failures (Donabedian, 1988). Diagram (Source: Self-created using design tools)

The beauty of this model is that the adverse impacts were not accidental, because they were pre-established with ineffective constructions and unsafe working. This aids in arguing that organisational change and not frontline correction is required to change the maternity care safety.

2.6 SWOT analysis to make the service plan better.

SWOT analysis assists the linking of diagnosis with planning by establishing the internal strengths and weaknesses, external opportunities and threats. One such strength is the capability to now retrieve the results of investigations, national maternity safety standards, and existing levels of improvement (Ockenden, 2022; NHS England, 2019). The major weaknesses include ineffective governance, a fractured trust, ineffective learning systems, staffing strain, and defensive culture (Ockenden, 2022; Mannion and Davies, 2018). The most important opportunities are the redesign of the review systems, training on multidisciplinary basis, and greater engagement of women and families in service evaluation (NHS England, 2019). Some of the biggest threats are the workforce shortages, resistance to change, fatigue of implementation and blame culture (Kotter, 1996; Edmondson, 1999).

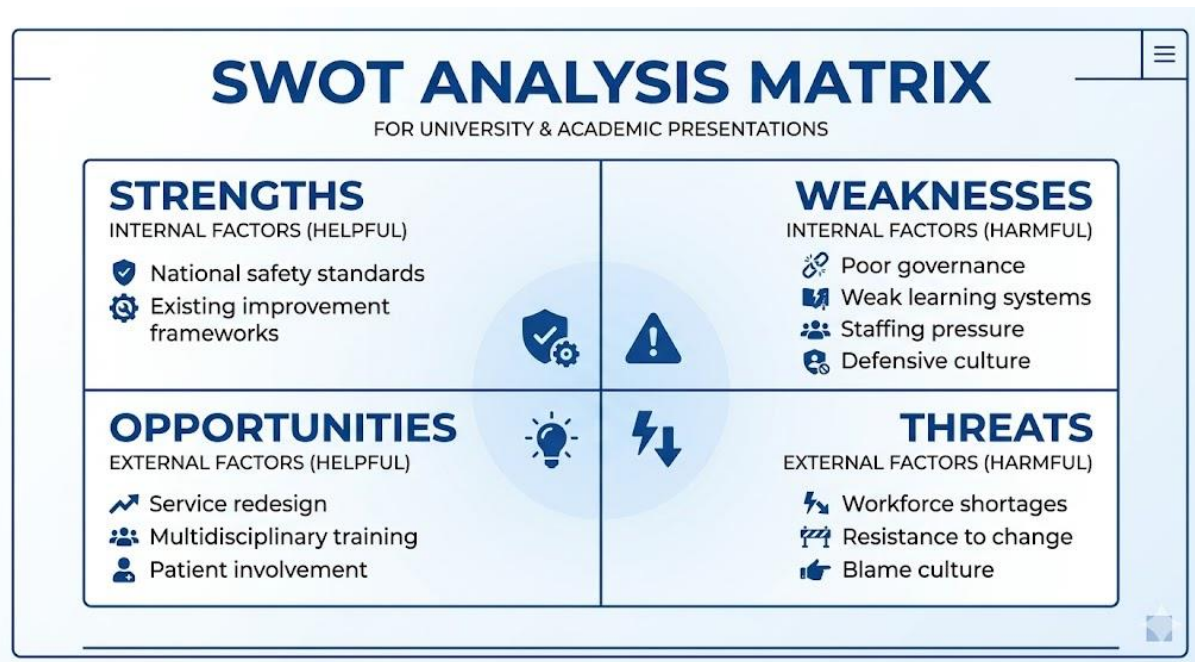


Figure 5: SWOT Analysis of Shrewsbury and Telford maternity services. (Image Source: Self-created using design tools)

All in all, these structures demonstrate that the Shrewsbury and Telford maternity scandal was a failure in quality assurance at a system level. The concept of continuous quality improvement did not work, various safeguards were not working and root causes were spread to other parts of the organisation. Evidence-based recommendations are based on this analysis.

Recommendations

The analysis shows that the collapse of Shrewsbury and Telford has been systemic and thus needs system level recommendations, as opposed to corrective measures in solitude. The identified root causes such as weak governance, poor organisational learning, ineffective communication, staffing pressure, and defensive culture, are directly related to the recommendations as follows. They are also connected with the general literature on patient safety, which emphasizes that the meaningful change can only be achieved through leadership, learning systems, multidisciplinary practice, and accountability (Vincent, 2010; Ockenden, 2022).

3.1 Enhancing governance and accountability

The initial one is the improvement of governance and accountability of maternity services. The board-level oversight of maternity safety should be built by routinely taking into account safety indicators, serious incidents, complaints, and escalation data (Ockenden, 2022;

Francis, 2013). This is necessary because the situation could allow repeated traumas without taking any immediate measures. The governance structures should be in a way that they should evaluate maternity risks periodically, that they raise issues among themselves in a timely manner and that there is a clear responsibility to act correctly. Practically, this means assigning specified senior leaders responsible to maternity safety and the necessity to show that incidents-related actions are taken and completed.

3.2 Improving reporting and organisational learning

The second recommendation is to re-architecture reporting and learning systems in a manner that will allow incidents, near misses, and complaints to be not only documented, but transformed to quantifiable change. The incident investigation has to be timely, routine, and interdisciplinary, and results have to be delivered in the form of feedback to the staff and as specific service improvements (Vincent, 2010; Ockenden, 2022). This is as dictated by the principle of closed-loop learning whereby information is translated into action and the action is evaluated on its effectiveness. The complaint systems also need to be strengthened to make sure that the issues of women and families are considered as valuable safety intelligence, rather than the discontent that is perceived as a single problem. This would be a direct reaction to one of the biggest blunders of the scandal the inability to learn meaningfully in the organisation when recurrent red flags indicate it.

