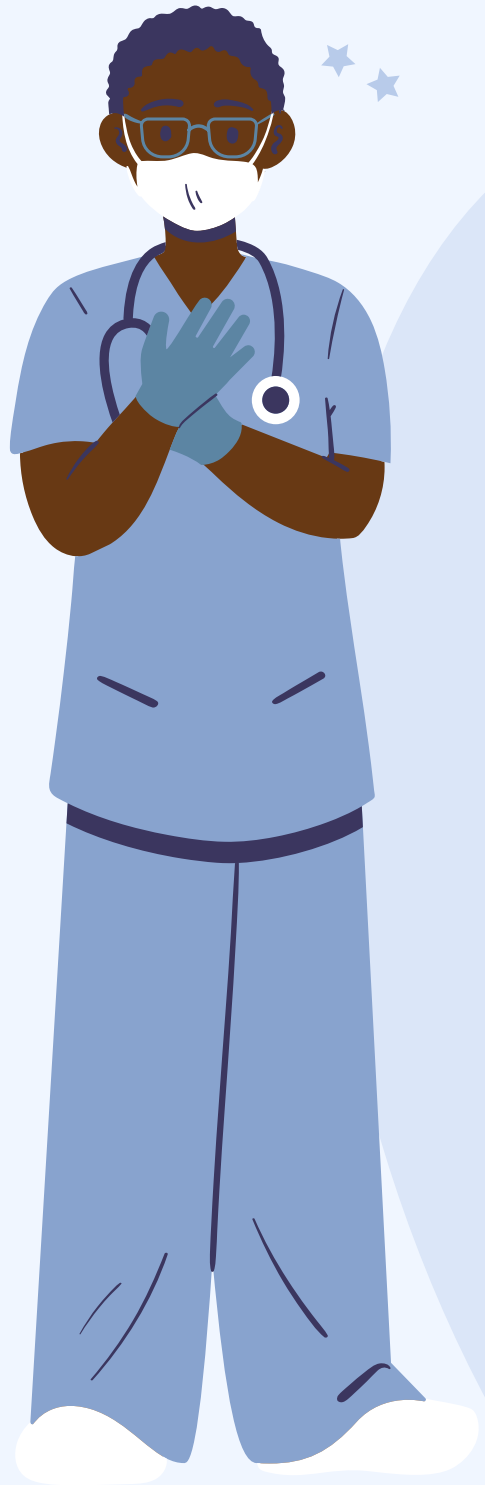


Mid Staffordshire NHS

# Systemic Failures and Policy Gaps in the Mid Staffordshire NHS Foundation Trust: A Systems-Based Safety Analysis

|                                              |                                      |                                                                          |                                               |
|----------------------------------------------|--------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------|
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# Aims & Learning Objectives



- Deliberate on the case of the Mid Staffordshire NHS Foundation Trust using a system-based approach.
- Identify the major underlying causes and policy mistakes that influence patient safety.
- Use the Swiss Cheese and Fishbone models in the analysis of system gaps.
- Suggest evidence-based measures and approaches to improve care quality and governance.



# Case Study Summary



- Period: 2005–2009, characterised by drastic quality-of-care failures.
- An excess of patient deaths is estimated at 400–1,200 (Dixon-Woods, 2024).
- Inquiry related to Robert Francis QC in 2013.
- Exposed poor hygienic conditions, negligence and understaffing (Dixon-Woods, 2024).
- The leadership considered monetary and performance goals more than patient care and safety.

# Context & Scope



Mid Staffordshire NHS Foundation Trust is a district hospital in England, with approximately 300 beds (Yardley et al., 2022).

Became a Foundation Trust and became more focused on financial efficiency.

