

LCHS7006 · QUALITY ASSURANCE AND SERVICE IMPROVEMENTS

# Leadership, Governance and Patient Safety During Nurse Staffing Shortages

*A Critical Analysis of Mid Staffordshire  
NHS Foundation Trust*

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Assessment: Component 1 – Individual Presentation





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# The Mid Staffordshire Case Study

*Mid Staffordshire NHS Foundation Trust, 2005–2009*

27–45%

**Mortality:** emergency-care mortality above expected levels (Francis, 2013)



400–1,200

**Excess deaths:** public estimates, which the Inquiry cautioned were not directly attributable individual deaths (Francis, 2013)



**Quality problem:** unsafe nurse staffing contributed to poor standards of care and patient harm (Francis, 2013)



**Time frame:** 2005–2009



**Drivers:** cost pressures and the push for Foundation Trust status (Francis, 2013)



**Warning signals:** complaints and reports of poor nursing standards (Francis, 2013)



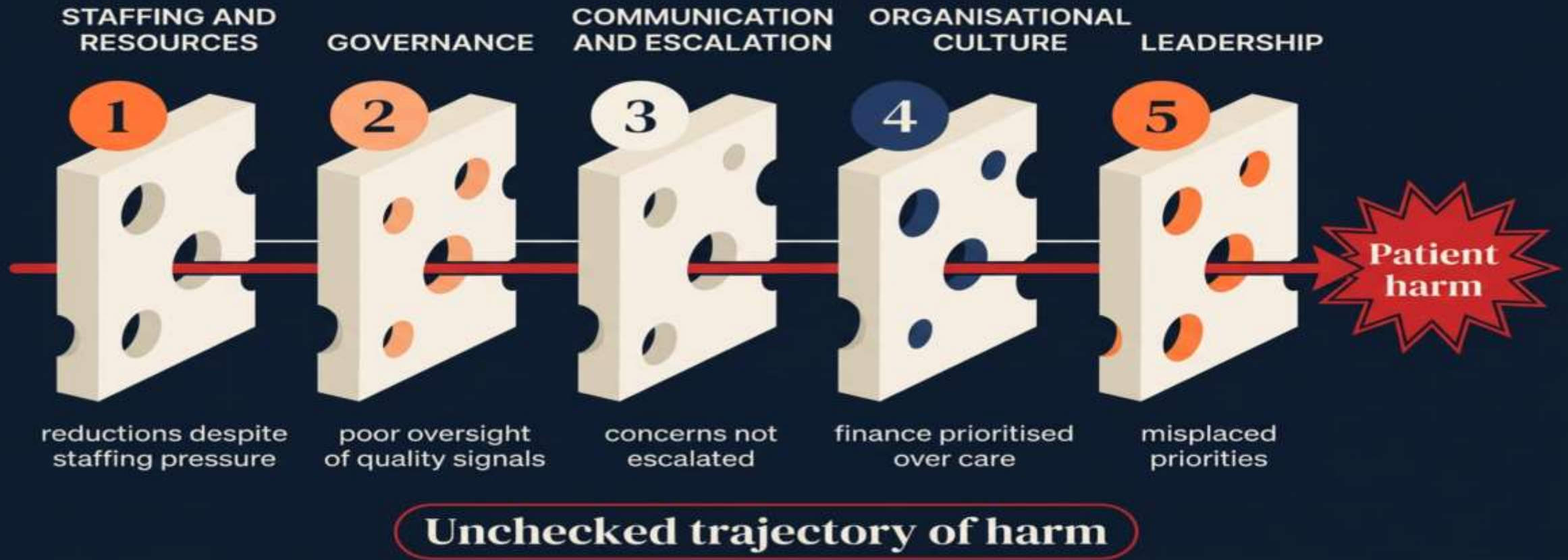


# Overview of the Mid Staffordshire Case

- 1 Cost pressures and the drive towards Foundation Trust status shaped staffing and resource decisions (Francis, 2013)
- 2 Governance weaknesses included poor oversight, weak escalation and insufficient attention to patient experience (Francis, 2013)
- 3 Complaints and mortality signals were not converted into timely assurance action (Francis, 2013)
- 4 A systems problem linking workforce, finance, leadership, culture and quality assurance (Reason, 2000)

Contemporary evidence links lower nurse staffing with poorer patient outcomes, supporting the workforce-risk mechanism identified in the case (Dall'Ora et al., 2022)

# Swiss Cheese Model: Systemic Failures at Mid Staffordshire



Reason's Swiss Cheese Model holds that harm occurs when weaknesses across several defensive layers align, rather than through one individual error (Reason, 2000).

