

- **TITLE: A CASE STUDY OF MID STAFFORDSHIRE NHS FOUNDATION TRUST**
- **MODULE: QUALITY ASSURANCE AND SERVICE IMPROVEMENTS (LCHS7006)**
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- **SUBMITTED ON: 23-03-2026**

CASE STUDY OVERVIEW

- PURPOSE: TO CRITICALLY ANALYSE THE SYSTEMIC FAILURE AT MID STAFFORDSHIRE BETWEEN 2005 AND 2009 AND CREATE A FRAMEWORK FOR A SUSTAINABLE SERVICE IMPROVEMENT.
- SCOPE: ANALYSIS OF CLINICAL GOVERNANCE, ORGANISATIONAL CULTURE, AND IMPLEMENTATION OF QUALITY IMPROVEMENT (QI) MODELS.
- CONTEXT: THE CRISIS IS THE BIGGEST FAILURE OF CARE IN THE HISTORY OF THE NHS. THE FRANCIS INQUIRY IS A LANDMARK INVESTIGATION INTO THE CRISIS (FRANCIS, 2013).



THE MID STAFFORDSHIRE CRISIS

- THE FINDINGS: THE INVESTIGATION FOUND DEPLORABLE STANDARDS OF CARE, WITH PATIENTS FOUND IN DIRTY BED LINEN AND WITHOUT BASIC NUTRITION (HEALTHCARE COMMISSION, 2009).
- MORTALITY: HIGH HOSPITAL STANDARDISED MORTALITY RATIOS (HSMR) SUGGESTED BETWEEN 400 AND 1,200 "EXCESS" DEATHS.
- THE ROOT CAUSE: THE ROOT CAUSE OF THE CRISIS IS A CULTURE OF MANAGEMENT WHERE FINANCIAL OBJECTIVES AND ACHIEVING "FOUNDATION TRUST" STATUS WERE PRIORITISED.(THEGUARDIAN.COM)



DEFINING QUALITY IN HEALTH AND SOCIAL CARE

- THE FRAMEWORK- THE (IOM) INSTITUTE OF MEDICINE FRAMEWORK- SAFE, EFFECTIVE, PATIENT-CENTRED, TIMELY, EFFICIENT, AND EQUITABLE.
- APPLICATION TO MID STAFFS:-
- SAFETY FAILURE- EVIDENCE OF 400-1,200 'EXCESS' DEATHS.
- PATIENT-CENTEREDNESS FAILURE- PATIENTS WERE FOUND IN 'DEPLORABLE STANDARDS' WITHOUT BASIC NUTRITION OR CLEAN LINEN.
- EFFICIENCY V/S QUALITY- THE TRUST PRIORITISED FINANCIAL TARGETS AND ACHIEVING 'FOUNDATION TRUST' STATUS OVER CLINICAL SAFETY.

