
Service Improvement Report

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1. Introduction

Healthcare quality improvement is a fundamental priority within the National Health Service (NHS), aiming to deliver care that is safe, effective, patient-centred, timely, efficient and equitable (Institute of Medicine, 2001). As healthcare systems become increasingly complex, ensuring high-quality care requires more than clinical expertise alone; it depends upon effective leadership, robust governance, continuous organisational learning and systematic quality improvement processes (Donabedian, 1980; The King's Fund, 2017). Contemporary approaches to quality management recognise that patient harm rarely results from isolated human error but instead reflects failures within wider organisational systems, including communication, organisational culture, leadership and clinical governance (Reason, 1997). Consequently, quality improvement within the NHS has evolved from reactive responses to adverse events towards proactive systems-based approaches that seek to identify risks, learn from incidents and embed sustainable improvements into everyday practice (NHS England, 2023).

Patient safety remains one of the greatest challenges facing healthcare systems internationally. The World Health Organization (WHO, 2023) identifies avoidable harm as a major public health concern, while recent evidence suggests that healthcare organisations continue to operate under considerable workforce, financial and operational pressures, increasing the importance of effective quality improvement strategies (Illingworth *et al.*, 2024). Within England, organisations including the Care Quality Commission (CQC) and the National Institute for Health and Care Excellence (NICE) promote continuous monitoring, evidence-based practice and organisational accountability to improve patient outcomes and maintain public confidence in healthcare services (Care Quality Commission, 2022; National Institute for Health and Care Excellence, 2012).

The Ockenden Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust represents one of the most significant examples of systemic healthcare failure within the NHS. The independent review investigated hundreds of cases involving avoidable maternal and neonatal deaths, severe harm and repeated failures to recognise and respond appropriately to clinical concerns (Ockenden, 2022).

This report critically evaluates the quality failures identified within the Ockenden Review through the application of recognised healthcare quality improvement frameworks. The analysis begins with a structured evaluation of the case study before examining underlying causes using Root Cause Analysis (RCA) and a Fishbone Diagram. The findings are then

critically assessed using Donabedian's Structure–Process–Outcome Model, benchmarking against recognised national standards and a SWOT analysis to evaluate organisational readiness for improvement. Evidence-based recommendations are subsequently developed using the Plan–Do–Study–Act (PDSA) cycle, supported by Kotter's Eight-Step Change Model to facilitate sustainable organisational change. Through integrating quality improvement theory, NHS policy and patient safety principles, the report demonstrates how systematic approaches to quality management can strengthen governance, improve organisational learning and enhance patient safety within NHS maternity services.

2. Critical Evaluation of Quality and Service Improvement Frameworks

The Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust identified significant and sustained failures in maternity care over almost two decades, resulting in avoidable maternal deaths, stillbirths, neonatal deaths and life-changing injuries (Ockenden, 2022). Rather than attributing these outcomes to isolated clinical errors, the review concluded that they reflected systemic organisational failures involving leadership, governance, workforce capability, communication and clinical decision-making. Repeated concerns raised by women, families and healthcare professionals were frequently dismissed or inadequately investigated, allowing unsafe practices to persist over many years. These findings reinforce the importance of adopting a systems-based approach to patient safety, recognising that adverse events often arise from organisational weaknesses rather than individual negligence (Reason, 1997).

To understand how these failures occurred and identify opportunities for sustainable improvement, three complementary quality improvement frameworks are applied: the Fishbone (Ishikawa) Diagram, Donabedian's Structure–Process–Outcome (SPO) Model and SWOT analysis. Collectively, these frameworks facilitate critical evaluation of the root causes of failure, explain how organisational deficiencies translated into unsafe care and provide a strategic perspective for sustainable service improvement (Donabedian, 1980; Van Wijngaarden, Scholten and Van Wijk, 2012).

2.1 Fishbone (Ishikawa) Diagram

The Fishbone (Ishikawa) Diagram is a recognised quality improvement tool that supports systematic root cause analysis by identifying the interacting organisational, human and environmental factors contributing to adverse events (Ishikawa, 1986). Within healthcare, it complements systems-based approaches to patient safety by encouraging organisations to move beyond attributing harm to individual error and instead examine the latent organisational conditions that contribute to failure (Reason, 1997). This perspective is particularly appropriate when analysing the Ockenden Review, which concluded that avoidable maternal and neonatal harm resulted from widespread organisational failures rather than isolated clinical mistakes (Ockenden, 2022).

