

Programme: MSc Public Health and Social Care in Practice

Module code: LCHS7006

Module: Quality Assurance and Service Improvements

**Title: Independent Review of Maternity Services at Shrewsbury and Telford
Hospital NHS Trust**

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Introduction: The Shrewsbury and Telford Maternity Scandal

- Period of scrutiny: Mostly 2000-2019 onwards at Shrewsbury and Telford Hospital NHS Trust.
- The study of 1,486 families possessing 1,592 clinical incidents in 1973-2020 was reviewed independently (Ockenden, 2022).
- NHS Improvement was commissioned in May 2017 after Kate Stanton-Davies (2009) and Pippa Griffiths (2016) died (Ockenden, 2022).



Scale and Scope of the Crisis

12 maternal deaths; 75% of the reviewed cases were major care issues (Ockenden, 2022).

HIE (brain injury) cases were found to have major maternal care concerns in 65.9% of the cases (Ockenden, 2022).

Stillbirths that had been reviewed amounted to 498, with 25% having significant care concerns (Ockenden, 2022).

Neonatal deaths that occurred as major maternity issues were 27.9% (Ockenden, 2022).



Key Quality Assurance Failures Identified



Quality Assurance Measures

The absence of strong accountability or taking action on reviews.

Clinical Governance

Ineffective mechanisms of incident investigation and learning from errors.

Leadership and Culture

Organisational culture is defensive and non-listening, which discourages the concerns of the staff (Titcombe, 2025).

Audit and Review Processes

Lost chances to find patterns and trends of harm.

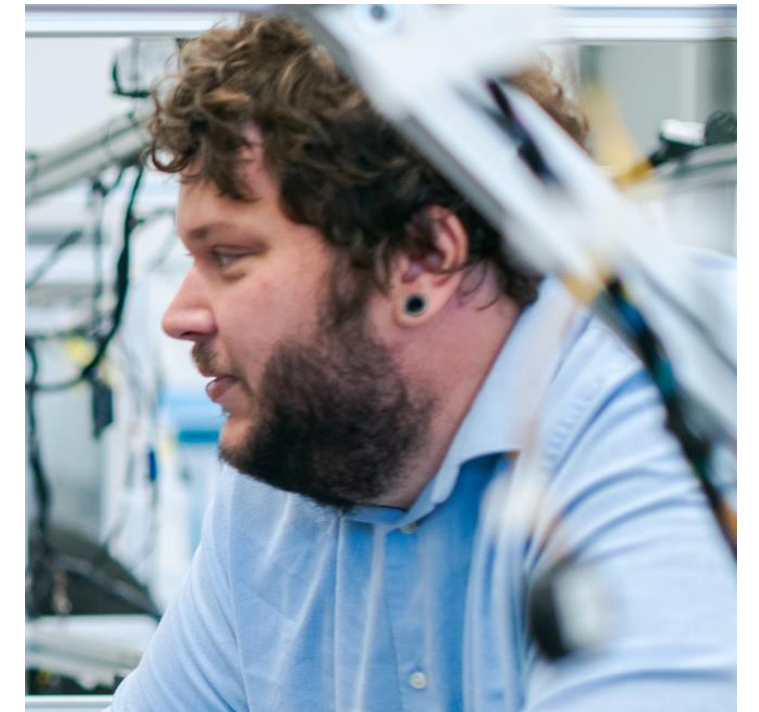
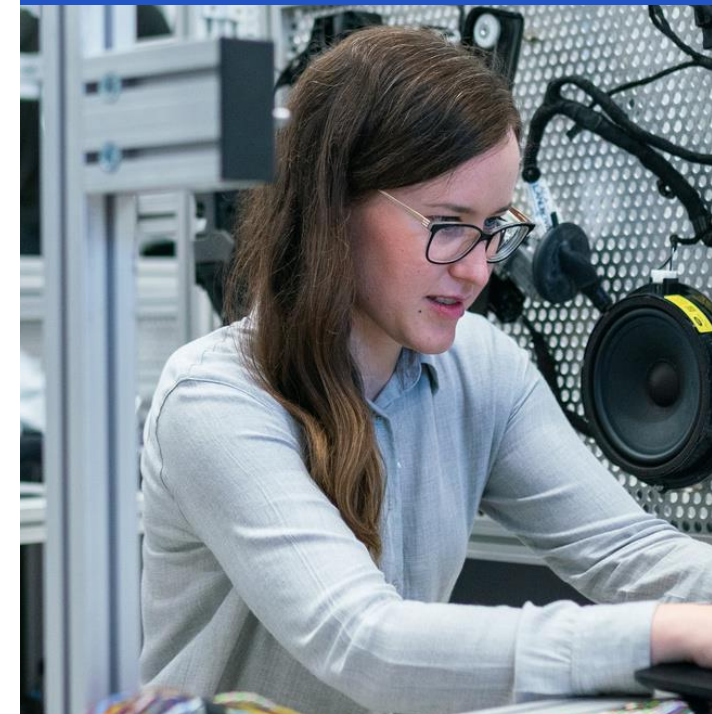
Compliance with the Policy

