



**Programme :** MSc Public Health and Social Care in Practice

**Module:** Quality Assurance and Service Improvements (LCHS7006)

**Silenced Concerns, Systemic Failure:  
A Service Improvement Report on Quality Assurance Failings at the  
Countess of Chester Hospital Neonatal Unit**

Assignment Component 2: Service Improvement Report

**Student Name:** Ripon Kumar Kar  
**Student Number:** 2525519

**Lecturer:** Christopher Mafuva

| <b>Index</b> |                                                          |                |
|--------------|----------------------------------------------------------|----------------|
| <b>SI No</b> | <b>Contents</b>                                          | <b>Page no</b> |
| 01           | Introduction                                             | 3              |
| 02           | Rationale for the Theoretical Framework                  | 4-5            |
| 03           | Root Cause Analysis                                      | 5-6            |
| 04           | A systemic Perspective:The Swiss cheese Model            | 6-7            |
| 05           | Structure,Process,Outcome:The Donabedian Model           | 7              |
| 06           | Impact on Quality,Efficiency & Equity                    | 7              |
| 07           | SWOT Analysis of the Trust's Quality Assurance Functions | 8-9            |
| 08           | Wider Policy context                                     | 9-10           |
| 09           | Recommendation                                           | 10-12          |
| 10           | Conclusion                                               | 13             |
| 11           | Reference List                                           | 14-16          |

## Introduction

Quality assurance in health and social care means the systems organisations put in place to monitor, evaluate and improve how safely and effectively care is delivered (Donabedian, 1988; Vincent, 2010). When those systems fail, the consequences are not abstract. Between June 2015 and June 2016, an unusually high number of infant deaths and collapses occurred on the neonatal unit at the Countess of Chester Hospital (BBC News, 2026), and it is this case that this report takes as its starting point. Table 1 sets out the key events.

| Date      | Event                                                                                                                   |
|-----------|-------------------------------------------------------------------------------------------------------------------------|
| Oct 2015  | Senior consultants first raise concerns linking the deaths to a named nurse (Health Service Journal, 2024)              |
| 2016      | RCPCH invited review finds no single cause; the recommended detailed case review is not fully carried out (RCPCH, 2016) |
| Jun 2016  | The nurse is moved to administrative duties, and the deaths cease (BBC News, 2026)                                      |
| 2023-2024 | Two Crown Court trials result in convictions on multiple counts of murder and attempted murder                          |

*Table 1: Timeline of key events, Countess of Chester Hospital neonatal unit (adapted from BBC News, 2026; Health Service Journal, 2024; RCPCH, 2016).*

The case eventually led to the Thirlwall Inquiry, set up to examine how the killings went undetected for so long (Thirlwall Inquiry, 2026). Its final report has not yet appeared; the timetable has slipped repeatedly, and publication is not now expected before autumn 2026 (Neil Wilby Media, 2026).

Criminal responsibility here rests with an individual, but that is not really what this report is about. The more useful question for a module on quality assurance is why the organisation's own systems failed to act on clinical concerns for roughly eight months once they had been raised. Seen that way, Chester fits a pattern that keeps

recurring across the NHS: staff who raise concerns are not believed, management cultures close ranks to protect reputation, and external bodies are not given the full picture (Francis, 2013; Kirkup, 2015; Ockenden, 2022). What follows treats the case as an example of quality assurance breaking down, not as a commentary on the criminal trial.

The report does three things. It analyses the root causes of the escalation failure using the Fishbone Diagram (Ishikawa, 1985), the Swiss Cheese Model (Reason, 2000) and Donabedian's (1988) structure-process-outcome model, and looks at the resulting impact on quality, efficiency and equity, supported by a SWOT analysis of the trust's quality assurance function. It then places these findings in a wider national policy context, comparing the case with other well-known NHS safety failures to show that the weaknesses involved are systemic rather than specific to one trust. Finally, it sets out recommendations built around the Six Sigma DMAIC methodology (George, 2002) for strengthening how frontline concerns are escalated and acted on.

This is not unique to healthcare's hardest cases: the wider patient safety literature is consistent that preventable harm rarely comes down to one bad decision, but results from several organisational weaknesses interacting with a specific event (Leape, 1994; Institute of Medicine, 2000; Panagioti et al., 2019).

