

Quality Assurance Failures at Mid Staffordshire NHS Foundation Trust: Root Causes and Service Improvement

LCHS7006

Quality Assurance and Service Improvements

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Introduction



Between 2005 and 2009, Mid Staffordshire NHS Foundation Trust made fundamental errors in its healthcare quality, resulting in poor standards of patient care and avoidable patient deaths (Francis, 2013).

The presentation dissects the causes and shortcomings of policies, and organisational factors that exacerbate the crisis.

It emphasises the need for robust quality assurance and ongoing service enhancements to deliver safe and patient-centred healthcare services.

Overview of Case Study



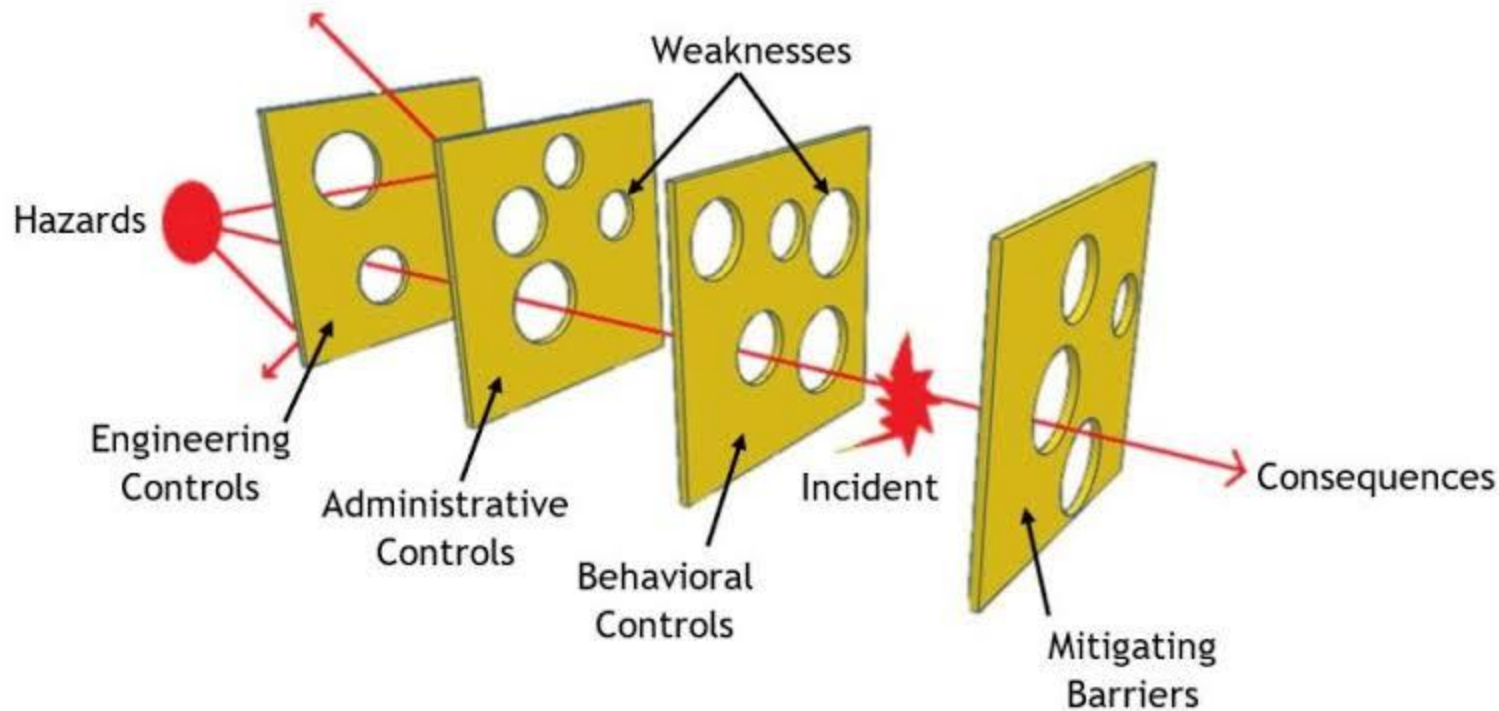
Mid Staffordshire NHS Foundation Trust was subjected to massive failures of care for patients from 2005-09 and drew a lot of attention in the national press (Rafferty and Leary, 2023).