Continued negligence of observing national maternity safety requirements and escalation protocols (Dobson, 2022).

Clinical Governance Failures: Investigation Quality

- 40% of 168 stillbirths from 2011 to 2019 were not investigated at all (Ockenden, 2022).
- Royal College of Obstetricians and Gynaecologists (2017) discovered that the investigators were not trained in RCA methodology, but each was on an individual error basis, as opposed to a system.

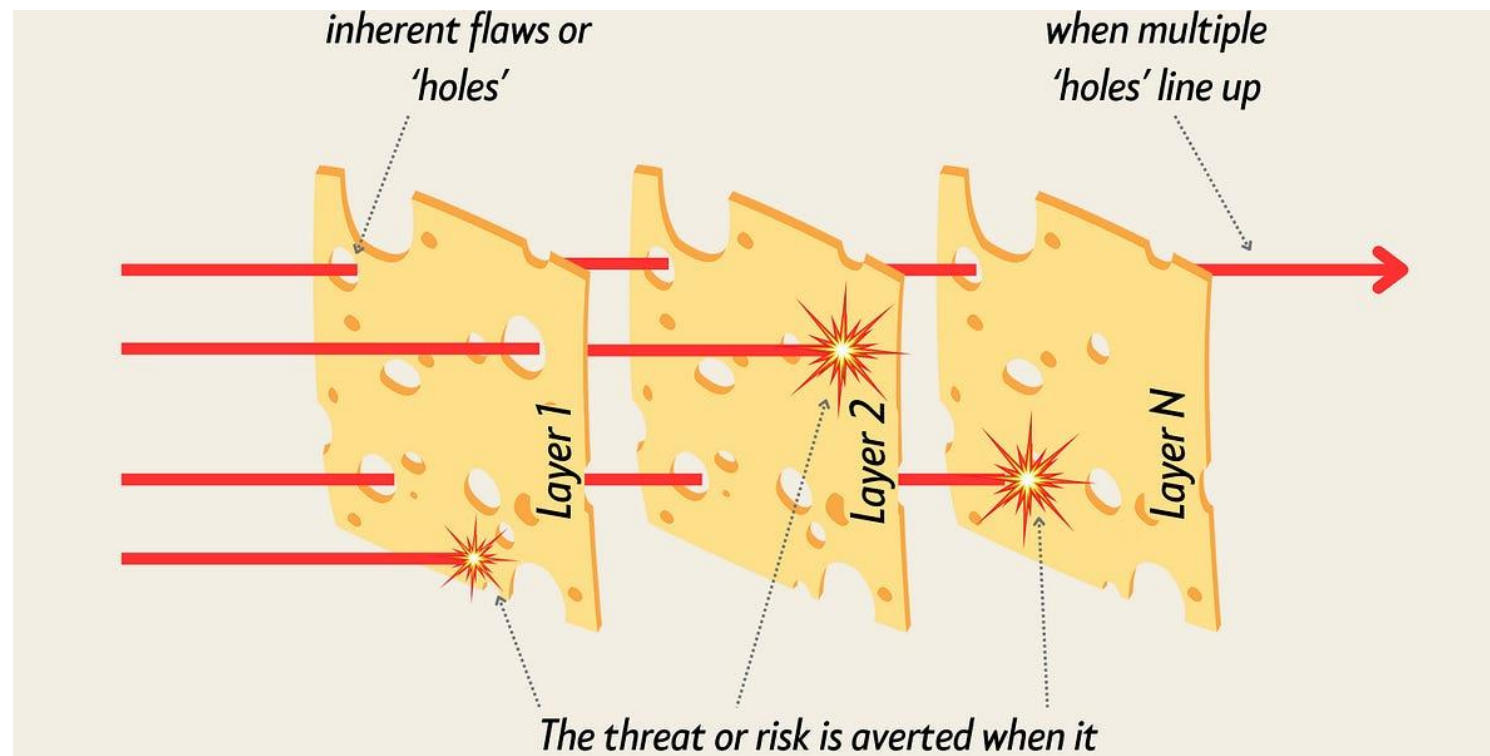
Investigations which were conducted among them 36% were adequate (Ockenden, 2022).