ROOT CAUSE ANALYSIS

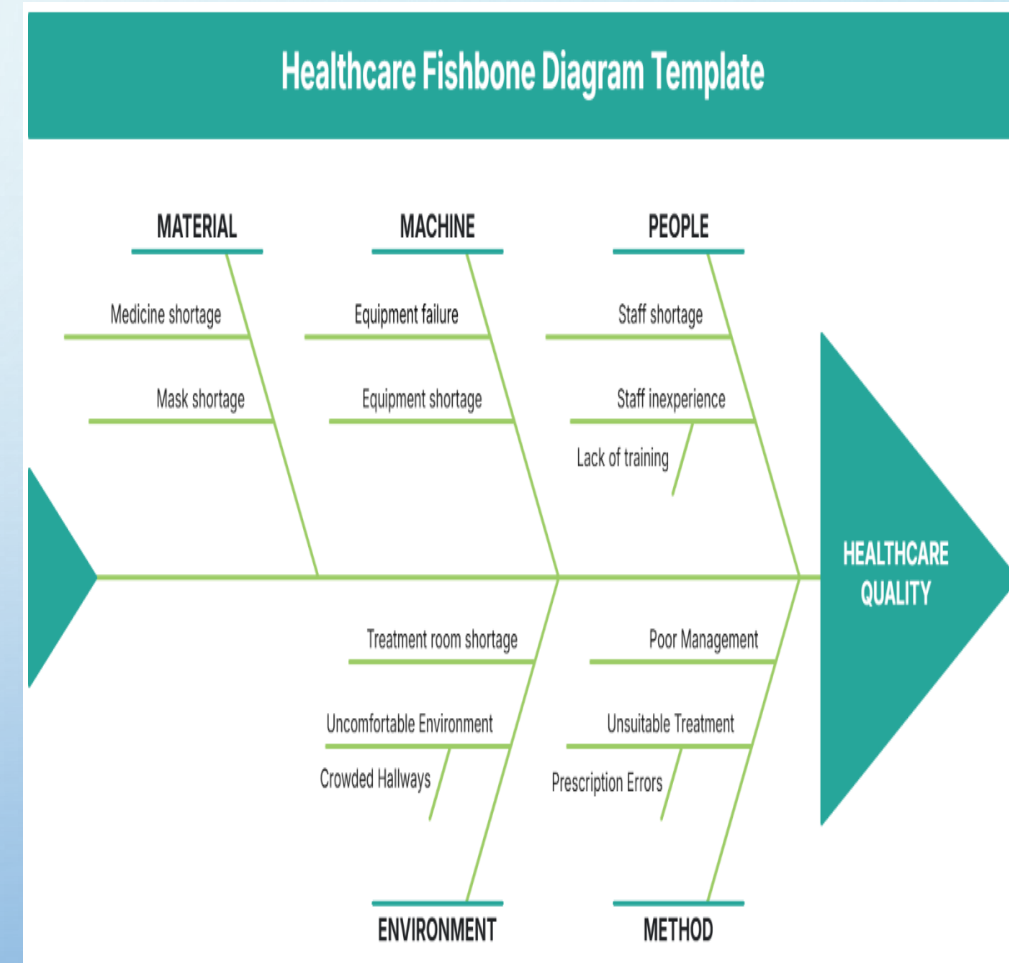
- RCA IS A STRUCTURED, NON-PUNITIVE METHOD USED TO ANALYSE SERIOUS ADVERSE EVENTS IN HEALTHCARE BY IDENTIFYING UNDERLYING PROCESS PROBLEMS.
- SHIFTING THE FOCUS: EFFECTIVE RCA IDENTIFIES CONTRIBUTING FACTORS TO IMPROVE PATIENT SAFETY AND REDUCE FUTURE INCIDENTS RATHER THAN ASSIGNING INDIVIDUAL BLAME.
- METHODOLOGIES APPLIED: THIS CASE UTILIZES A SYSTEMS-BASED APPROACH, COMBINING THE FISHBONE DIAGRAM FOR CATEGORIZATION AND HUMAN FACTORS ANALYSIS TO UNDERSTAND ENVIRONMENTAL PRECONDITIONS.



(shutterstock)