## **Rationale for the Theoretical Framework**

Several tools exist for analyzing organizational failure, and each does a slightly different job. The Fishbone Diagram (Ishikawa, 1985) is useful here because it breaks a multi-causal failure down into categories that can be compared against each other (Vincent, 2010). The Swiss Cheese Model (Reason, 2000), by contrast, explains why

the failure persisted despite several safeguards being in place, which keeps the analysis focused on the system rather than any one person. Donabedian's (1988) structure-process-outcome model is included because it remains the standard framework for evaluating quality in health services, and a SWOT analysis is used later to draw these findings together into something closer to strategic reflection (Learned et al., 1965).

## Root Cause Analysis: The Fishbone Diagram

Using Ishikawa's (1985) Fishbone Diagram, four categories of contributing cause emerge, all pointing towards the same underlying effect: concerns were raised but not acted on in time. Table 2 sets these out.

| Category | Root Cause Identified                                                                                                                                                            |
|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| People   | Consultants' concerns, raised from October 2015, were dismissed as coincidence rather than treated as a safety signal (Health Service Journal, 2024)                             |
| Process  | The detailed case review recommended by the RCPCH was not carried out as specified; no standardised investigation mechanism existed before 2022 (RCPCH, 2016; NHS England, 2022) |
| Policy   | Local whistleblowing routes were weak, echoing gaps later addressed nationally (Francis, 2015)                                                                                   |
| Culture  | A defensive, reputation-focused culture pressured staff towards reassurance rather than investigation (Francis, 2013; Kirkup, 2015)                                              |

*Table 2: Fishbone root cause summary (adapted from Ishikawa, 1985).*

What stands out is how these four categories reinforce each other rather than operating in isolation. A weak policy environment made a defensive culture easier to sustain; that culture, in turn, made it easier to dismiss what individual clinicians were saying, a pattern that recurs across NHS whistleblowing cases, where staff who raise concerns often carry real personal and professional risk for doing so (Vincent and

Amalberti, 2016). The value of Ishikawa's (1985) model is that it will not let the analysis settle on a single cause; the failure only makes sense as something systemic.

## A Systemic Perspective: The Swiss Cheese Model

Reason (2000) argues, essentially, that accidents happen when the gaps in several layers of an organisation's defences line up at the same moment, rather than because any one layer fails completely. At the Countess of Chester, four layers had weaknesses running concurrently, summarised in Table 3.

| Defence Layer      | Weakness Identified                                                                                             |
|--------------------|-----------------------------------------------------------------------------------------------------------------|
| Leadership         | Concerns raised from October 2015 were repeatedly downplayed by trust management (Health Service Journal, 2024) |
| Investigation      | The RCPCH-recommended detailed case review was not fully completed as specified (RCPCH, 2016)                   |
| Culture            | A reputational, defensive culture discouraged consultants from escalating further                               |
| External oversight | External review bodies were not given full information with which to act decisively                             |

*Table 3: Swiss Cheese Model defence-layer summary (adapted from Reason, 2000).*

None of these gaps on its own explains eight months of continued harm; it is their alignment that does. The model has its critics, and it is worth engaging with that. Perneger (2005) points out that the Swiss Cheese metaphor can end up doing accountability no favors, since it makes harm sound like an almost inevitable by-product of complexity, which risks letting individuals who ignored clear warning signs off the hook. That tension is real here, too. Treating failure as systemic does not mean nobody made a specific, avoidable choice to delay or dismiss a concern; it means the model is best read as an explanation of how the harm became possible, not an excuse for the people involved.

## **Structure, Process and Outcome: The Donabedian Model**

Donabedian's (1988) model separates quality into structure, process and outcome. Here, the structural weaknesses, an underdeveloped whistleblowing route and unclear escalation lines, set up the conditions for the process failure that followed: concerns arrived but were never turned into a formal, time-bound investigation. That process failure then produced the outcome that mattered most, continued preventable harm, and a longer-lasting one too, in the form of badly damaged public trust in the unit (Vincent, 2010). What the model adds here is the causal chain: it links organisational design directly to patient outcomes, supporting the argument running through this report that fixes need to be structural rather than a matter of expecting individuals to be more vigilant (Institute of Medicine, 2000; Panagioti et al., 2019).

