

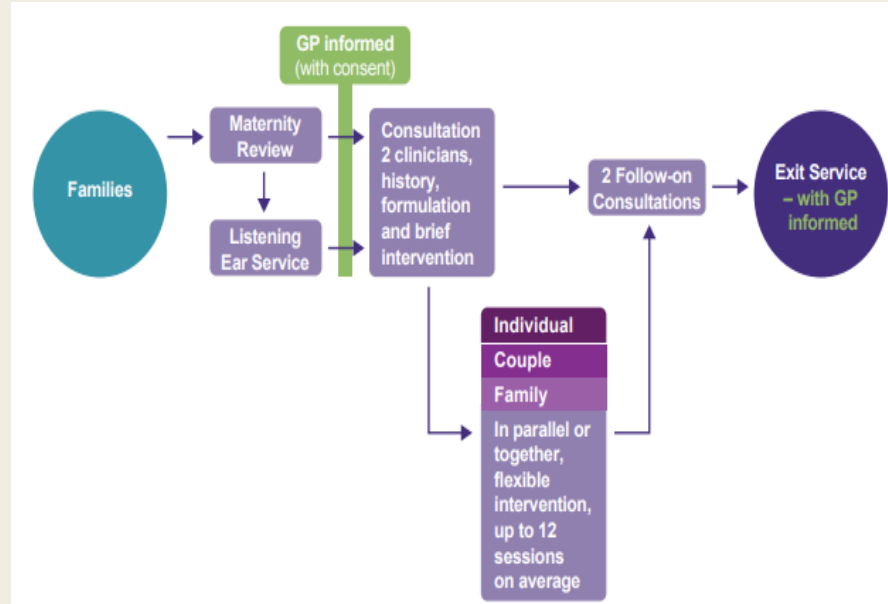
Programme: MSc Public Health and Social Care in Practice

Module: Quality Assurance and Service Improvements

Module code: LCHS7006

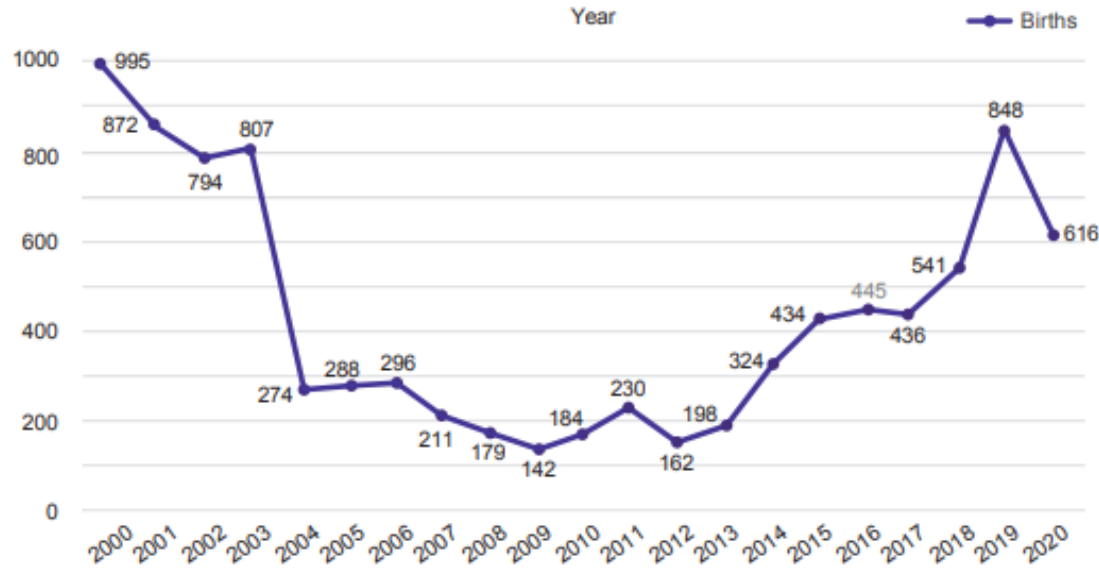
Introduction

- The study highlights a case study that is based on a quality concern
- The study aims to capture root causes of the specific problem to develop a holistic view o
- The selected case study is Shrewsbury and Telford Hospital NHS Trust UK Maternity Scandal.
- The Ockenden report 2022 identified that lack of compassion, poor quality management, ineffective care, inadequate monitoring, and other systematic failures led to the deadly outcomes (Gov.UK, 2026)



(Source: Gov.UK, 2026)

Introduction (Contd..)