Figure 1. Root Cause Analysis.



Reference: Ockenden, D. (2022) Final Report of the Ockenden Review: Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. London: Department of Health and Social Care.

Figure 1. Fishbone (Ishikawa) Diagram illustrating contributory factors associated with avoidable maternal and neonatal harm identified in the Ockenden Review.

Source: Adapted from Ockenden (2022).

The Fishbone analysis demonstrates that the failures identified by Ockenden were multifactorial and reflected the interaction of deficiencies across workforce, clinical practice, leadership and organisational governance. Rather than occurring independently, these factors reinforced one another, creating conditions in which unsafe maternity care became embedded over an extended period.

Table 1. The importance of root causes in quality and patient safety.

Fishbone Category	Key findings from the Ockenden Review	Implications for patient safety
People & Workforce	Inadequate consultant oversight; poor multidisciplinary working; insufficient escalation of concerns; lack of compassionate care.	Reduced clinical decision-making, delayed intervention and diminished patient confidence.
Clinical Processes	Poor CTG interpretation; inappropriate oxytocin use; delayed recognition of deterioration; inconsistent adherence to evidence-based guidance.	Unsafe clinical practice increased the risk of preventable maternal and neonatal harm.
Leadership & Governance	Weak governance; ineffective incident investigations; limited organisational learning; poor safety culture.	Recurrent failures remained unaddressed, preventing continuous quality improvement.
Communication	Women <u>not listened</u> to; ineffective handovers; poor multidisciplinary communication; inadequate bereavement support.	Delayed escalation, poorer patient experience and increased risk of adverse outcomes. Source: Adapted from Ockenden (2022).

Table 1, demonstrates that the failures identified within the Ockenden Review were multifactorial and reflected the interaction of workforce, organisational and clinical factors. Whilst each category contributed independently to deteriorating standards of maternity care, the findings indicate that leadership and governance failures underpinned many of the remaining deficiencies. Weak organisational oversight limited effective multidisciplinary working, reduced adherence to evidence-based clinical processes and prevented learning from previous incidents, allowing unsafe practice to become embedded over almost two decades (Francis, 2013; Reason, 1997).

2.2 Donabedian Structure–Process–Outcome Model

Donabedian's Structure–Process–Outcome (SPO) Model provides a complementary framework for evaluating healthcare quality by examining how organisational structures influence clinical processes and ultimately determine patient outcomes (Donabedian, 1980). Whilst the Fishbone Diagram identifies the contributory factors underpinning organisational failure, the SPO model explains how these factors interact to influence the quality and safety of care. Consequently, applying the model to the Ockenden Review demonstrates that avoidable maternal and neonatal harm resulted not from isolated clinical errors but from failures occurring across the entire healthcare system.

Table 2. Application of Donabedian's Structure–Process–Outcome Model to the Ockenden Review

Component	Evidence from the Ockenden Review	Quality implications
Structure	Inconsistent consultant oversight; ineffective governance; poor multidisciplinary working; inadequate organisational learning.	Structural weaknesses limited the Trust's ability to provide safe, evidence-based maternity care and prevented effective identification of recurring risks (Donabedian, 1980; Ayanian and Markel, 2016).
Process	Poor CTG interpretation; delayed escalation; inappropriate oxytocin use; ineffective communication; women <u>not listened to</u> .	Unsafe clinical practices became embedded within routine care, increasing the likelihood of preventable harm (Manser, 2009; Dixon-Woods et al., 2014).
Outcome	Avoidable maternal deaths, stillbirths, neonatal deaths, birth injuries, psychological trauma and loss of public confidence.	Demonstrates the cumulative impact of structural and process failures on patient safety and organisational performance (Braithwaite et al., 2017).

Source: Adapted from Donabedian (1980) and Ockenden (2022).