3.3 Building the workforce capacity, collaboration and communication

The third suggestion is to increase the workforce capacity through periodical multidisciplinary training on communication, escalation, and teamwork and reflective learning. Teamwork is important in the context of the maternity care as only through the coordination of professional judgement and prompt intervention in the situation that may rapidly deteriorate, the safe outcomes can be guaranteed (Leonard, Graham and Bonacum, 2004; West et al., 2014). In the same way, proper communication is another patient safety tool since the inefficiency of handover, information transfer, and escalation could directly lead to the negative consequences (Vincent, 2010). It must be an educational experience, therefore, not merely clinical competence, but also concerning human factors, communications and joint decision making. Along with this, the leaders should promote psychological safety in a manner that the employees are not afraid to express themselves without fear of being reproached (Edmondson, 1999). This is needed since one of the key aspects of the scandal was a defensive culture.

3.4 Involving women and families in quality assurance

The fourth recommendation is to involve women and families in the review of safety monitoring and service more actively. Their experience should be used to inform incident review and complaint systems and service evaluation (Ockenden, 2022). This is explained by the fact that the issues brought up by families were not consistently taken into account, although they were related to patient safety. The more human approach would promote trust, increase quality assurance, and complicate the process of hiding maleficent patterns.

3.5 Implementation through PDSA

The PDSA cycle should be used to support implementation. Within the Plan stage, Trust ought to choose a priority area of maternity safety, e.g., delayed escalation or weak complaint-learning systems and formulate measurable objectives of improvement (Langley et al., 2009). Piloting of the intervention during the Do stage should be undertaken, e.g., by introducing an organized handover tool or multidisciplinary review meeting. The audit statistical data, the trends of incidents, the staff comments and the patient experience will be analyzed during the Stage of Study. Successful changes must be tested and implemented in routine practice in the Act stage (Deming, 1986; Langley et al., 2009). The improvement process can also be made easier with the help of lean principles that contribute to minimizing workflow inefficiencies, although the main tool in this scenario is PDSA as it is practical, iterative, and it suits the maternity service improvement better.

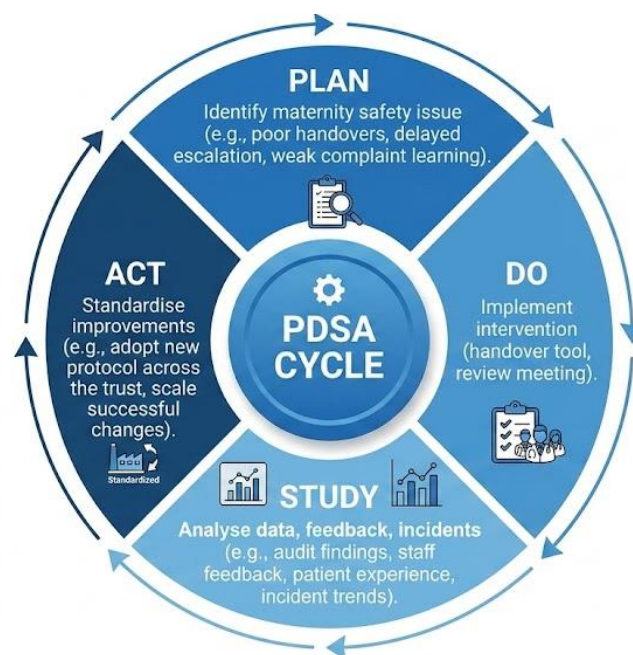


Figure 6: PDSA Cycle for maternity service improvement (Langley et al., 2009). (Image Source: Self-created using design tools)

Conclusion

The Case of the Shrewsbury and Telford maternity scandal is one of the biggest failures of quality assurance of the NHS maternity services. This report has demonstrated that a single clinical error was not the cause of the problem, but rather a series of weaknesses in governance, communication, staffing, reporting systems, organisational culture and leadership. Such malpractices were still experienced decades later and this allowed the normalisation of unsafe practice and did not allow meaningful organisational learning via incidents, complaints and service-user concerns.

The frameworks in this report have facilitated the discussion of the intricacy of the failure. The absence of effective learning and adaptation comes to the forefront courtesy of continuous quality improvement. The Swiss Cheese Model illustrated the way in which

several safety barriers broke down in a domino effect. The Fishbone Diagram and 5 Whys model were useful to relate more structural and cultural root causes but the Donabedian model was used to demonstrate how weak structures and processes of the unsafe type contributed to the adverse outcomes. The SWOT analysis also explained the internal and external factors that will likely impact future reform.

The suggestions of this report will assist in enhancing the governance, organisational learning, communication and capability of workforce to avoid future harm. All in all, the report concludes that safer maternity care needs to be more governable, better to learn and develop as an organisation, improve teamwork and communication and be open and accountable culture. Implementing an evidence-based change through monitoring, reviewing and incorporating the change into routine practice over time through systematic quality improvement methods like the PDSA cycle will ensure that improvements are not only introduced but sustained in the long term. Ultimately, this case highlights the importance of placing women and families at the centre of care, fostering a culture of openness and learning, and ensuring that past failures lead to meaningful and lasting improvements in patient safety.

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