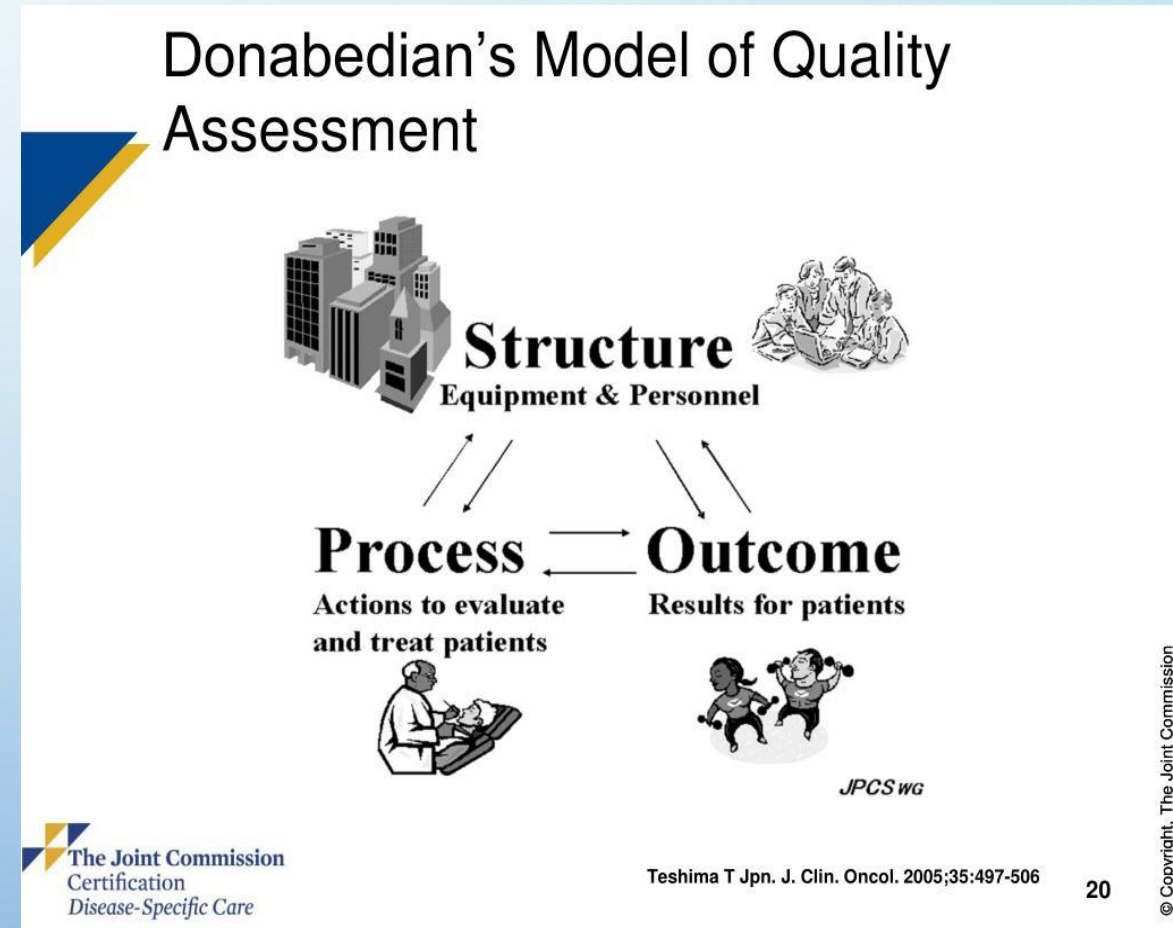
APPLICATION : FISHBONE (ISHIKAWA)

- APPLICATION: IDENTIFY THE "WHY" BEHIND THE FAILURE (HAREL ET AL., 2016).
- CATEGORIES:
- EQUIPMENT: LACK OF BASIC MONITORING AND LINEN SUPPLIES.
- PROCESS: INEFFECTIVE TRIAGE IN THE A&E DEPARTMENT.
- PEOPLE: ACUTE NURSING SHORTAGES AND LOW MORALE (BALL AND GRIFFITHS, 2021).
- MANAGEMENT: BULLYING AND 'TARGET-DRIVEN' CLINICAL PRIORITIES (DIXON-WOODS ET AL., 2013).(TEMPLATE.NET)
- ACTIVE FAILURES: CLINICAL ERRORS AND NEGLECT.