Table 2, demonstrates that deficiencies identified by Ockenden occurred across all three components of the Donabedian model. Weak governance, inconsistent consultant involvement and ineffective organisational leadership created structural conditions that failed to support safe maternity care. These weaknesses subsequently influenced clinical processes, including delayed escalation, poor multidisciplinary communication and inconsistent adherence to evidence-based practice, ultimately contributing to avoidable maternal and neonatal harm. This relationship supports Donabedian's (1980) proposition that improvements in patient outcomes require simultaneous investment in organisational structures and clinical processes rather than isolated intervention. Whilst the Donabedian model provides a clear framework for evaluating healthcare quality, it has recognised limitations. The model assumes a relatively linear relationship between structures, processes and outcomes, whereas healthcare quality is influenced by dynamic interactions between leadership, organisational culture and human behaviour (Ayanian and Markel, 2016). Nevertheless, when considered alongside the Fishbone Diagram, the framework provides a more comprehensive explanation of how systemic organisational failures translated into poor maternity outcomes.

2.3 SWOT Analysis

The SWOT framework extends the preceding analyses by considering the strategic context in which quality improvement can be implemented. Unlike the Fishbone Diagram and Donabedian model, which primarily examine existing failures, SWOT identifies the organisational strengths and weaknesses that may influence improvement alongside the external opportunities and threats affecting implementation (Van Wijngaarden, Scholten and Van Wijk, 2012).

Table 3. SWOT Analysis of the Shrewsbury and Telford Maternity Service

Strengths	Weaknesses
Comprehensive independent review providing a clear evidence base for change	Weak governance and organisational learning
National maternity safety guidance available	Inconsistent consultant oversight
Established multidisciplinary workforce	Poor patient engagement and failure to respond to women's concerns.
National commitment to improving maternity safety	Failure to implement previous learning
Opportunities	Threats
Implementation of Ockenden recommendations	Workforce shortages and retention challenges
NHS Patient Safety Strategy	Financial and operational pressures
Enhanced multidisciplinary education and simulation training	Resistance to organisational change
Improved digital governance and incident reporting	Increasing demand on maternity services

Source: Adapted from Van Wijngaarden, Scholten and Van Wijk (2012) and Ockenden (2022).

The SWOT analysis indicates that the Trust's greatest opportunity lies in strengthening governance, leadership and organisational learning. Whilst national policy initiatives and the recommendations arising from the Ockenden Review provide a robust foundation for improvement, these opportunities are unlikely to be realised without first addressing internal weaknesses in safety culture, multidisciplinary working and accountability.

Strengthening governance is likely to generate wider organisational benefits by improving workforce performance, supporting adherence to evidence-based practice and embedding a culture of continuous learning and patient safety.

This strategic perspective complements both the Fishbone and Donabedian analyses by translating organisational diagnosis into priorities for sustainable quality improvement (Van Wijngaarden, Scholten and Van Wijk, 2012).

Collectively, the three quality improvement frameworks provide complementary perspectives on the organisational failures identified within the Ockenden Review. Whilst the Fishbone Diagram identifies the root causes of failure, Donabedian's Structure–Process–Outcome model explains how organisational deficiencies translated into unsafe clinical processes and poor patient outcomes. The SWOT analysis extends this evaluation by identifying the strategic priorities required to support sustainable improvement. Together, these frameworks demonstrate that meaningful service improvement depends not only on improving clinical practice but also on strengthening leadership, governance, organisational learning and organisational culture. This integrated evaluation provides a robust evidence base for the recommendations presented in the following section.

3. Recommendations for Service Improvement

The recommendations presented in this section follow a structured quality improvement pathway. The Plan–Do–Study–Act (PDSA) cycle provides a framework for testing and refining proposed interventions before wider implementation. Kotter's (1996) Eight-Step Change Model then provides the organisational change framework required to implement, sustain and embed these improvements within maternity services. Building upon these approaches, evidence-based recommendations are presented to address the root causes identified in the preceding analysis, while benchmarking against national standards provides a mechanism for evaluating performance and ensuring continuous quality improvement. Together, these approaches support the development of a learning organisation capable of delivering safe, person-centred and sustainable maternity care (Kotter, 1996; Langley *et al.*, 2009; Ockenden, 2022).