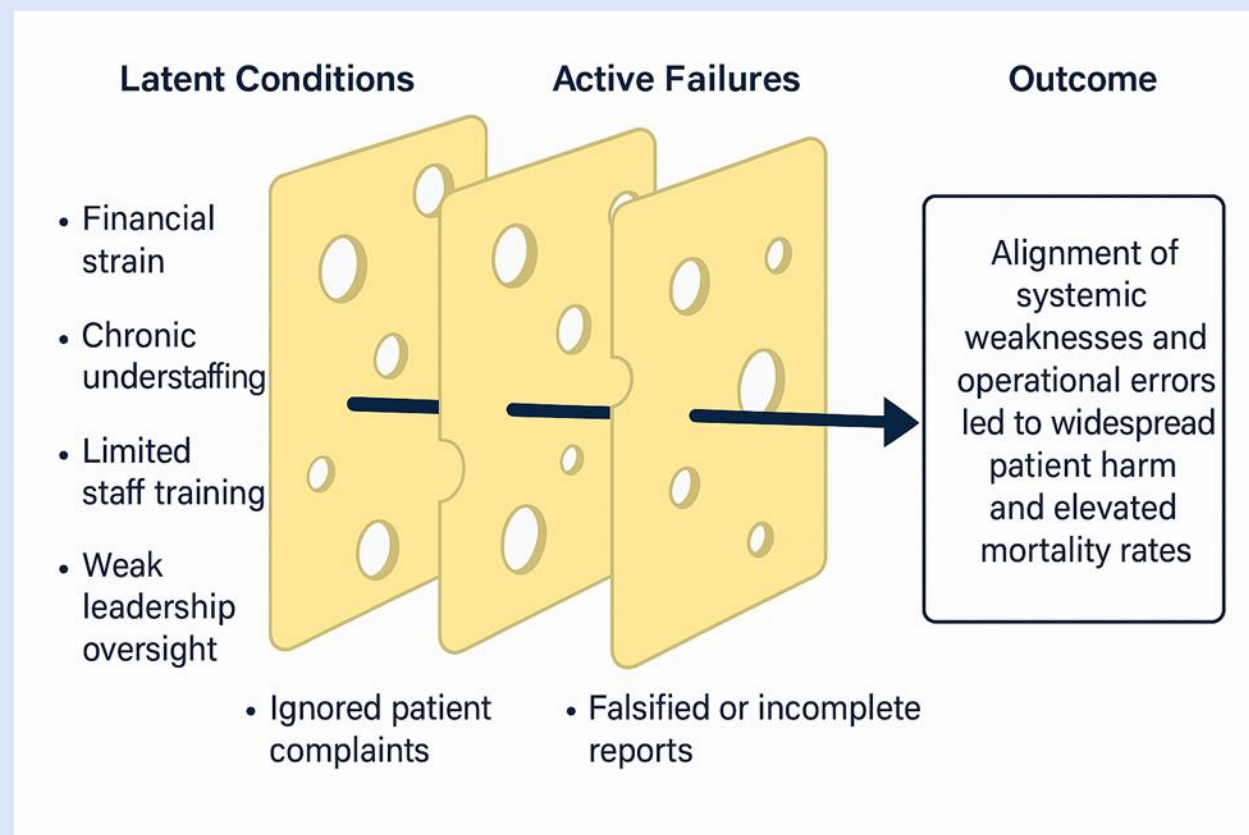


Public trust was undermined by systemic maltreatment and preventable injuries to the patients (Yardley et al., 2022).

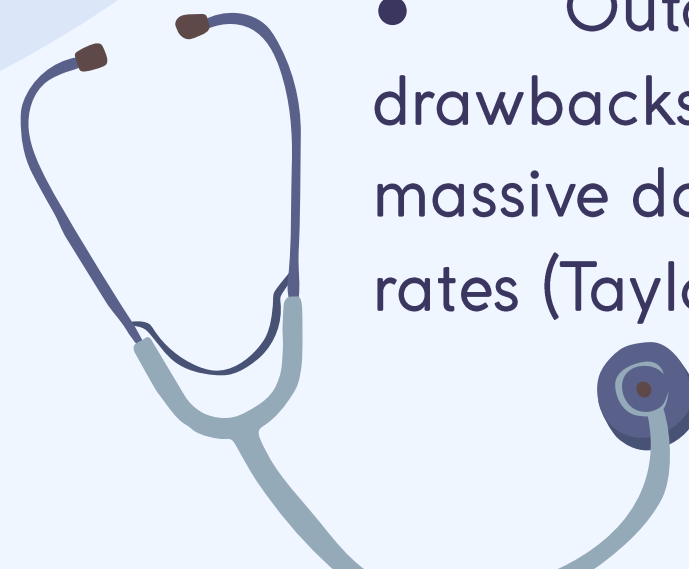
The main stakeholders were patients, staff, regulators, policymakers and the entire NHS leadership network (Yardley et al., 2022).