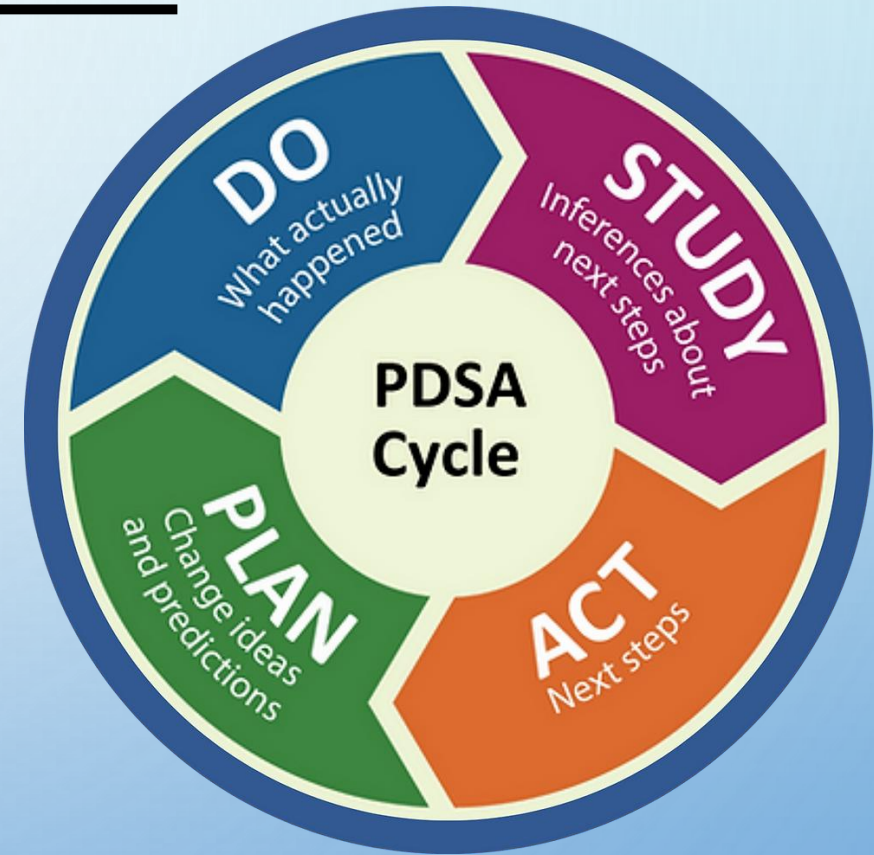
MEASURING QUALITY: DONABEDIAN'S MODEL

- STRUCTURE: POOR NURSE-TO-PATIENT RATIOS AND INADEQUATE FACILITIES (DONABEDIAN, 1988).
- PROCESS: FAILURE TO MONITOR VITAL SIGNS OR PROVIDE PAIN RELIEF.
- OUTCOME: UNACCEPTABLY HIGH MORTALITY RATES AND LOSS OF PUBLIC TRUST (BEST AND NEUHAUSER, 2004).