Serious incidents were downgraded by the High-Risk Case Reviews (HRCR).

Swiss Cheese Model

Application to the Case



Multiple aligned system failures created conditions for harm, which refers to holes in cheese as per the **Swiss Cheese Model**.

Active Failures

Personal clinical mistakes in fetal monitoring, escalation delays and breaking the guidelines (BBC, 2022).

Latent Conditions

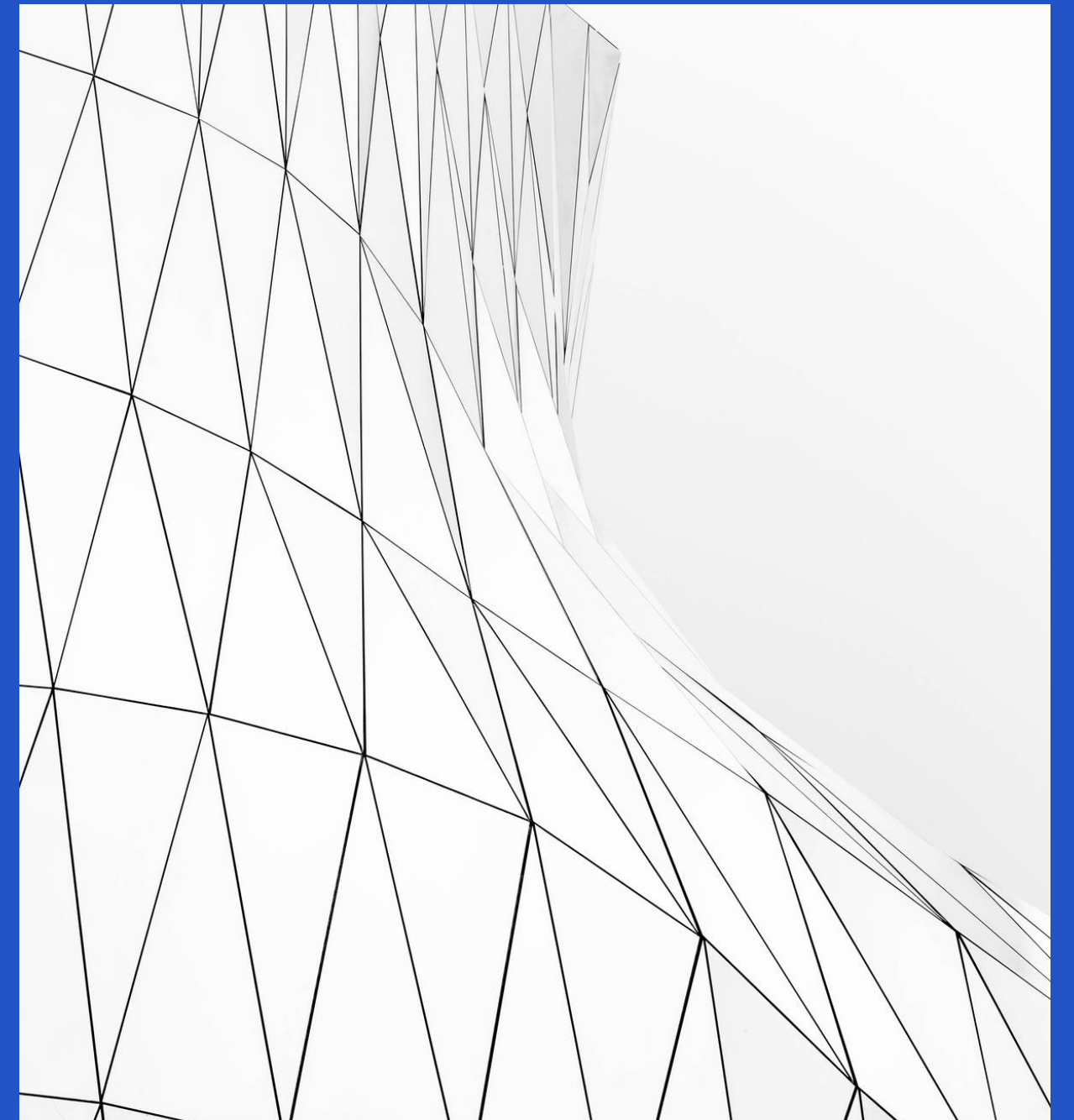
Understaffing, substandard training, bad governance systems, and inability to supervise (Siobhan, 2022).