# Systems Model Visual (Swiss Cheese Model)

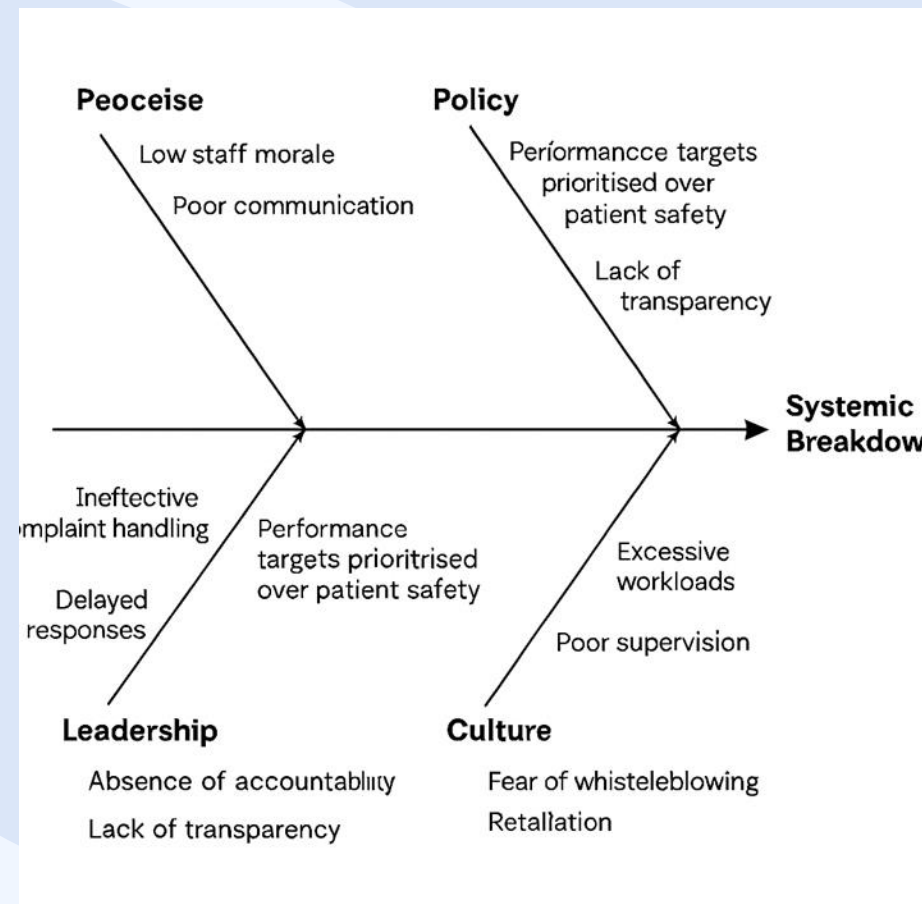


- Latent Conditions: Financial Stress, Chronic Understaffing, inadequate staff training, poor leadership (Taylor and Goodwin, 2022).
- Active Failures: Overlooked complaints of patients, fabricated or missing reports, and unsafe clinical judgments.
- Outcome: Coordination of structural drawbacks and mistakes in operations resulted in massive damage of patients and high mortality rates (Taylor and Goodwin, 2022).



# Root Cause Analysis (Fishbone Diagram)

- People: Decreased morale of the staff and interdepartmental communication.
- Processes: ineffective complaint handling and response (Maarse, 2023).
- Policy: Goals in performance, not patient safety.
- Leadership: Lack of accountability and transparency.
- Environment: Workloads and bad supervision.
- Culture: Fear of being a whistleblower and becoming a victim (Maarse, 2023).