## **Impact on Quality, Efficiency and Equity**

Outcome, in Donabedian's terms, can be broken down further into three consequences commonly used when evaluating a service failure like this one: quality, efficiency and equity, summarized in Table 4. This inefficiency is a direct result of never having had a single, time-bound escalation pathway. The equity issue is about power: concerned staff and families were operating from a weaker position relative to trust management, a dynamic Francis (2015) also found nationally, where those who raise concerns are disproportionately the ones exposed to risk for doing so.

| Dimension  | Consequence                                                                                                |
|------------|------------------------------------------------------------------------------------------------------------|
| Quality    | Preventable harm continued for months; public trust in the unit severely damaged (Vincent, 2010)           |
| Efficiency | Overlapping reviews consumed time and resource without triggering timely, decisive action (RCPCH, 2016)    |
| Equity     | Families and concerned consultants faced an unequal power dynamic against trust management (Francis, 2015) |

*Table 4: Impact of the quality assurance failure on quality, efficiency and equity.*

## **SWOT Analysis of the Trust's Quality Assurance Function**

A SWOT analysis of the trust's quality assurance function at the time shows a clear mismatch between what it had and what it needed. On the strengths side, there were experienced consultants prepared to raise concerns, and an existing relationship with the RCPCH for external review. The weaknesses were structural: an unclear, non-independent escalation route and a defensive management culture. There were opportunities too, mainly in policy developments already underway nationally, including the Francis (2015) review, that could have been used to justify a stronger local whistleblowing route. The threats were reputational risk aversion on the trust's part, and a regulatory model that depended on local reporting being accurate in the first place (Care Quality Commission, 2023b). Put together with the Fishbone and Swiss Cheese findings, the picture is consistent: the trust had some of the raw ingredients of a working quality assurance system, just not the structural independence or the cultural openness to use them.

The SWOT analysis is also useful for separating what the trust could have fixed on its own from what depended on the wider system it sat within, such as the national regulatory model in place at the time. That distinction matters for service improvement planning because it clarifies which weaknesses could have been addressed through

internal governance reform, and which needed the trust to engage with and adopt national policy change as it emerged (Berwick, 2013).

## Wider Policy Context

Chester is not a one-off. Similar failures have been documented at Mid Staffordshire (Francis, 2013), Morecambe Bay (Kirkup, 2015), Shrewsbury and Telford (Ockenden, 2022) and East Kent (Kirkup, 2022), with the same threads recurring: inconsistent whistleblowing protection, delayed openness with families, and regulatory oversight dependent on honest local self-reporting. Table 5 sets each gap against the reform that has since followed it.

| Policy Gap Present (2015-2016)                                | National Reform Since Introduced                                        |
|---------------------------------------------------------------|-------------------------------------------------------------------------|
| Weak, inconsistent local whistleblowing protection            | Freedom to Speak Up Guardians (National Guardian's Office, 2023)        |
| Delayed openness with families and regulators                 | Statutory duty of candour requirements (Care Quality Commission, 2023a) |
| Regulatory oversight dependent on local self-reporting        | CQC Fundamental Standards regime (Care Quality Commission, 2023b)       |
| Inconsistent depth and independence of incident investigation | Patient Safety Incident Response Framework (NHS England, 2022)          |

*Table 5: National policy gaps identified at the Countess of Chester and subsequent reforms.*

These reforms are a genuine response to a repeating pattern, though how consistently they have been implemented across NHS trusts is a separate question, and one that deserves ongoing scrutiny (World Health Organization, 2021). It is worth remembering, too, that most of these reforms post-date the events at Chester, so the trust was operating in 2015 and 2016 within a policy environment that had not yet absorbed the lessons of Mid Staffordshire (Francis, 2013) to the extent it has since. That does not excuse the specific decisions taken locally. But it does place the case within a period of transition in NHS patient safety policy, which supports the view that

individual accountability and systemic reform are not rival explanations here, but complementary ones (Perneger, 2005).

## Recommendation

What the root cause analysis points to is not a lack of clinical concern, since concerns were raised repeatedly and early, but the absence of any structured, independent, time-bound mechanism for acting on them. Fixing that means redesigning the concerns pathway itself, rather than continuing to rely on individual staff being brave enough to keep pushing (Vincent and Amalberti, 2016). Six Sigma's DMAIC cycle, Define, Measure, Analyse, Improve, Control, offers a reasonably structured way to do that redesign (George, 2002). It was chosen over PDSA, the Plan-Do-Study-Act cycle that traces back to the Shewhart cycle (Deming, 1986) and has since been adapted for healthcare improvement (Langley et al., 2009), mainly because DMAIC's phased, data-driven structure suits redesigning an entire governance pathway better than testing one small change at a time. Lean (Womack and Jones, 2003) was also considered, but its focus on cutting waste from existing processes does not, by itself, touch the structural independence problem this case actually reveals. Table 6 sets out the proposed action at each stage; each is discussed briefly below.