Inadequate staffing, neglect, poor hygiene and poor clinical governance were the main concerns.

This is a groundbreaking case of healthcare quality in the UK highlighted by the Francis Report (2013), which found a failure of the system.



Root Causes - Swiss Cheese Model

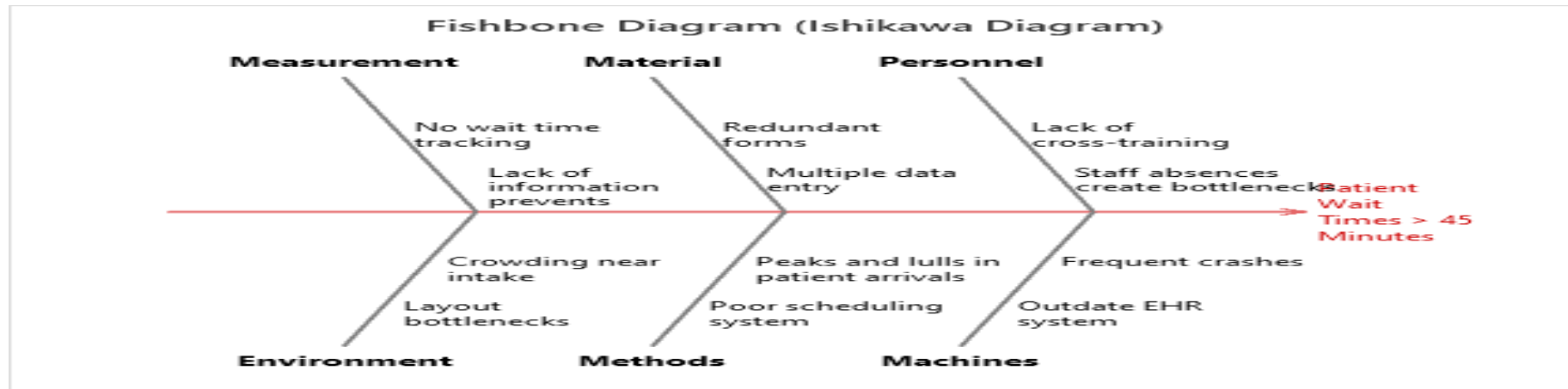


Through the Swiss Cheese Model, the Swiss failures of multiple elements that could have prevented a significant healthcare failure were described (Shabani *et al.*, 2024).

Leadership shortcomings, ineffective communications, and governance issues left holes in patient safety.

Lack of organisational culture, inadequacy of human factors made early identification and correction of risk difficult (Sameera *et al.*, 2021).

Root Cause Analysis Using the Fishbone (Ishikawa) Diagram



Poor leadership, staffing deficit and inadequate communication resulted in poor health care quality and patient safety (Ardha *et al.*, 2023).

There were operational risks due to weak policies, limited resource capabilities and insufficient clinical governance.