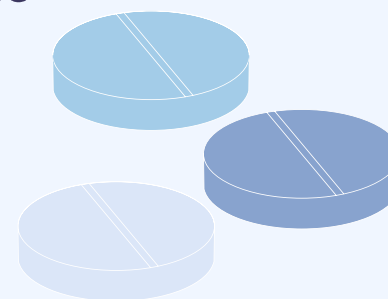
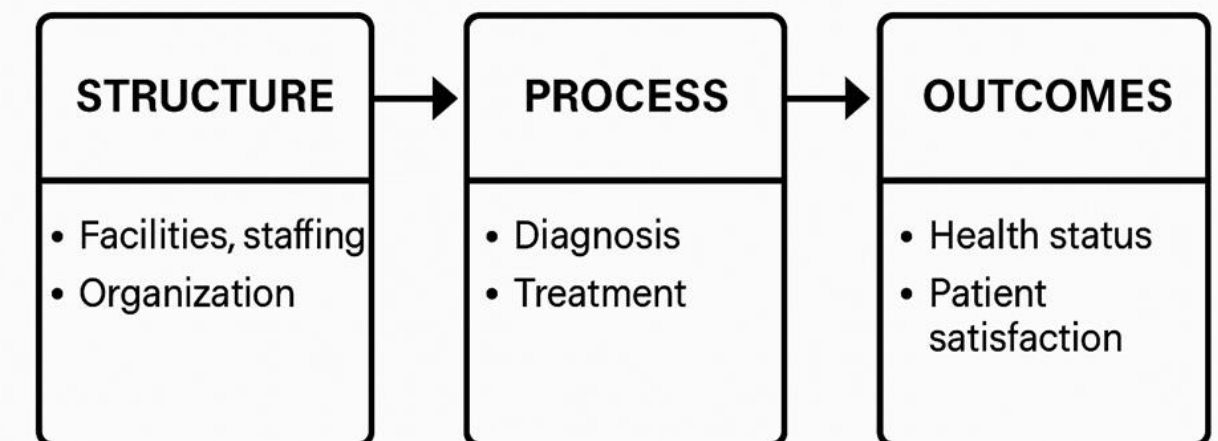


# Theoretical Frameworks

- **Swiss Cheese Model:** It shows how organisational vulnerabilities and human failures interrelate to generate bad events (Jones and Armit, 2025).
- **Donabedian Model:** Relates healthcare structure, processes, and results to determine the quality of services (Jones and Armit, 2025).
- **Root Cause Analysis (RCA):** It is used to find the root organisational causes of recurring failures as opposed to individual errors.



## Donabedian Model



# Policy Analysis



- Poor clinical governance by the policies of NHS modernisation was not aligned with quality objectives.
- Poorly applied NHS Quality Accounts (2008).
- Poor regulatory compliance of Monitor and CQC.
- Weak safeguards for whistleblowers.
- Policies were based upon financial performance instead of quality of care and staff burnout, and moral distress.



# Impact on Quality, Efficiency, and Equity

## Quality

Risky treatment, preventable fatalities, inadequate hygiene, and negligence (Kuosmanen, 2021).

## Efficiency

Abuse of clinical resources, poor managerial control.

## Equity

Inappropriate disfavour to elderly and vulnerable patients (Kuosmanen, 2021).



# Evidence & Literature



- Francis Report (2013): Rampant governance and care deficiencies.
- Department of Health (2013): Reforms to be made in the restoration of patient safety (Brooks et al., 2024).
- Mannion and Davies (2018): Evaluated unhealthy organisational culture.
- Dixon-Woods (2019): Governance and accountability gaps that were analysed.
- NHS Improvement (2020): Patient safety through learning culture (Brooks et al., 2024).



# Recommendations / Interventions

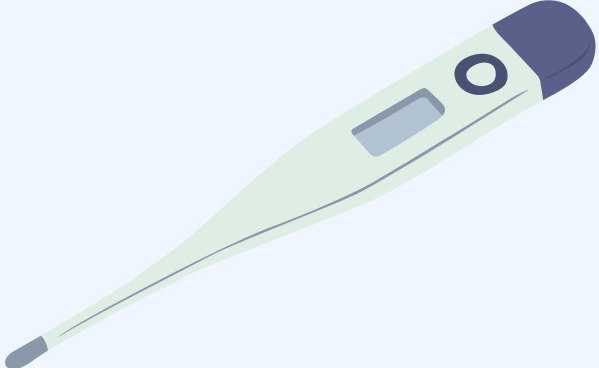
## Short-Term

- Reduce the workloads on nurses to secure safe levels.
- Intensify internal reporting and feedback.
- Whistleblowers should be protected and empowered to bring up safety issues (Haraldseid-Driftland et al., 2022).