Organisational Failures

Lack of accountability, low-quality incident investigation, and incompetent learning philosophy.

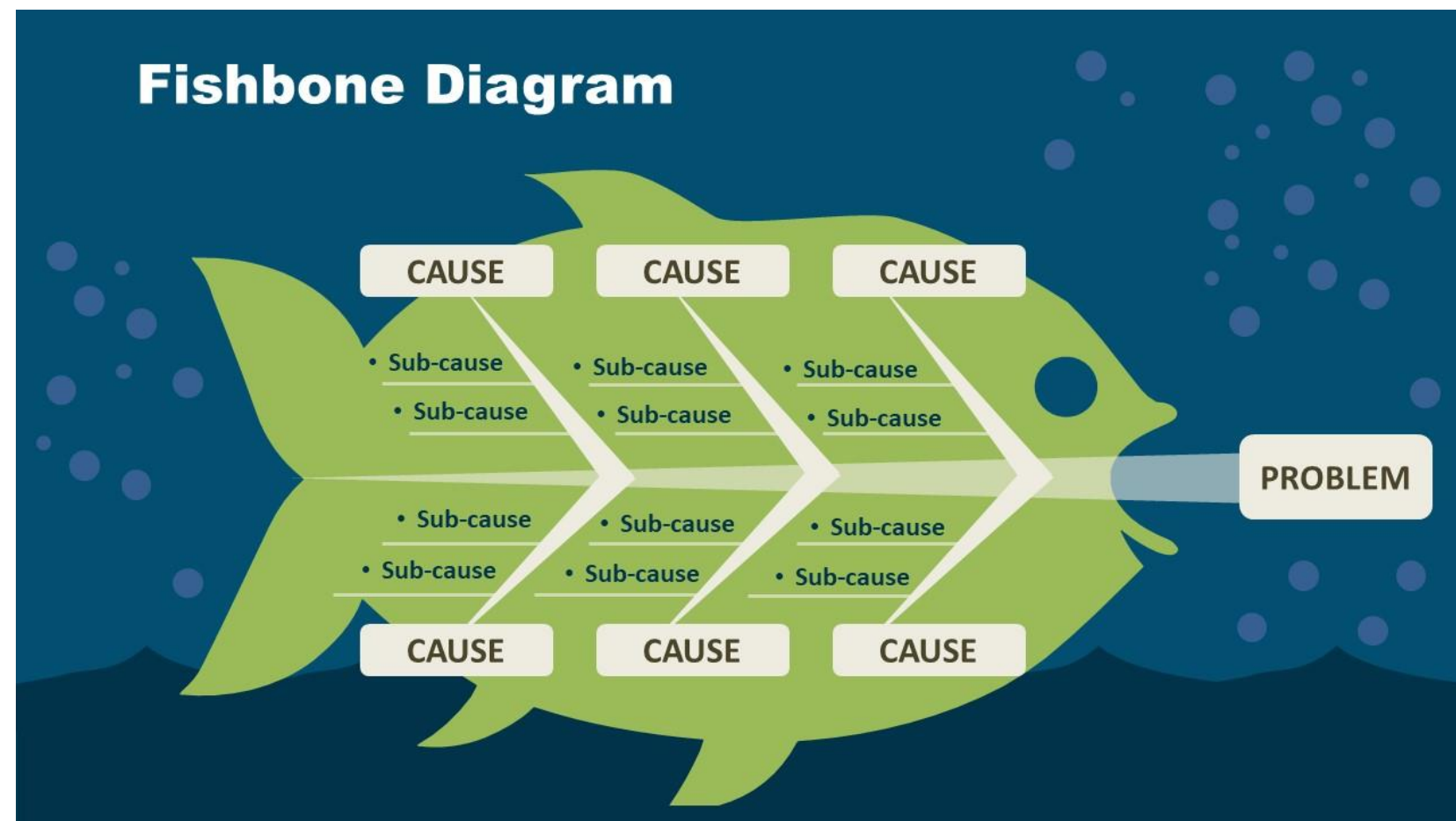
Root Cause Analysis: Systemic Failures Identified