PROPOSED SERVICE IMPROVEMENTS: **THE PDSA CYCLE**

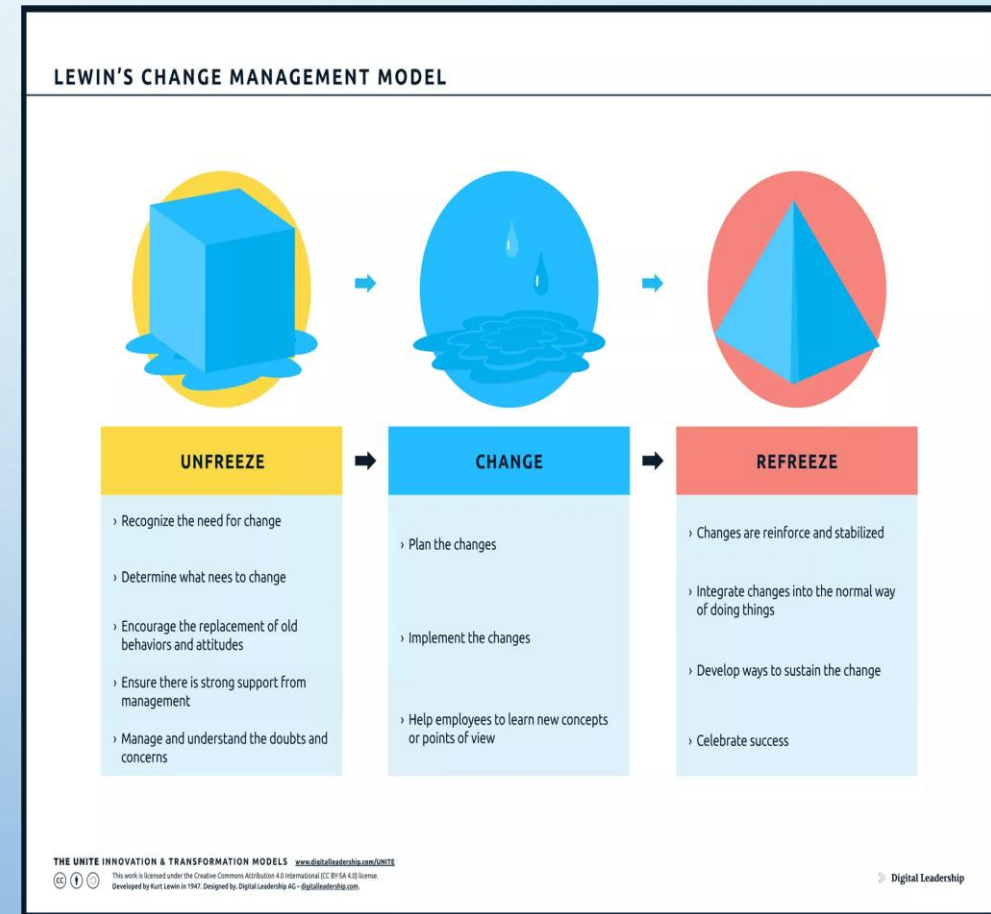
- MODEL: PLAN-DO-STUDY-ACT
- PLAN: IMPLEMENT A "PATIENT SAFETY WALKAROUND" FOR SENIOR LEADERSHIP TO ENGAGE WITH FRONTLINE STAFF.
- DO: PILOT THE WALKAROUNDS IN THE EMERGENCY DEPARTMENT FOR 4 WEEKS.
- STUDY: EVALUATE STAFF FEEDBACK AND INCIDENT REPORTING RATES.
- ACT: REFINE THE PROCESS AND ROLL OUT HOSPITAL-WIDE TO BRIDGE THE "WARD TO BOARD" GAP (KEEN ET AL., 2018).



(adobestock.com)

IMPLEMENTING CHANGE: LEWIN'S THEORY

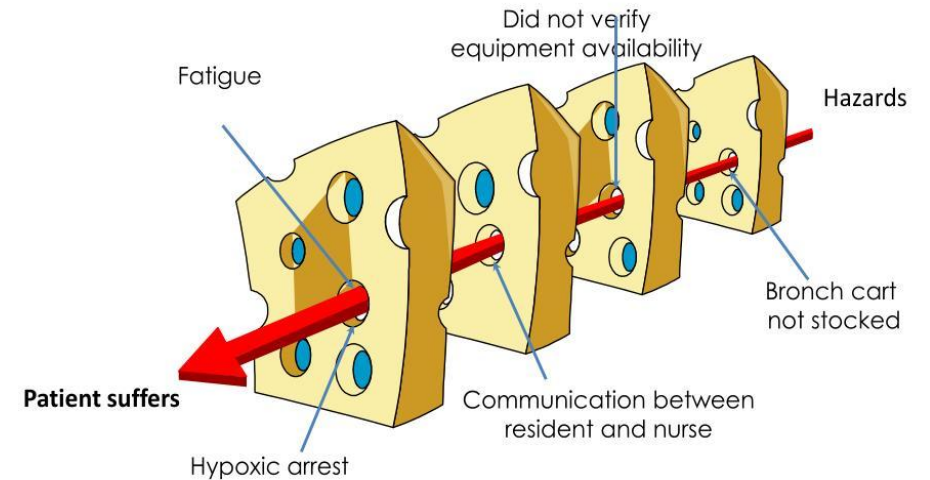
- UNFREEZE: USE THE FRANCIS REPORT TO HIGHLIGHT THE NEED FOR A "DUTY OF CANDOUR".
- CHANGE: SHIFT THE FOCUS FROM FINANCIAL TARGETS TO CLINICAL OUTCOMES (LYNAS, 2015).
- REFREEZE: EMBED TRANSPARENCY AND PATIENT VOICE INTO THE TRUST'S CORE VALUES (WHILE, 2015).