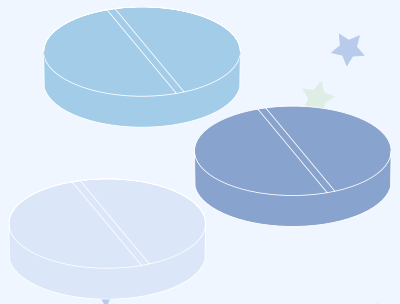
## Long-Term

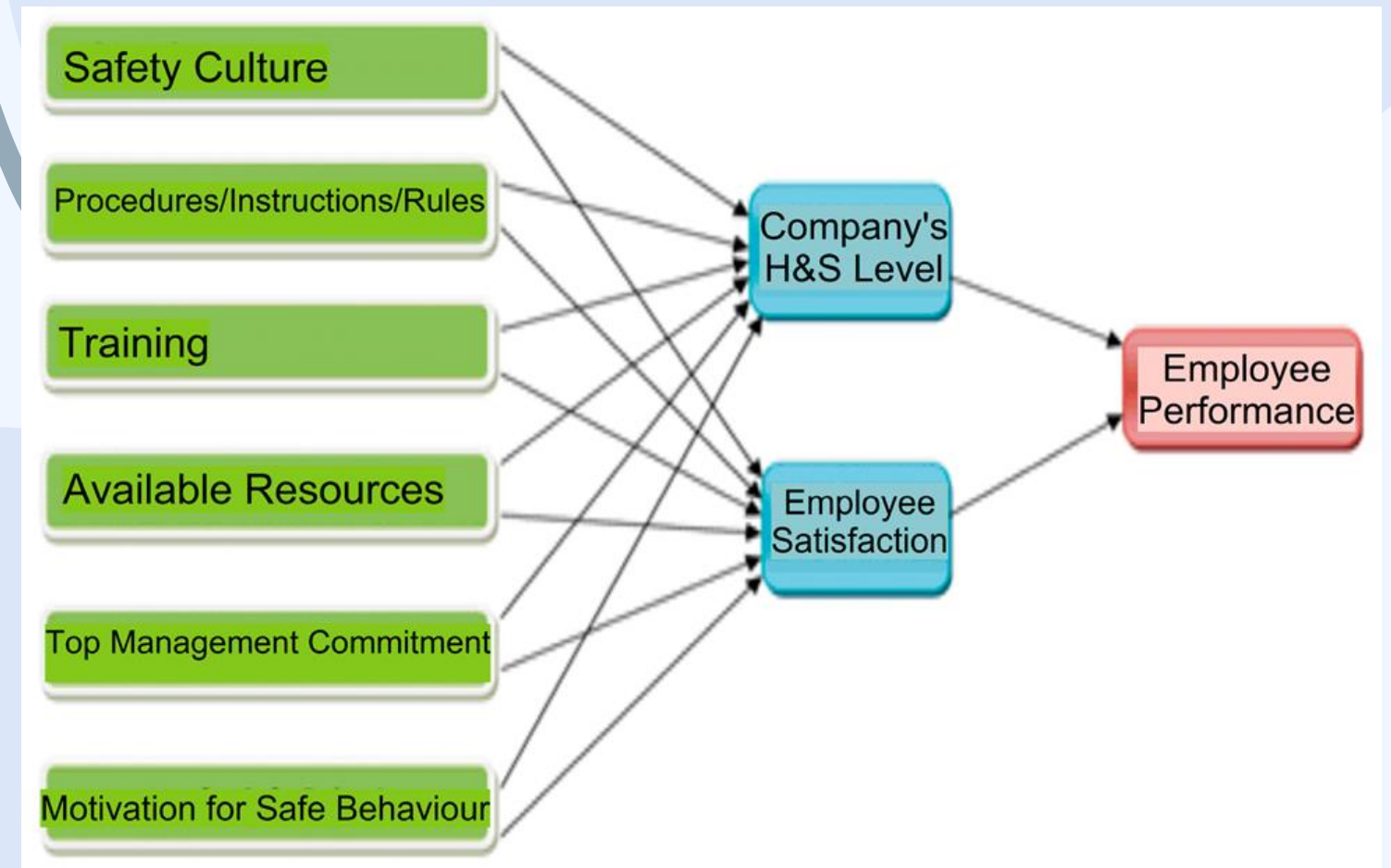
- Create an organisational culture that puts the patient first.
- Bring in leadership training and regulation changes.
- Carry out routine and open safety inspections (Haraldseid-Driftland et al., 2022).