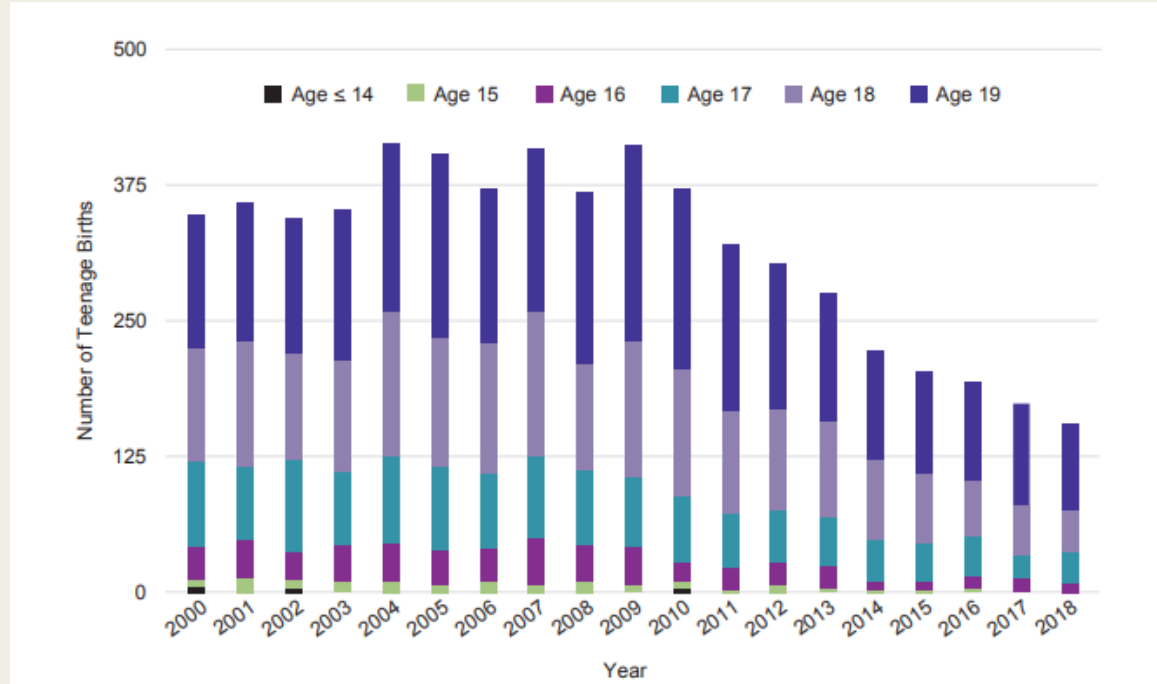


(Source: Gov.UK, 2026)

- Evidence shows that the investigation started due to the cluster of 23 families' cases in 2017
- The impact of the serious health complications and death were the direct results of maternity care failure
- The case study is important since thousands of families and individuals are involved
- The independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust began in 2017 (Gov.UK, 2026)

Identification of the root causes by using systems-based safety model

- **Overview of the case:** It has been identified that the plot of the Shrewsbury and Telford Hospital NHS Trust was in the summer of 2017
- The original 23 families involved in the case
- In July 2020, more 1862 individual families were included
- The majority of cases are from 2002 to 2019



(Source: Gov.UK, 2026)

Identification of the root causes by using systems-based safety model

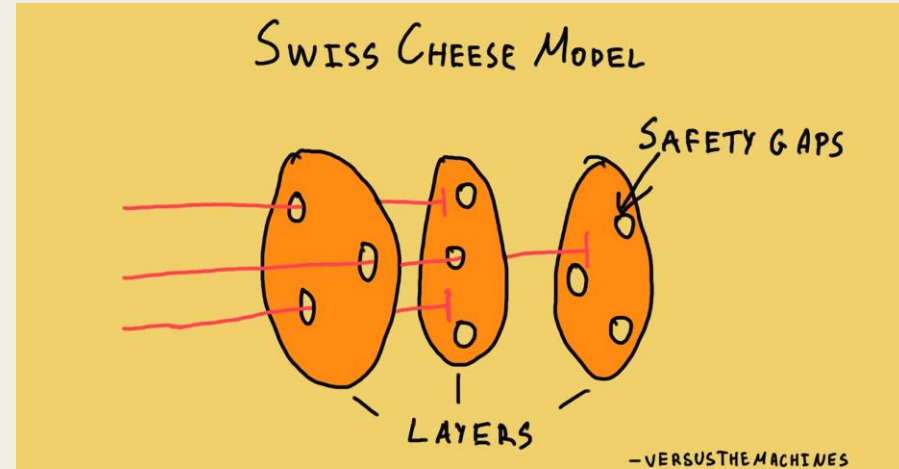
YEARS	FAMILIES	CLINICAL INCIDENTS
Pre-2000	170	181
2000-2019	1,305	1,393
Post-2019	15	18
Totals	1,486*	1,592