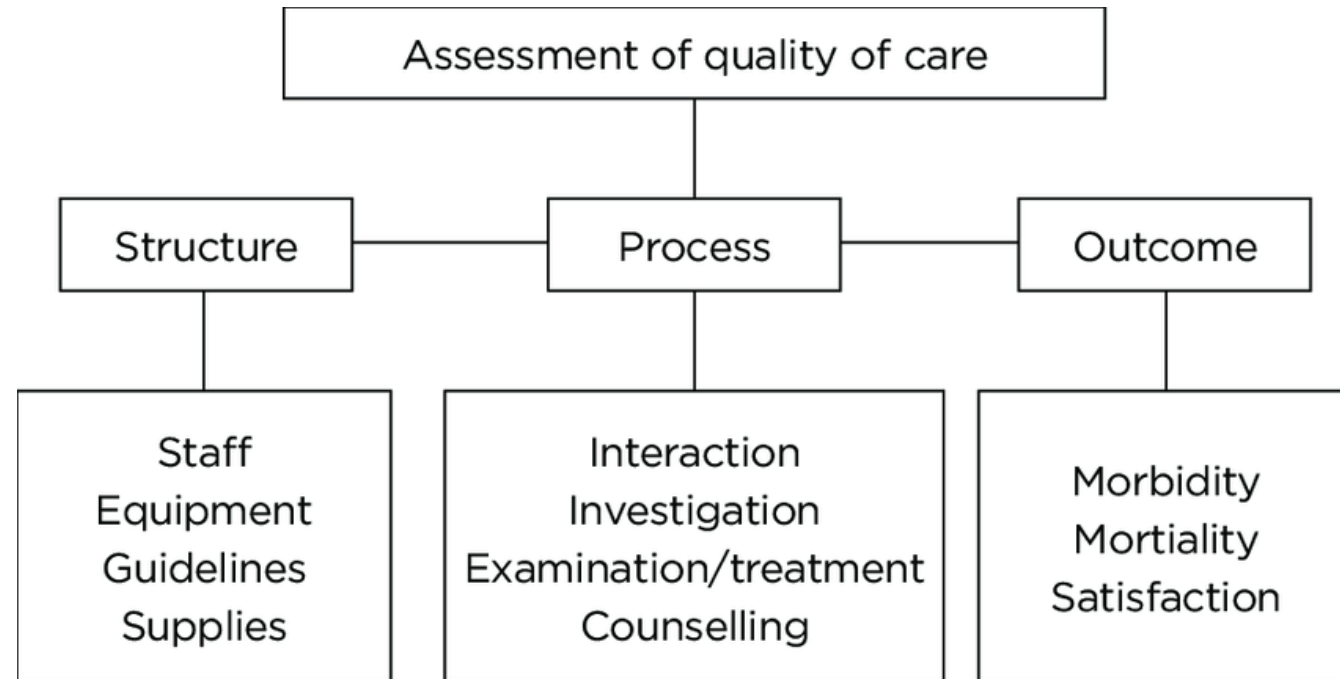
Unwanted organisational culture was hindering accountability, learning and continuous quality improvement (Pazhayattil and Sharma, 2025).

Application of Quality Improvement Theory

The Donabedian Model is a quality assessment technique involving three levels: structure, process, and outcome (Tossaint-Schoenmakers *et al.*, 2021).

The quality of the patients' outcomes was low due to weak organisational structures and the lack of effective clinical processes.

This model proved to be effective in illustrating the direct impact of system deficiencies upon health care quality.



Policy Issues Affecting Quality of Care

**Healthcare
system quality
(performance)**

**Healthcare
service quality**

Weak NHS Foundation Trust governance was a limitation on accountability and on the monitoring of the quality of healthcare (NHS England, 2022).

A lack of effective clinical governance, staffing policy and whistle-blowing policy held up action to correct the situation.

Restrictions in regulation before the Francis inquiry meant that patient safety monitoring was limited (Campbell, 2013).

POLICY



'Standards & Expectations'



Guiding Principles
(e.g., Person-Centred Care, Dignity, Safety)



Long-term Goals & Values



Regulatory & Legal Compliance



Overall Approach to Communication & Support

Sets the Direction
& Purpose

PROCEDURE



Step-by-Step Actions Staff Follow



1. Identify & Check
(Verify identity, assess needs, check medication)



2. Deliver Care
(Administer treatment, provide support, use correct equipment)



3. Record & Document
(Accurate, timely reporting in care plans)



4. Report & Escalate
(Identify risks, report incidents, notify supervisor)

Bridge Between
Strategy & Practice



Policies inform Procedures;
Procedures implement Policies.