# The Application of the Swiss Cheese

| Layer of Defence<br>(Slice of the Cheese) | Intended Function                                                                | Hole (Weakness)                                                 | Peer Reviewed Evidence                                                                                                                                               |
|-------------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Safe staffing                          | Staffing levels matched to patient acuity, dependency and local workload.        | Nurse staffing reduced despite staffing pressure and poor care. | NICE expects staffing assessed using evidence, acuity and dependency (NICE, 2014). Lower nurse staffing linked with poorer patient outcomes (Dall'Ora et al., 2022). |
| 2. Clinical governance                    | Connects staffing, complaints, mortality and quality data into timely assurance. | Quality signals not converted into assurance action.            | Emergency-care mortality <b>27–45%</b> above expected levels while governance failed to act (Francis, 2013).                                                         |
| 3. Communication and escalation           | Frontline concerns reach senior decision-makers quickly.                         | Weak escalation; staff concerns not heard.                      | Speak-up arrangements must ensure concerns heard and acted upon without fear (NHS England, 2022b).                                                                   |
| 4. Organisational culture                 | Patient safety prioritised above financial and performance targets.              | Financial and Foundation Trust pressures dominated priorities.  | The Inquiry found misplaced priorities and insufficient attention to patient experience (Francis, 2013).                                                             |
| 5. Incident learning                      | Incidents and near misses produce organisational learning.                       | Reactive, blame-focused incident handling.                      | PSIRF requires proportionate, system-based learning from incidents (NHS England, 2022a). Harm results when weaknesses across layers align (Reason, 2000).            |

# Policy, Governance and Centralisation

*Misalignment, not absence of policy.*

| Area                       | Issue at Mid Staffordshire                                                               | Current policy direction                                                   |
|----------------------------|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <b>1. Policy</b>           | Financial priorities and Foundation Trust pressures competed with safety (Francis, 2013) | Openness, accountability and staffing transparency (NHS England, 2022a)    |
| <b>2. Governance</b>       | Staffing, complaints and mortality not linked into assurance (Francis, 2013)             | System-based learning and staff voice (NHS England, 2022a; 2022b)          |
| <b>3. Centralisation</b>   | National financial and performance pressures shaped local priorities (Francis, 2013)     | National standards with local decision-making (NHS England, 2023)          |
| <b>4. Decentralisation</b> | Local teams lacked authority to escalate unsafe staffing (Francis, 2013)                 | Protect local clinical challenge and information flows (NHS England, 2023) |

# Impact on Quality, Efficiency and Equity



## Quality

Poor standards, missed care, inadequate staffing and safety risks (Francis, 2013)



## Efficiency

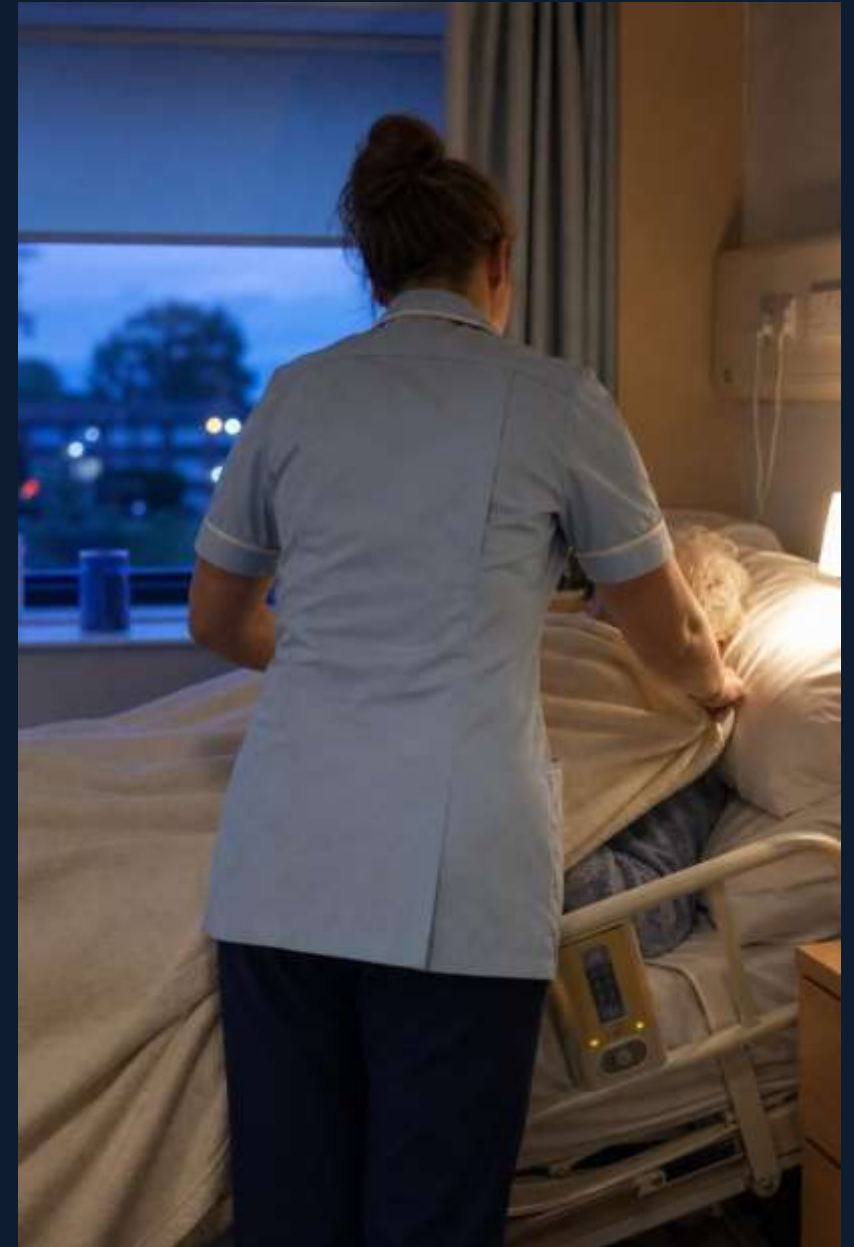
Workforce pressure, higher workload, sickness absence and reactive management (Dall'Ora et al., 2022)