3.1 Quality Improvement Strategy: Plan–Do–Study–Act (PDSA) Cycle

The Plan–Do–Study–Act (PDSA) cycle is a widely recognised quality improvement methodology that supports the incremental testing, evaluation and refinement of service improvements before wider implementation (Taylor *et al.*, 2014). Unlike one-off organisational change initiatives, PDSA promotes continuous learning by enabling healthcare organisations to evaluate interventions through repeated cycles of implementation and feedback (Taylor *et al.*, 2014). This iterative approach is particularly appropriate for maternity services because patient safety depends upon consistent adherence to evidence-based practice, effective multidisciplinary communication and ongoing organisational learning. Given the systemic failures identified within the Ockenden Review, introducing changes through a structured PDSA cycle would allow interventions to be evaluated, refined and embedded whilst minimising unintended consequences.

Table 4. Application of the PDSA Cycle to Maternity Service Improvement.

PDSA Stage	Application to the Ockenden Review
Plan	Introduce a standardised fetal surveillance and escalation pathway, mandatory annual CTG competency assessments, multidisciplinary safety huddles and strengthened governance arrangements. Define success measures including CTG compliance, incident reporting, escalation times and patient experience.
Do	Pilot the interventions within one maternity unit over a three-month period. Deliver multidisciplinary training, implement revised escalation protocols and introduce routine governance meetings to monitor progress.
Study	Evaluate quantitative and qualitative data, including clinical audit results, serious incident reports, staff competency assessments, patient feedback and compliance with national maternity standards. Compare outcomes against baseline performance to determine effectiveness.
Act	Refine interventions in response to audit findings and stakeholder feedback before implementing the programme across the Trust. Establish continuous monitoring through governance committees and regular quality improvement cycles to sustain improvements.

Source: Adapted from Langley et al. (2009) and Ockenden (2022).

The proposed PDSA cycle directly addresses the principal failures identified within the Ockenden Review by strengthening governance, improving workforce capability and standardising clinical processes. The Plan phase focuses on interventions that target the root causes identified through the Fishbone analysis, whilst the Study phase incorporates both process indicators, such as compliance with fetal monitoring protocols and escalation procedures, and outcome indicators, including reductions in avoidable incidents and improvements in patient experience. Importantly, staff and patient feedback should be incorporated throughout the cycle to ensure that learning reflects both clinical performance and the experiences of women and families.

Whilst the PDSA cycle provides a structured method for testing and refining improvements, successful implementation depends upon effective leadership, stakeholder engagement and organisational commitment. Consequently, a structured change management approach is required to ensure that these improvements are adopted and sustained across the organisation.

3.2 Leading Sustainable Organisational Change: Kotter's Eight-Step Change Model

Implementing the recommendations arising from the Ockenden Review requires more than introducing new clinical protocols; it demands a sustained transformation of organisational culture, leadership and governance. Several organisational change models could support this process, including Lewin's (1947) Three-Stage Model and Kotter's (1996) Eight-Step Change Model. Whilst Lewin's model provides a valuable framework for implementing planned organisational change through the stages of unfreezing, changing and refreezing, it is better suited to discrete or incremental improvements. By contrast, the failures identified within the Ockenden Review developed over almost two decades and reflected deeply embedded organisational weaknesses, including poor leadership, ineffective governance, inadequate multidisciplinary communication and a persistent failure to listen to women and their families (Ockenden, 2022). These systemic issues require long-term cultural transformation rather than isolated procedural change. Consequently, Kotter's Eight-Step Change Model provides a more appropriate framework because it emphasises leadership, stakeholder engagement, communication and embedding change within organisational culture, all of which are essential for achieving sustainable improvements in maternity safety (Kotter, 1996; Appelbaum *et al.*, 2012).

Table 5. Application of Kotter's Eight-Step Change Model to Maternity Service Improvement.