- Leadership and culture contributed to the creation of a psychologically unsafe working environment.
- ***Midwife-consultant conflict:*** Them vs. us did not allow further intensification.
- ***Repeated non-observance of national guidelines:*** Fetal heart rate monitoring, gestational diabetes screening, and the procedure of escalation (Ockenden, 2022).
- Ineffective multidisciplinary communication and unwillingness to transfer complicated cases to tertiary units of specialists.
- ***Lack of accountability:*** Major clinicians did not receive any repercussions when they ignored escalations (Brown, 2022).



Root Cause Analysis Model: Fishbone Diagram Framework

A fishbone diagram or a cause-and-effect diagram or Ishikawa diagram is a tool of root cause analysis (Sakdiyah, Eltivia and Afandi, 2022).



People

Staffing issues, insufficient training, demotivation, a fear culture that does not allow individuals to report any mistakes (Baines, 2022)

Process

Outdated policies, inadequate incident investigation policies, ineffective escalation channels, and unequal multidisciplinary conferences.

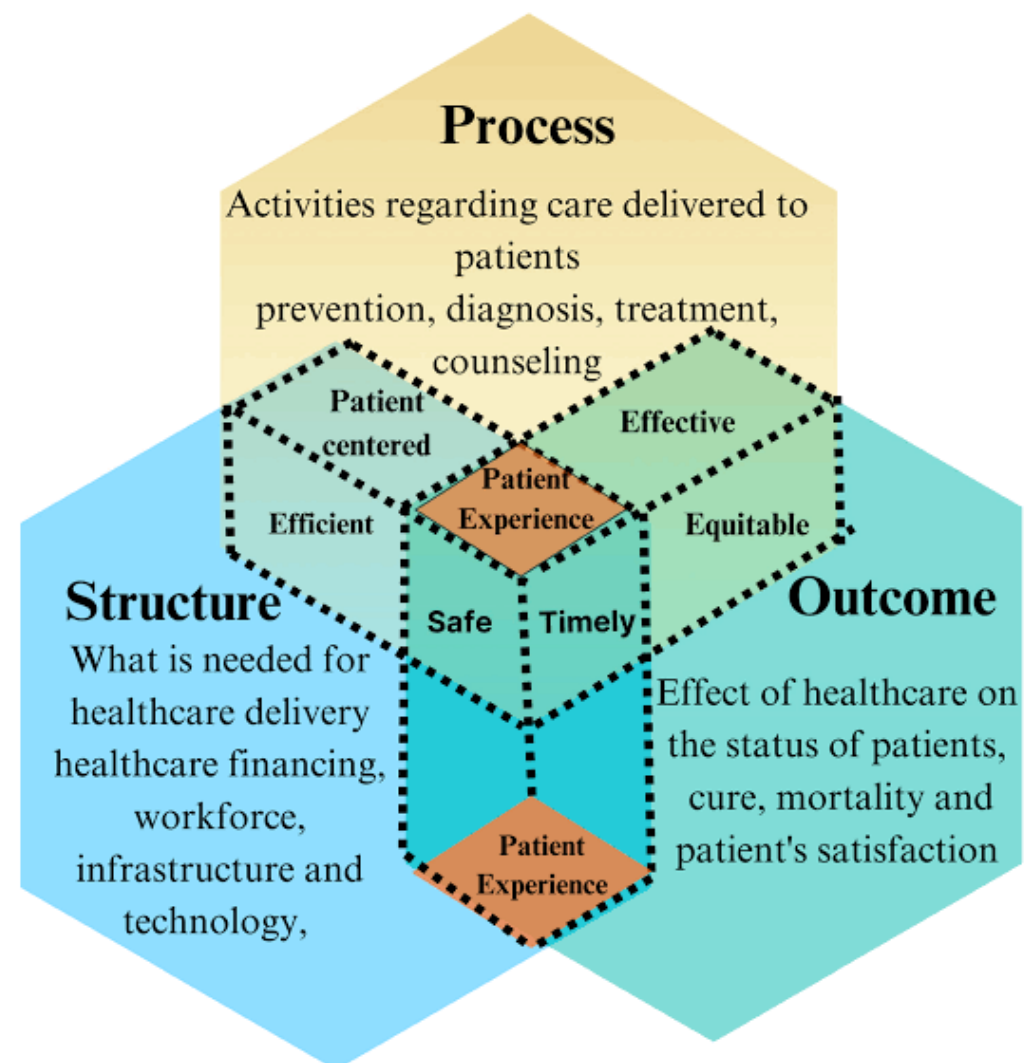
Systems

Lack of accountability systems, no external control, poor incident reporting, poor governance frameworks (Brown, 2022).

Environment

Not listening leadership, culture of defences, blame-oriented response, insensitivity to families.

Donabedian Model: Structure, Process, Outcome Analysis



Organisation

Weak system of governance; failure to have a strong incident investigation mechanism; unfavourable staffing.

Procedure

No compliance with guidelines, ineffective multidisciplinary communication, insufficient fetal monitoring, and ineffective defensive investigation practices

Outcome

Avoidable death, stillbirth, brain damage (HIE), women become morbid, suffering families lack the opportunity to be compassionately communicated with, and distrust the NHS (Ockenden, 2022).

Policy Issues Contributing to Root Causes



Violation of National Guidelines: The fetal heart rate, gestational diabetes screening, CTG and how to escalate were all contravened.

Absence of Compulsory Enforcement: There were guidelines, which were not mandatory to be followed; no auditing and enforcement systems.

Obsolete Local Policy