## Equity

Reliable, respectful, timely care for patients most dependent on safe staffing (CQC, 2025)

*Quality assurance should triangulate outcomes, workforce indicators, incidents and experience data (Donabedian, 1988; CQC, 2025).*



# The Benchmarking Gap: National Standards Unmet

| Indicator                   | National Standard                                                                  | Present performance                                                 | Succinct overview                                |
|-----------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------|
| 1. Safe staffing            | Assessed using evidence, acuity, dependency and local circumstances (NICE, 2014).  | Reduced 2005–2009; mortality 27–45% above expected (Francis, 2013). | Driven by finance, not patient safety.           |
| 2. Incident learning        | PSIRF: proportionate, system-based learning (NHS England, 2022a).                  | Weak and reactive (Francis, 2013).                                  | Incidents must become measurable learning.       |
| 3. Speaking up              | National Speak Up Policy minimum standard (NHS England, 2022b).                    | Concerns about poor care not acted upon (Francis, 2013).            | Concerns heard and acted on without fear.        |
| 4. Workforce sustainability | Long Term Workforce Plan: supply, retention, redesigned roles (NHS England, 2023). | Short-term pressure; still a service risk (CQC, 2025).              | Link planning to quality, capacity and outcomes. |

Benchmarking compares systems, identifies discrepancies in performance and uses this to improve care by learning from the most successful institutions.



# Component 2: The Report

## COMPONENT ONE (INDIVIDUAL PRESENTATION)

**The Mid Staffordshire case demonstrated how nurse staffing shortages, governance weaknesses and leadership priorities combined to cause patient harm.**

## COMPONENT TWO

### 1 Introduction

Define the problem and its interacting root causes

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### 2 Main body

Critically evaluate governance, policy and leadership

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### 3 Recommendations

Assess safer staffing, speaking up and incident learning options

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### 4 Conclusions

Set out implementation, measures and governance

# Acronyms and Jargons

| Acronym      | Meaning                                           |
|--------------|---------------------------------------------------|
| <b>CQC</b>   | Care Quality Commission                           |
| <b>NHS</b>   | National Health Service                           |
| <b>NICE</b>  | National Institute for Health and Care Excellence |
| <b>PSIRF</b> | Patient Safety Incident Response Framework        |
| <b>FT</b>    | Foundation Trust                                  |

| Jargon                     | Meaning                                                         |
|----------------------------|-----------------------------------------------------------------|
| <b>Acuity</b>              | The level of care a patient needs based on how unwell they are  |
| <b>Benchmarking</b>        | Comparing performance against standards to identify gaps        |
| <b>Clinical governance</b> | A system holding NHS organisations accountable for care quality |
| <b>Escalation</b>          | Raising a concern to a higher level of authority                |
| <b>Excess deaths</b>       | Deaths above the number statistically expected                  |
| <b>Triangulation</b>       | Combining several data sources to confirm a finding             |

# References

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