Kotter Step	Application to the Ockenden Review
Create a sense of urgency	Use findings from the Ockenden Review, incident data and patient experiences to demonstrate the immediate need for improvement in maternity safety (Ockenden, 2022).
Build a guiding coalition	Establish a multidisciplinary leadership group comprising executive leaders, obstetricians, midwives, governance leads, Maternity and Neonatal Voices Partnership (MNVP) representatives and women with lived experience to lead the improvement programme.
Develop and communicate the vision	Promote a shared vision of safe, compassionate and person-centred maternity care through regular communication, education and engagement with all staff.
Empower broad-based action	Remove barriers to safe practice through mandatory CTG competency assessments, revised escalation pathways, improved incident reporting systems and training in compassionate communication and shared decision-making.
Generate short-term wins	Monitor early improvements through audit findings, staff competency assessments, patient-reported experience measures (PREMs), Friends and Family Test results and reductions in avoidable safety incidents.
Anchor change within	Embed continuous learning through routine clinical audit, governance oversight, patient involvement, reflective practice and

Source: Adapted from Kotter (1996) and Ockenden (2022).

The application of Kotter's model reinforces that sustainable improvement depends upon changing organisational behaviours as well as clinical practice. A central lesson emerging from the Ockenden Review was that women repeatedly raised concerns about their care, yet these concerns were frequently dismissed or inadequately investigated, contributing to missed opportunities to prevent avoidable harm (Ockenden, 2022). This reflects wider patient safety evidence demonstrating that patients and families frequently identify risks, communication failures and deterioration that are not recognised through conventional reporting systems (O'Hara *et al.*, 2018; Schwappach, 2010). Consequently, women and their families should be regarded as active partners in patient safety rather than passive recipients of care.

Incorporating patient representatives within maternity governance structures, systematically reviewing patient feedback alongside clinical incidents and promoting shared decision-making are therefore integral components of sustainable organisational change.

Collectively, the PDSA cycle and Kotter's Eight-Step Change Model provide complementary approaches to quality improvement. Whilst PDSA establishes how interventions should be tested and evaluated, Kotter provides the organisational framework required to implement and sustain change. These frameworks therefore underpin the evidence-based recommendations presented below.

3.3 Evidence-Based Recommendations

The analysis identified that the failures highlighted within the Ockenden Review were not attributable to isolated clinical errors but reflected systemic weaknesses in leadership, governance, workforce capability, organisational learning and patient engagement. Consequently, the recommendations focus on strengthening organisational systems alongside improving clinical practice. Each recommendation aligns with the quality improvement strategy outlined through the PDSA cycle and is designed to support the sustainable organisational change facilitated by Kotter's Eight-Step Change Model. Together, these recommendations aim to improve patient safety, restore public confidence and establish a culture of continuous learning within maternity services (Ockenden, 2022; NHS England, 2019a).

Table 6. Recommendations

Recommendation	Rationale	Expected Impact
Strengthen clinical governance and leadership oversight	The Fishbone and SWOT analyses identified ineffective governance and weak organisational accountability as fundamental contributors to patient harm. Strengthening governance through regular board oversight, safety dashboards and multidisciplinary governance meetings will improve organisational learning and accountability (Francis, 2013; Ockenden, 2022).	Improved governance, greater accountability, earlier identification of safety risks and sustained organisational learning.
Implement mandatory competency-based education and annual assessment	The Ockenden Review identified repeated deficiencies in CTG interpretation, fetal surveillance and emergency obstetric management. Annual competency assessments, simulation training and protected learning time should ensure staff maintain evidence-based clinical skills (NHS England, 2019a; Ockenden, 2022).	Improved clinical competence, earlier recognition of deterioration and reductions in avoidable maternal and neonatal harm.
Standardise multidisciplinary communication and escalation pathways	Communication failures and delayed escalation were recurrent themes throughout the Ockenden Review. Introducing structured safety huddles, standardised escalation protocols and multidisciplinary debriefs will improve situational awareness and decision-making (Manser, 2009; Ockenden, 2022).	Improved teamwork, timely escalation of deteriorating patients and safer clinical decision-making.