(Source: Gov.UK, 2026)

- The ultimate aim of the report is to highlight the fact that the maternity service failure
- The mentioned healthcare organization is a remarkable report to understand the importance of quality management
- From the very early period of investigation, the government has played a critical role
- Almost 1486 families within the care of the maternity ward were trying to raise their concerns (Gov.UK, 2026)

Identification of the root causes by using systems-based safety model

- **The Swiss Cheese Model:** The Swiss cheese model demonstrates how failures typically result due to a combination of aspects instead of a single root cause (Thedecisionlab, 2025)
- The model is primarily viewed as multiple layers of Swiss cheese
- When these particular loopholes align with each other, a failure typically occurs
- It has been observed that key elements of the model are layers of defense and active failures or latent conditions



(Source: Thedecisionlab, 2025)

Annual birth rate at the Trust 2008 – 2020

YEAR												
WARD	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20
Shrewsbury MLU	503	478	550	478	421	367	235	207	140	120	69	15
Wrekin MLU	477	488	436	435	401	362	336	359	338	351	285	224
Bridgnorth MLU	86	59	98	69	68	75	68	82	75	26	4	0
Ludlow MLU	100	77	81	86	71	62	49	51	37	12	4	0
Oswestry MLU	90	82	83	87	72	74	69	83	46	15	4	0
MLU Totals	1256	1184	1248	1155	1033	940	757	782	636	524	366	239
Home Births	92	90	96	86	91	86	82	63	63	68	75	56
BBA Other	15	11	19	18	21	8	19	14	25	3	8	41
MLU Totals plus Home Births	1348	1274	1344	1241	1124	1026	839	845	699	592	441	295
All Non CU Births (MLU+Home+BBA)	1363	1285	1363	1259	1145	1034	858	859	724	595	449	336
Shrewsbury/Telford CU	3871	3965	3856	3983	4009	3978	3796	4001	4204	4060	4062	4086
TOTAL BIRTHS	5234	5250	5219	5240	5154	5012	4654	4859	4928	4655	4511	4422

(Source: Gov.UK, 2026)

Identification of the root causes by using systems-based safety model

- The model reveals that poor patterns of care in the trusted hospital or healthcare organization represent frontline errors
- Inadequate monitoring also impacted the quality of the care and investigation procedures carried out by the trust
- Role of staff competence while these incidents were building up
- An example is Rhiannon Davies on 1 March 2009 gave birth to Kate Stanton-Davies at the Ludlow midwifery-led unit

Total number of cases	GRADING OF INVESTIGATION			
	Total number of cases where an investigation took place	Appropriate	Poor	Unable to grade
168	100	36%	49%	15%

(Source: Gov.UK, 2026)

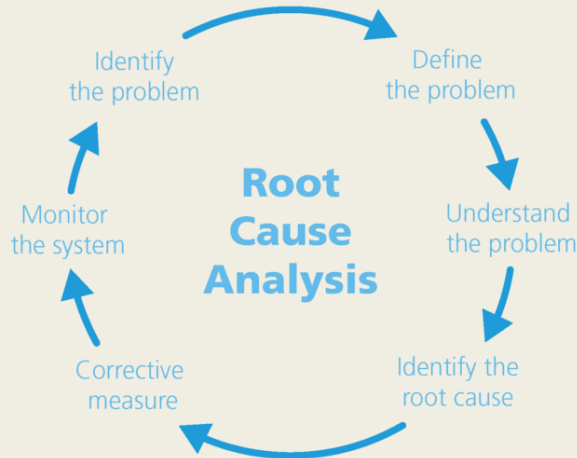
Identification of the root causes by using systems-based safety model

MLU	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Bridgnorth	69	68	75	68	82	77	26	4	0
Oswestry	87	72	74	69	83	52	15	4	0
Ludlow	86	71	62	49	51	36	12	4	0
Shrewsbury	478	421	367	235	207	142	120	69	15
Wrekin	435	401	362	336	359	337	351	285	224

(Source: Gov.UK, 2026)

- Ineffective and untimely reporting mechanisms represent organizational system failures
- Case study also raises questions or concerns over the leadership position of the NHS Trust (Oliverandco, 2026)
- Latent conditions, including policy and regulatory aspects

Elaborating the theories or models that will be applied in depth in the report



(Source: Lamarr-institute, 2026)

1. Why was there a delay in addressing concerns of families in the maternity unit at Shrewsbury and Telford NHS hospital trust?
2. Why did the organization fail to recognize the fetal distress?
3. Why did the organization fail to incorporate proper monitoring systems?
4. Why did the organization fail at offering the quality of care they promised?
5. Why was the organization associated with weak governance and a lack of accountability?