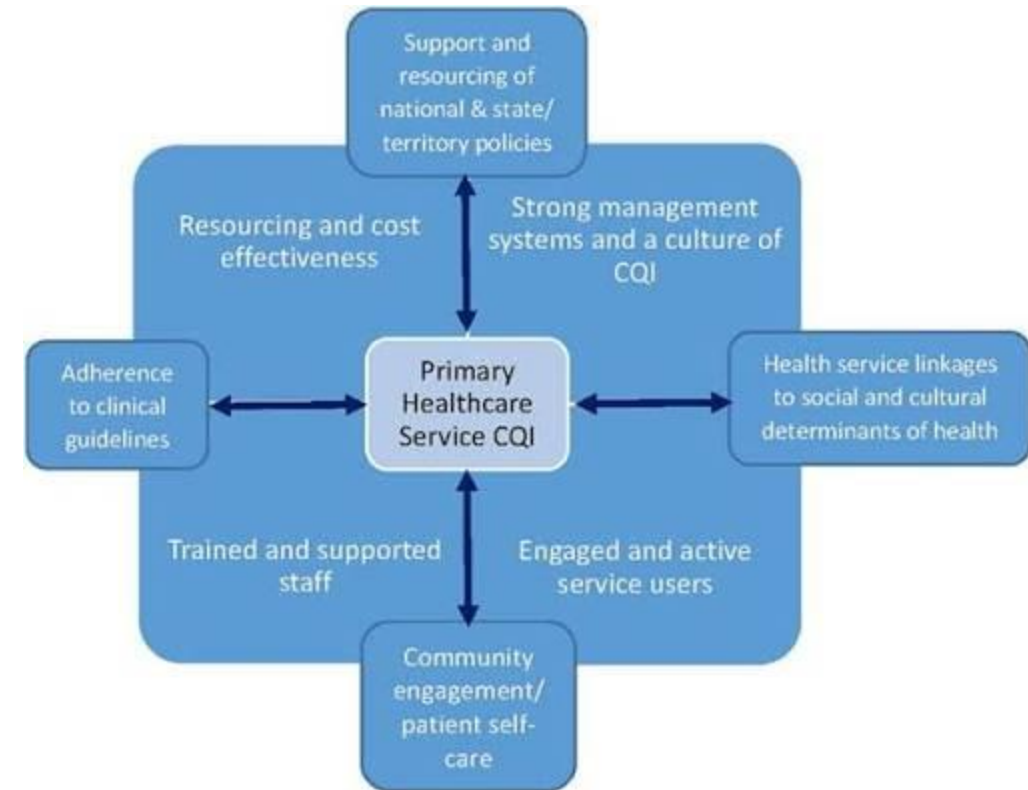
Details the Specific
Actions to Take

Impact on Health and Social Care Service Provision

Patient safety decreased, leading to avoidable harm, higher mortality rates, and lower levels of patient healthcare experience (Erku *et al.*, 2023).

Morale among staff members suffered as they worked excessive hours, underperforming management and pressure from the organisation (The Health Foundation, 2013).

In the NHS the public trust and the reputation of the Trust was seriously compromised.