| Stage   | Proposed Action                                                                                                     |
|---------|---------------------------------------------------------------------------------------------------------------------|
| Define  | Define what constitutes a patient safety concern requiring mandatory escalation, and a maximum target response time |
| Measure | Track, as a standing governance metric, how many concerns are raised and how long each takes to reach a decision    |
| Analyse | Analyse where concerns have historically stalled or been downgraded, and which defense layer is implicated          |
| Improve | Introduce an independent, non-managerial escalation route with mandatory external referral where unresolved         |
| Control | Audit escalation timelines quarterly and report outcomes directly to the trust board                                |

*Table 6: DMAIC action plan for redesigning the concerns pathway (adapted from George, 2002).*

Define largely deals with the ambiguity the Fishbone analysis surfaced, where consultants' concerns were treated as informal chat rather than as a defined trigger for formal action. Measure turns the RCPCH's (2016) call for a full case review into something ongoing and auditable, rather than a one-off exercise that can quietly be shelved once the immediate pressure passes.

Analyses feedback into the Swiss Cheese work, using it to identify which defence layer has historically been the one most often implicated when concerns stall or get downgraded (Reason, 2000).

Improvement is really the centre of this report's recommendation: an independent, non-managerial escalation route, shown in Table 6, that sits structurally apart from the line-management relationships that let concerns be downplayed in this case. It should be built into the existing national Freedom to Speak Up Guardian model (National Guardian's Office, 2023; NHS Improvement, 2018) rather than run alongside it, with a mandatory, time-bound referral to an external clinical review body, similar to the role the RCPCH played in 2016, whenever an internal review has not resolved a concern in time. That closes the process gap identified under Donabedian's model, since it converts concern into structured action regardless of whether local management is inclined to investigate. Duty of candour compliance (Care Quality Commission, 2023a) should sit within the same pathway, and the trust should formally adopt NHS England's (2022) Patient Safety Incident Response Framework so that investigation depth and independence stop being a matter of local discretion.

Control closes the external oversight gap the Swiss Cheese analysis identified, so that what the board sees does not depend on the same management layer whose

defensiveness contributed to the original failure, choosing to volunteer it. The professional duties to raise concerns set out by the General Medical Council (2013) and the Nursing and Midwifery Council (2018) should also be built into local induction and appraisal, so individual responsibility and structural reform reinforce each other rather than substituting for one another.

Rolling this out over roughly twelve months seems realistic: Define and Measure first, to establish a baseline, before Improve introduces the independent route itself. Progress can be judged against measures drawn from the Donabedian analysis: the proportion of concerns resolved on time as a process measure, and incident rates alongside staff confidence in speaking up, taken from the NHS Staff Survey, as outcome measures. The Control stage only works if genuinely independent of local management, since this case is a direct demonstration that local self-monitoring alone was not enough to prevent harm (Perneger, 2005; Institute of Medicine, 2000).

## Conclusion

This report has treated the Countess of Chester neonatal unit case as a quality assurance failure rather than simply a criminal one. The Fishbone Diagram (Ishikawa, 1985) pointed to interlocking failures across people, process, policy and culture; the Swiss Cheese Model (Reason, 2000) showed how leadership, investigation, culture and oversight all weakened at the same time, which is what let preventable harm continue for around eight months after concerns were first raised. Donabedian's (1988) model traced how structural weaknesses became process failure and, eventually, patient harm, and the SWOT analysis confirmed that the trust had some of the components of an effective quality assurance system without the structural independence or cultural openness needed to use them. Set alongside Mid Staffordshire (Francis, 2013), Morecambe Bay (Kirkup, 2015), Shrewsbury and Telford (Ockenden, 2022) and East Kent (Kirkup, 2022), it is clear these weaknesses recur across the NHS rather than belonging to one organisation.

The recommendations, built around the Six Sigma DMAIC cycle (George, 2002), center on an independent, non-managerial escalation route with mandatory external referral, duty of candour compliance built into the same pathway, and board-level audit of how escalations are resolved. Together, these are meant to close the gap this report keeps returning to: the absence of a mechanism that turns clinical concern into decisive action without depending on local management's willingness to act. The Thirlwall Inquiry's findings are still pending as this is written (Neil Wilby Media, 2026), so what is said here is necessarily based on what is currently available. Even so, the broader lesson for NHS quality assurance seems clear: sustainable improvement in patient safety depends less on how vigilant individual clinicians are, and more on how independent the systems built to listen to them are.