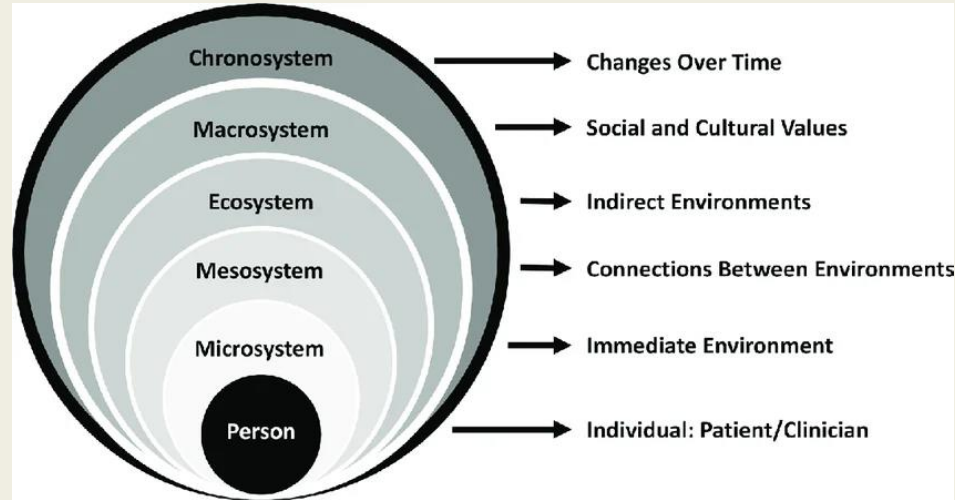
Clinical review findings for each of the major incident categories

INCIDENT CATEGORY	REVIEW TYPE	NUMBER OF REVIEWS*	GRADING OF CARE SCORE				PERCENTAGE OF CARE AT GRADE 2 AND 3
			0	1	2	3	
Maternal Death		12	0	3	6	3	75.0%
Stillbirth		498	193	174	93	38	26.3%
Hypoxic Ischaemic Encephalopathy	Mother**	44	10	5	16	13	65.9%
	Baby***	41	26	13	2	0	4.9%
Neonatal Death	Mother**	251	107	74	38	32	27.9%
	Baby***	237	182	38	13	4	7.2%
Cerebral Palsy/ Brain Damage	Mother**	147	35	47	45	20	44.2%
	Baby***	139	99	30	8	2	7.2%

(Source: Gov.UK, 2026)

- **Systems theory:** The concept behind the systems theory is that open systems are based on interconnected components that exhibit emerging ideas and trends (Lo and Liu, 2023)
- Basically, the systems theory views organizational elements as interconnected
- A single failure or issue also influences other aspects of the systems network as well.
- Shrewsbury and Telford Hospitals NHS Trust reveals that interconnected systems were ineffective.
- Systems include audit review processes, leadership, culture, policy adherence, QA systems, and others were either ineffective or not considered to deliver quality of care

Elaborating the theories or models that will be applied in depth in the report



(Source: Ventres et al, 2024)

Analyzing the policy issues contributing to these root causes and how they influence service delivery



(Source: Sath, 2026)

- There were different quality issues directly contributing to the root cause of the maternity scandal
- This ended up revealing about other 1486 families and 1592 clinical incidents (Gov.UK, 2026)
- The Ockenden report identified that staff were extremely confident
- Investigators experienced repeated failures to escalate concerns
- NHS staff also failed at accurately monitoring baby's heart rates

Demonstrating the impact of these root causes and policy issues on the quality, efficiency, and equity of health and care service provision

- Impact of these root causes as well as policy issues severely impacted efficiency, quality and equity of health (Theguardian, 2022)
- A lack of clinical governance and leadership impacted quality
- England experienced thousands of deaths of mothers and babies throughout decades
- Efficient outcomes were just a promise



(Source: Sath, 2026)

Outlining how the report (component 2) will be structured

- Component 2 will be structured following a more systematic approach
- Introduction, case study analysis, application of models, policy analysis, identification of the recent literature, impact assessment, recommendations, and conclusion
- The aim will be to ensure a more comprehensive understanding

Conclusion

	INVESTIGATION	FAMILY INVOLVEMENT
Appropriate	Incident investigated by team of clinicians. Evidence of recommendations for improvement.	Compassionate communication with family at time of incident.
Poor	Any of the above missing.	Very little or non-compassionate communication with family.
None	Incident not investigated.	No family involvement.

(Source: Gov.UK, 2026)

- The analysis suggests that quality management is the foundational pillar of healthcare delivery
- Promising organizations must play a critical role in ensuring the quality of care
- The case study of Shrewsbury and Telford Hospital NHS Trust reveals a lot
- Healthcare providers to remain efficient and knowledgeable

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Thank You