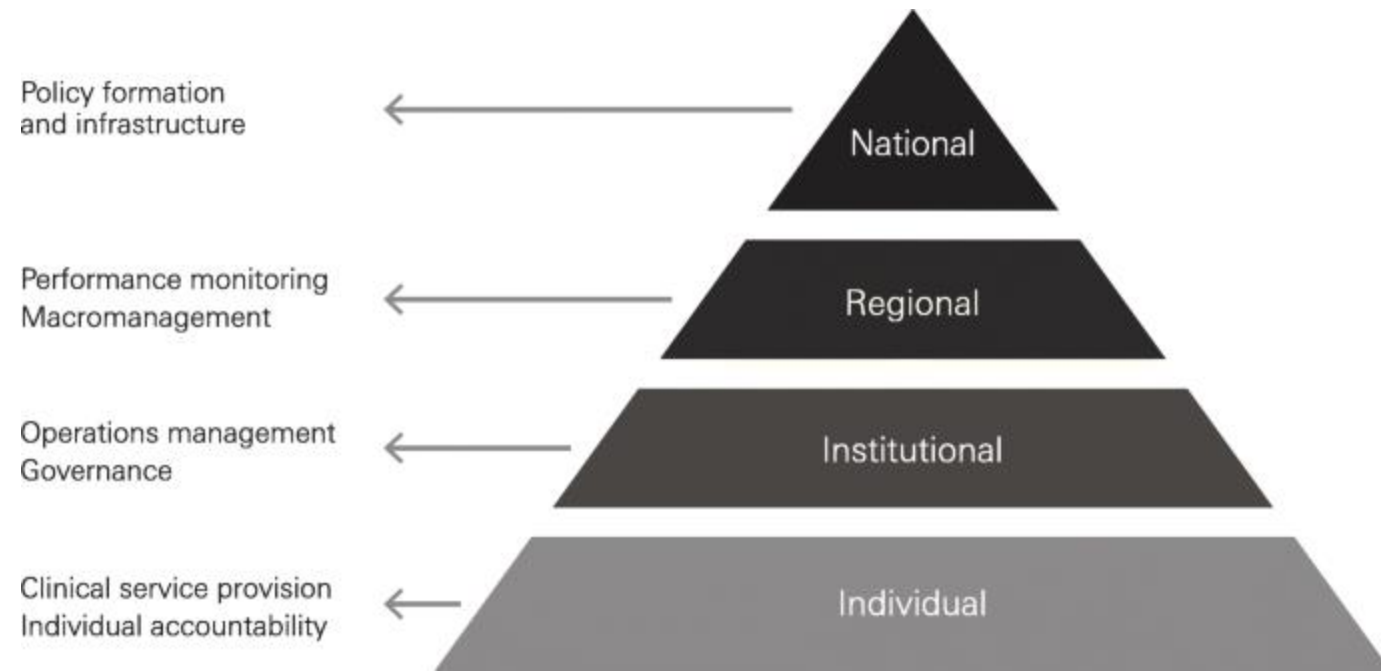


Impact on Quality, Efficiency and Equity

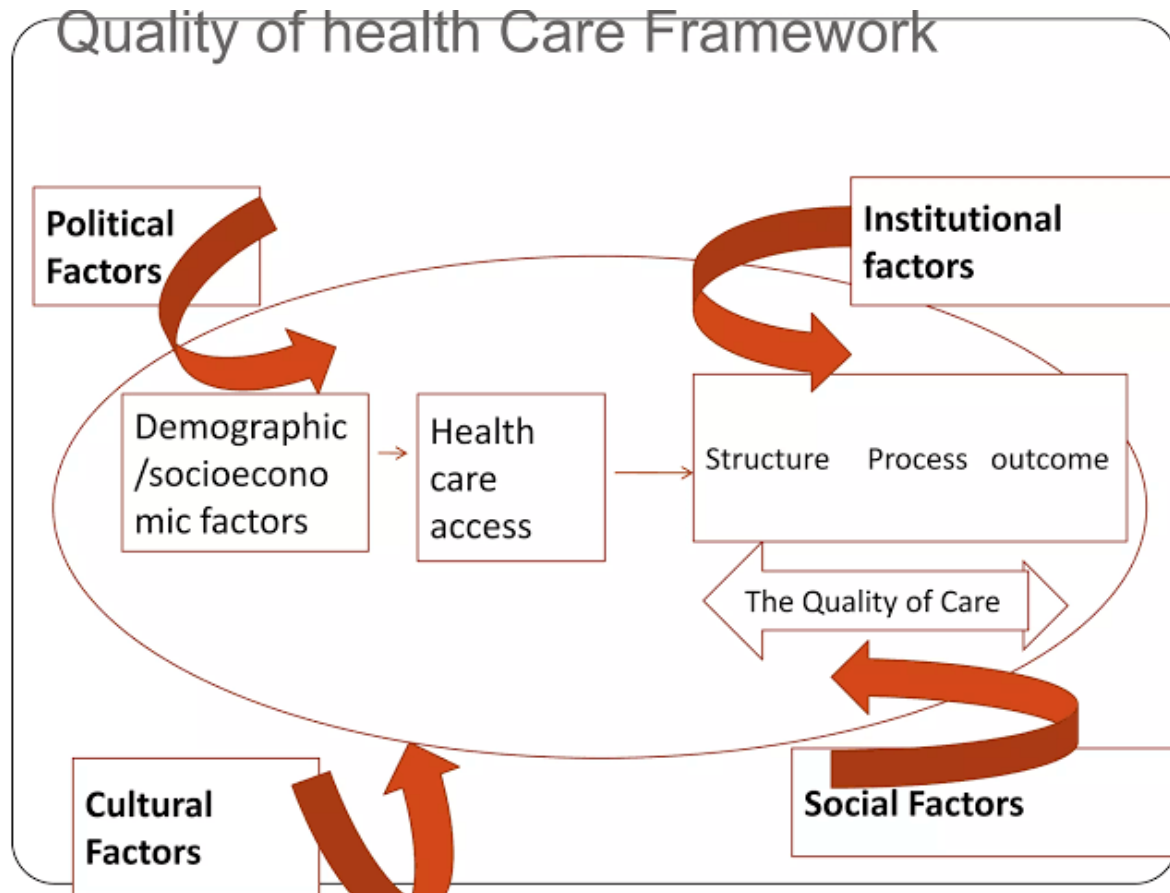
The standards of care were inadequate, compromising healthcare quality and leading to unsafe practices with patients (Itchhaporia, 2021).