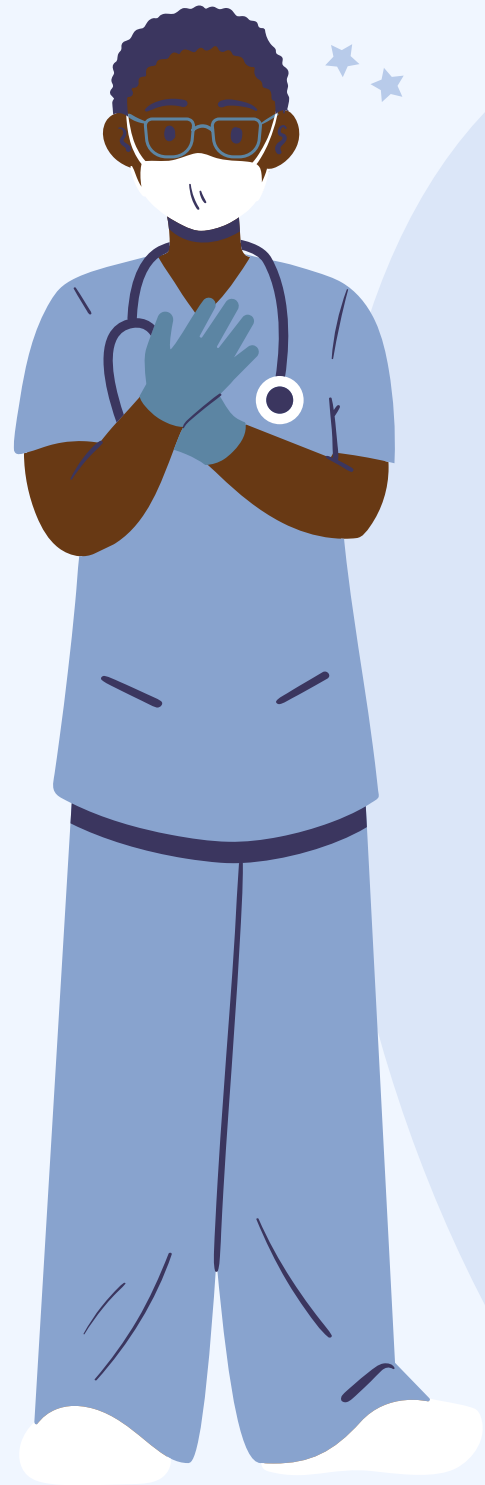


# Implications for Practice

- **Frontline Staff:** Safety is promoted by better communication and workloads, which are manageable.
  - **Managers:** The accountability and clarity of the governance are enhanced.
  - **Regulators:** The implementation of proactive data-driven oversight.
  - **Patients:** Regained trust in NHS services due to compassion, openness and quality care delivery in a steady manner (Yardley et al., 2022).
- 



# Outline of Component 2 (Report)



- **Introduction:** Background and reason behind the Mid Staffordshire case.
- **Literature Review:** Theories and past literature on healthcare failure.
- **Approaches:** Systems analytical framework.
- **Case Analysis:** Swiss Cheese and RCA model.
- **Critique of the Policy, Discussion, Recommendations, Conclusion and References** (Francis, 2013).



# Limitations & Ethical Considerations



- Depending on secondary data like inquiry reports and press coverage.
- There is a risk of bias in the testimony and interpretation of the data (Dixon-Woods, 2024).



- Care was necessary when dealing with victims and families.
- Adherence to ethical responsibility and professional neutrality during the analysis and presentation of the findings (Dixon-Woods, 2024).

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**Thank you for  
your attention**