SYSTEM FAILURE- SWISS CHEESE MODEL

- THEORY: ACCIDENTS HAPPEN WHEN HOLES IN SYSTEM DEFENCES LINE UP (REASON, 1990).
- MID STAFFS ALIGNMENT:
- LATENT CONDITIONS: BOARD-LEVEL FOCUS ON FINANCE.
- HOLES IN DEFENCES: LACK OF EFFECTIVE REGULATORY OVERSIGHT AND STAFF TRAINING (CQC AND WIEGMANN ET AL., 2021).
- PROBLEMS INCLUDE MONEY PROBLEMS, "CHANGE FATIGUE," AND NOT WANTING TO CHANGE.
- GETTING PAST PROBLEMS: USE KOTTER'S 8-STEP PROCESS TO GIVE EMPLOYEES A "SENSE OF URGENCY" AND LET THEM TAKE CHARGE OF QUALITY (KOTTER, 1996).

System Failure Leading to Error: Reason's Swiss Cheese Model



FUTURE BENCHMARKING

- BENCHMARKING: USING OUTSIDE STANDARDS TO MAKE THINGS BETTER INSIDE.
- CRITICAL APPLICATION: THE TRUST MUST COMPARE ITS MORTALITY AND SAFETY DATA WITH THOSE OF NHS TRUSTS THAT HAVE BEEN RATED "GOOD" OR "OUTSTANDING" (ETTORCHI-TARDY ET AL., 2012; NOLTE, 2010).
- SUSTAINABILITY: CONSISTENT BENCHMARKING ENSURES THE TRUST DOES NOT BECOME COMPLACENT AFTER ACHIEVING INITIAL IMPROVEMENTS (NOLTE, 2010).



(freepik.com)

SUMMARY OF SYSTEMATIC FAILURES

- THE 'WARD-TO-BOARD' DISCONNECT: THE PRIMARY FAILURE AT MID STAFFORDSHIRE WAS THE LACK OF CLINICAL OVERSIGHT BY THE BOARD, WHO PRIORITISED FINANCIAL ' FOUNDATION TRUST ' STATUS OVER BEDSIDE SAFETY (FRANCIS, 2013).
- NORMALISATION OF DEVIANCE: CHRONIC UNDERSTAFFING LED TO A CULTURE WHERE SUB-STANDARD CARE (EG, POOR HYGIENE AND NUTRITION) BECAME 'NORMAL' AND WENT UNCHALLENGED (DIXON-WOODS ET AL., 2013).
- REGULATORY BLIND SPOTS: A RELIANCE ON HIGH-LEVEL QUALITY ASSURANCE (QA) METRICS MEANT THAT REGULATORS MISSED THE CLINICAL REALITY OF THE WARDS (HEALTHCARE COMMISSION, 2009).



(alamy.com)

STRATEGIC RECOMMENDATIONS FOR IMPROVEMENT

1. IMPLEMENTATION OF 'SAFE STAFFING' MODELS: ESTABLISH MANDATORY NURSE-TO-PATIENT RATIOS BASED ON PATIENT ACUITY RATHER THAN BUDGET. THIS ADDRESSES THE 'STRUCTURE' ELEMENT OF DONABEDIAN'S MODEL (RAFFERTY AND LEARY, 2023).
2. TRANSITION TO A 'JUST CULTURE': MOVE AWAY FROM A CULTURE OF FEAR. IMPLEMENT A FRAMEWORK THAT ENABLES STAFF TO REPORT 'NEAR MISSES' SAFELY, ALLOWING THE ORGANISATION TO LEARN RATHER THAN BLAME.
3. CONTINUOUS QI VIA PDSA CYCLES: SHIFT FROM STATIC QA MINDSET TO ACTIVE QUALITY IMPROVEMENT. USE PDSA CYCLES TO TEST SMALL CHANGES (BATALDEN AND DAVIDOFF, 2007).
4. EXTERNAL BENCHMARKING: USE DATA FROM 'OUTSTANDING' RATED TRUSTS TO IDENTIFY PERFORMANCE GAPS AND DRIVE CONTINUOUS SERVICE RE-ENGINEERING (NOLTE, 2010).



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