Advice on management of infections following rupture of membranes (2004), had not been updated in 10 years (2014) (Ockenden, 2022).

Lack of an External Control

CQC and commissioners never recognised or sufficiently investigated recurring failures (BBC, 2022).

Policy Influence On Service Delivery: Escalation and Monitoring

Failure to monitor the Fetal Heart Rate

There was inappropriate heart rate monitoring during the process of labour. (Ockenden, 2022).

Escalation Failures

Women spend a lot of time in the labour ward before being admitted.

Lack of Communication

A lack of strong multidisciplinary coordination, unwilling to refer complex cases to the tertiary units (Ockenden, 2022).



Impact on Service Quality: Patient Safety and Trust

Preventable Deaths



Three infants (Joshua, Thomas, Kate) were killed in the past 10 months and had the same pattern of failure (Ockenden, 2022).

Absence of Compassion



Clinicians are not ready to do family meetings; there is an error in responding to complaints or they accuse a family of outcomes

The loss of Trust



20 years of ignoring and not listening to families (Gall, 2024).

Systemic Pattern Failures



The same mistakes done in more than one family and not investigated.



Impact on Service Efficiency: Workforce and Resources

Staffing problems	Lack of effective incident management	Employee spirit	Wasted resources
There are persistent midwifery and medical personnel shortages that are putting operational strain.	Delays at incident to investigation as investigations were used to get conducted after 12 to 18 months (Ockenden, 2022).	Employees were scared to speak up; defensive organisational culture is not supportive of openness.	Admission of patients into emergency procedures multiple times because of failure to take previous interventions (McDonagh Hull, 2023).

Impact on Equity: Unequal Access and Outcomes

Geographic Inequity

The Ludlow-based unit's midwifery was unfunded, which had no important resuscitation devices.

Risk stratification failures

Women do not get referred to specialist assessment due to risk factor (Ockenden, 2022).

Mother Vulnerability Gaps

Teen mothers, women that had domestic violence in their lives, and multifaceted social factors received insufficient support and protection.