Recommendation	Rationale	Expected Impact
Embed women and families as partners in patient safety	Women repeatedly reported concerns that were dismissed or inadequately acted upon, resulting in missed opportunities to prevent avoidable harm (Ockenden, 2022). Evidence demonstrates that patients and families frequently identify safety risks that are overlooked through conventional reporting systems (O'Hara <i>et al.</i> , 2018; Schwappach, 2010). Patient representatives should therefore be included within governance structures, with routine analysis of patient feedback, complaints and Patient-Reported Experience Measures (PREMs) informing quality improvement.	Improved patient experience, earlier identification of safety concerns, strengthened trust between women and healthcare professionals and a more person-centred safety culture.
Establish continuous quality improvement through audit and benchmarking	Sustainable improvement requires routine monitoring rather than one-off interventions. Continuous audit of compliance with national maternity standards, incident reporting, patient experience and workforce competency should inform repeated PDSA cycles and organisational learning (Taylor <i>et al.</i> , 2014; NHS England, 2019b).	Continuous improvement, improved compliance with national standards and sustained improvements in patient safety and service quality.

Recommendation	Rationale	Expected Impact
Strengthen clinical governance and leadership oversight	The Fishbone and SWOT analyses identified ineffective governance and weak organisational accountability as fundamental contributors to patient harm. Strengthening governance through regular board oversight, safety dashboards and multidisciplinary governance meetings will improve organisational learning and accountability (Francis, 2013; Ockenden, 2022).	Improved governance, greater accountability, earlier identification of safety risks and sustained organisational learning.
Implement mandatory competency-based education and annual assessment	The Ockenden Review identified repeated deficiencies in CTG interpretation, fetal surveillance and emergency obstetric management. Annual competency assessments, simulation training and protected learning time should ensure staff maintain evidence-based clinical skills (NHS England, 2019a; Ockenden, 2022).	Improved clinical competence, earlier recognition of deterioration and reductions in avoidable maternal and neonatal harm.
Standardise multidisciplinary communication and escalation pathways	Communication failures and delayed escalation were recurrent themes throughout the Ockenden Review. Introducing structured safety huddles, standardised escalation protocols and multidisciplinary debriefs will improve situational awareness and decision-making (Manser, 2009; Ockenden, 2022).	Improved teamwork, timely escalation of deteriorating patients and safer clinical decision-making.

The proposed recommendations demonstrate that improving maternity safety requires an integrated organisational approach rather than isolated clinical interventions. Whilst competency-based education and standardised clinical pathways will strengthen frontline practice, sustainable improvement depends equally upon effective leadership, robust governance and an organisational culture that values continuous learning. Importantly, the recommendation to embed women and families as partners in patient safety represents a fundamental shift from a professionally led model of care towards genuine co-production. This reflects growing evidence that patient engagement is associated with improved safety, better communication and earlier identification of clinical deterioration (O'Hara *et al.*, 2018; Vincent and Coulter, 2002).

3.4 Benchmarking and Evaluation of Service Improvement

Benchmarking enables healthcare organisations to compare performance against national standards, identify unwarranted variation and evaluate quality improvement initiatives (Camp, 1989; Ettorchi-Tardy *et al.*, 2012). Following implementation of the proposed recommendations, benchmarking provides the mechanism through which the effectiveness of service improvements can be evaluated and sustained. Rather than relying solely on clinical outcomes, benchmarking should encompass measures of patient safety, organisational culture, leadership, governance and patient experience, reflecting the systems-based approach advocated throughout this report.

The primary benchmarking framework should utilise the NHS Digital Maternity Services Dashboard, which enables NHS maternity providers to compare performance using nationally reported Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs) (NHS Digital, 2025). Developed following the *Better Births* review, the dashboard supports continuous quality improvement by enabling organisations to benchmark their performance against peer trusts across multiple domains, including clinical outcomes, organisational culture and user experience (National Maternity Review, 2016; NHS Digital, 2025). This facilitates the identification of unwarranted variation and enables organisations to monitor whether service improvements result in measurable enhancements in quality and patient safety (Ettorchi-Tardy, Levif and Michel, 2012; NHS Digital, 2025).

However, benchmarking alone cannot demonstrate causality between service improvements and patient outcomes; consequently, benchmark data should be interpreted alongside local audit findings, incident investigations and patient feedback to provide a more comprehensive evaluation of organisational performance.