## Reference List

1. BBC News (2026) 'Lucy Letby inquiry report publication pushed back'. Available at: <https://www.bbc.co.uk/news> (Accessed: 30 July 2026).
2. Berwick, D. (2013) *A Promise to Learn – a Commitment to Act: Improving the Safety of Patients in England*. London: National Advisory Group on the Safety of Patients in England.
3. Care Quality Commission (2023a) *Regulation 20: Duty of Candour*. Newcastle upon Tyne: CQC.
4. Care Quality Commission (2023b) *The Fundamental Standards*. London: CQC.
5. Deming, W.E. (1986) *Out of the Crisis*. Cambridge, MA: MIT Press.
6. Donabedian, A. (1988) 'The quality of care: How can it be assessed?', *JAMA*, 260(12), pp. 1743-1748.
7. Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: The Stationery Office.
8. Francis, R. (2015) *Freedom to Speak Up: An Independent Review into Creating an Open and Honest Reporting Culture in the NHS*. London: Williams Lea Group.
9. General Medical Council (2013) *Good Medical Practice*. London: GMC.
10. George, M.L. (2002) *Lean Six Sigma: Combining Six Sigma Quality with Lean Speed*. New York: McGraw-Hill.
11. Health Service Journal (2024) 'Revealed: How trust execs resisted concerns over Letby'. Available at: [hsj.co.uk](https://www.hsj.co.uk) (Accessed: 14 July 2026).
12. Institute of Medicine (2000) *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academies Press.
13. Ishikawa, K. (1985) *What Is Total Quality Control? The Japanese Way*. Englewood Cliffs: Prentice-Hall.

14. Kirkup, B. (2015) The Report of the Morecambe Bay Investigation. London: The Stationery Office.
15. Kirkup, B. (2022) Reading the Signals: Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation. London: The Stationery Office.
16. Langley, G.J., Moen, R., Nolan, K.M., Nolan, T.W., Norman, C.L. and Provost, L.P. (2009) The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. 2nd edn. San Francisco: Jossey-Bass.
17. Leape, L.L. (1994) 'Error in medicine', JAMA, 272(23), pp. 1851-1857.
18. Learned, E.P., Christensen, C.R., Andrews, K.R. and Guth, W.D. (1965) Business Policy: Text and Cases. Homewood, IL: Irwin.
19. National Guardian's Office (2023) Freedom to Speak Up Guardian Role. London: NGO.
20. Neil Wilby Media (2026) 'Thirlwall Inquiry report set for further delays'. Available at: <https://neilwilby.com> (Accessed: 30 July 2026).
21. NHS England (2022) Patient Safety Incident Response Framework. London: NHS England.
22. NHS Improvement (2018) Freedom to Speak Up: Raising Concerns Policy for the NHS. London: NHS Improvement.
23. Nursing and Midwifery Council (2018) The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates. London: NMC.
24. Ockenden, D. (2022) Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. London: The Stationery Office.
25. Panagioti, M., Khan, K., Keers, R.N., Abuzour, A., Phipps, D., Kontopantelis, E., Bower, P., Campbell, S., Haneef, R., Avery, A.J. and Ashcroft, D.M. (2019) 'Prevalence, severity, and nature of preventable patient harm across medical care settings: systematic review and meta-analysis', BMJ, 366, l4185.

26. Perneger, T.V. (2005) 'The Swiss cheese model of safety incidents: are there holes in the metaphor?', BMC Health Services Research, 5, p. 71.
27. Reason, J. (2000) 'Human error: models and management', BMJ, 320(7237), pp. 768-770.
28. Royal College of Paediatrics and Child Health (2016) Invited Service Review of Neonatal Services, Countess of Chester Hospital. London: RCPCH.
29. Thirlwall Inquiry (2026) Progress and Publication Update. Available at: <https://www.thirlwall.public-inquiry.uk> (Accessed: 30 July 2026).
30. Vincent, C. (2010) Patient Safety. 2nd edn. Oxford: Wiley-Blackwell.
31. Vincent, C. and Amalberti, R. (2016) Safer Healthcare: Strategies for the Real World. Cham: Springer.
32. Womack, J.P. and Jones, D.T. (2003) Lean Thinking: Banish Waste and Create Wealth in Your Corporation. New York: Free Press.
33. World Health Organization (2021) Global Patient Safety Action Plan 2021–2030. Geneva: WHO.