Socioeconomic Factors

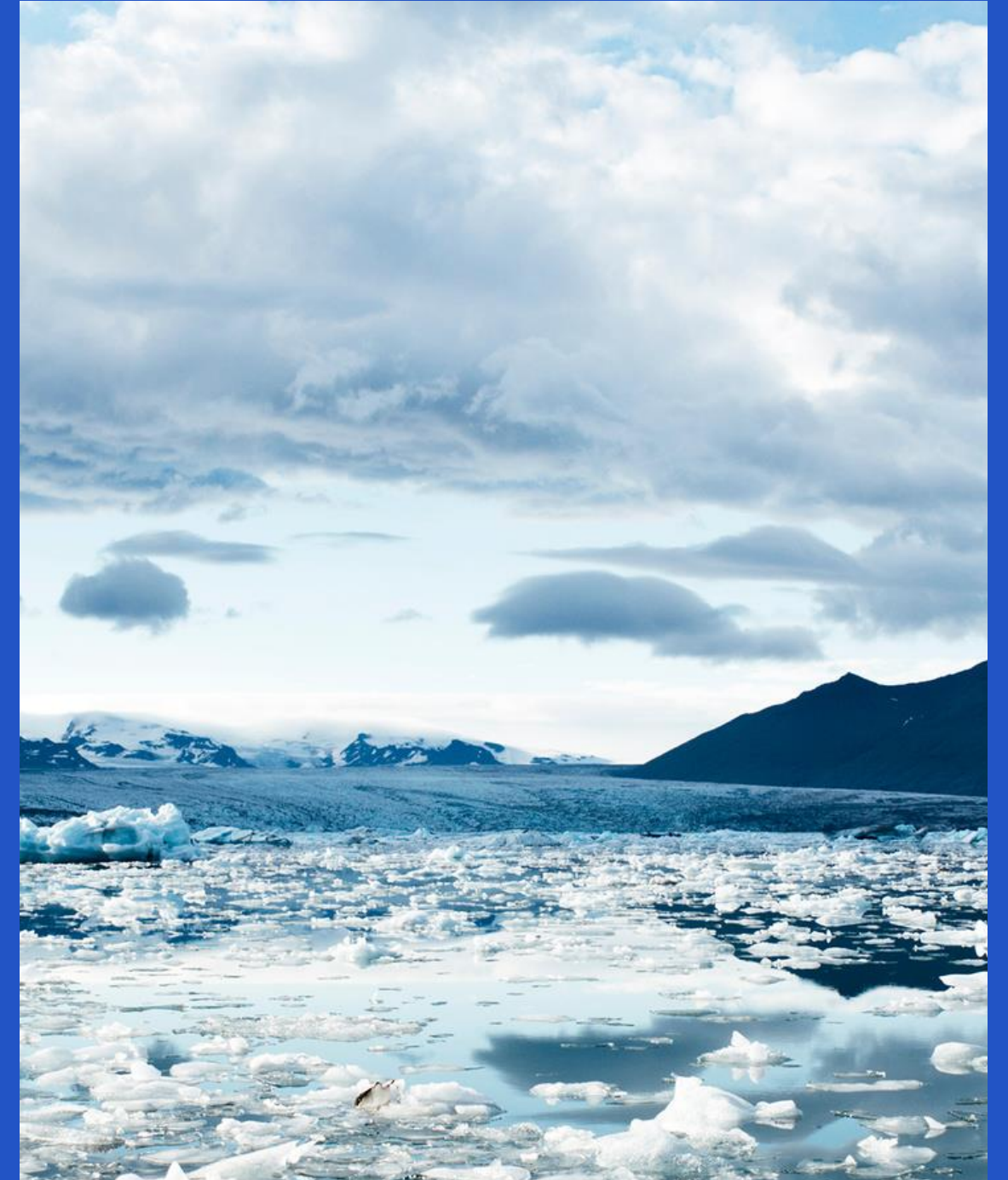
Young mothers, those with domestic violence were faced the disproportional gap in care (Ockenden, 2022).

Report Component 2 Structure and Recommendations

- Section 1: Evidence-based critique of the care failures.
- Section 2: Comprehensive governance and leadership analysis with case studies of systemic dysfunction.
- Section 3: Implementation of the root cause analysis, Fishbone Diagram, and Donabedian Model to failures at the organisational level.
- Section 4: Implementation Roadmap of Immediate and Essential Actions (IEAs) and Local Actions of Learning (LAFLs) having measurable outcomes.

Conclusion: Learning and Recommendations

- *Learning point:* Quality assurance needs structural, process, and cultural change on the organisational level.
- *Critical measures:* Install effective incident investigation protocols; ensure the obligatory adherence to guidelines.
- *Family-centred approach:* Diplomatic communication, openness and active participation in learning activities that are key in restoring trust.
- *System-wide change:* All NHS maternity services should implement Immediate and Essential Actions to avoid such failures.



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