Table 7. Benchmarking Framework for Evaluating Service Improvement

Improvement Priority	National Benchmark	Key Performance Measures	Purpose of Benchmarking
Clinical safety	NHS Digital Maternity Services Dashboard (CQIMs & NMIs)	Clinical Quality Improvement Metrics, National Maternity Indicators, fetal monitoring compliance, escalation of care and maternity safety indicators	Compare clinical performance with peer trusts and evaluate improvements in patient safety.
Maternal and neonatal outcomes	MBRRACE-UK	Maternal mortality, stillbirth, neonatal mortality and severe maternal morbidity	Assess whether service improvements contribute to reductions in avoidable harm and improve maternal and neonatal outcomes.
Patient experience and equity	Care Quality Commission (CQC) Maternity Survey; Maternity and Neonatal Equalities Dashboard	Communication, shared decision-making, patient-reported experience, demographic inequalities and variation in outcomes	Evaluate whether women feel listened to, involved in decision-making and whether improvements are delivered equitably across all population groups.
Leadership, governance and safety culture	NHS Resolution Maternity Incentive Scheme (MIS); CQC Inspection Reports	Compliance with maternity safety actions, governance arrangements, leadership effectiveness and organisational learning	Assess whether improvements have become embedded within organisational systems and support a sustainable culture of patient safety.

The proposed benchmarking framework aligns directly with the recommendations presented in this report. Whilst the Plan–Do–Study–Act (PDSA) cycle provides a structured method for testing and refining interventions, and Kotter's Eight-Step Change Model supports implementation and cultural transformation, benchmarking evaluates whether these interventions have translated into measurable improvements in clinical practice. This integrated approach ensures that improvements are not only implemented but are continually monitored against nationally recognised standards to support ongoing organisational learning.

A particular strength of this benchmarking framework is the inclusion of patient experience alongside clinical outcomes. The Ockenden Review demonstrated that many adverse outcomes were associated not only with clinical failings but also with failures to listen to women and families, poor communication and inadequate organisational responsiveness (Ockenden, 2022). Incorporating patient-reported experience measures and national maternity surveys therefore provides an additional mechanism for evaluating whether cultural and behavioural changes are improving women's experiences alongside traditional clinical indicators (Care Quality Commission, 2024; O'Hara et al., 2018).

However, benchmarking also has recognised limitations. Differences in organisational context, workforce capacity, patient demographics and socioeconomic deprivation may influence performance indicators, making direct comparisons between organisations difficult (Ettorchi-Tardy, Levif and Michel, 2012). Consequently, benchmarking should be interpreted alongside qualitative information, local audit findings and organisational learning rather than being used in isolation to judge performance.

Overall, benchmarking provides a structured approach to evaluating the effectiveness of the proposed service improvements. By integrating national maternity indicators, patient experience measures and governance standards, organisations can monitor progress, identify remaining gaps and embed a culture of continuous quality improvement. This supports sustained organisational learning while ensuring that improvements in maternity care translate into safer services and better outcomes for women, babies and families.

4. Conclusion

This report demonstrated that the failures identified in the Ockenden Review resulted from systemic organisational weaknesses rather than isolated clinical errors. Through the application of the Fishbone Diagram, Donabedian's Structure–Process–Outcome Model and SWOT analysis, the report identified ineffective leadership, weak governance, poor multidisciplinary communication, workforce capability issues and the failure to listen to women and their families as the principal factors contributing to unsafe maternity care. These findings reinforce the need for a systems-based approach to quality improvement.

The analysis informed the development of evidence-based recommendations supported by the Plan–Do–Study–Act (PDSA) cycle and Kotter's Eight-Step Change Model, demonstrating how quality improvement theory can be translated into practical and sustainable organisational change. Benchmarking against national frameworks, including the NHS Digital Maternity Services Dashboard, MBRRACE-UK, Care Quality Commission indicators and the NHS Resolution Maternity Incentive Scheme, provides an objective mechanism for evaluating improvements in patient safety, governance, patient experience and organisational performance.

A key leadership lesson emerging from this case study is that sustainable improvement depends upon strong clinical leadership, organisational learning and meaningful partnership with women and their families. Embedding these principles has the potential to improve patient outcomes, strengthen staff engagement and support a culture of continuous quality improvement.

Although focused on maternity services, the quality improvement framework proposed in this report is applicable across other high-risk healthcare settings. Future evaluation should examine the long-term impact of these interventions on patient safety, organisational culture and health inequalities to ensure improvements remain effective, sustainable and responsive to the needs of patients and healthcare services.

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