There were high numbers of complaints, investigations, litigation and financial cost, resulting in a significant reduction in organisational efficiency (Nundy *et al.*, 2022).

Care that was not equitable and patient-centred generated ethical issues and experiences of the care.



Key Lessons on Quality Assurance and Service Improvement

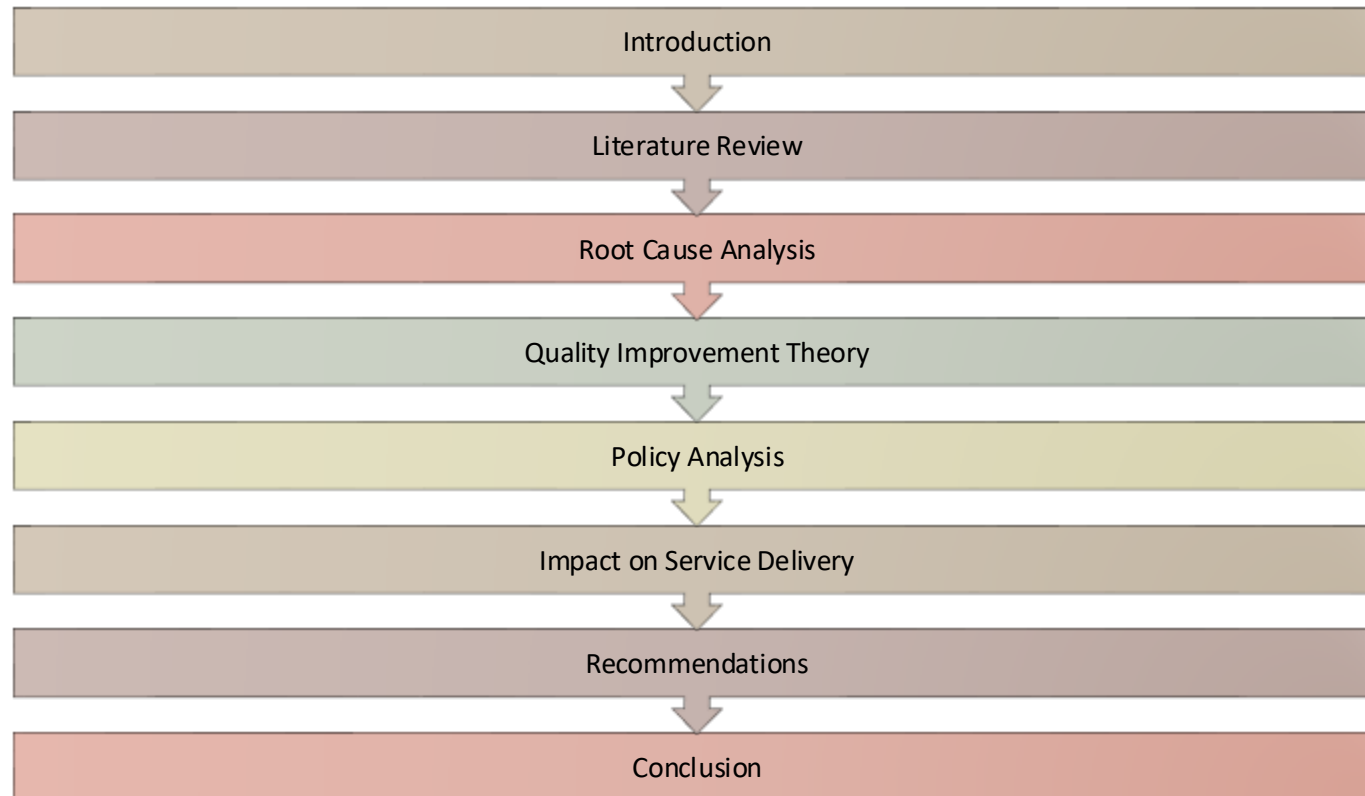


High-quality clinical governance and accountable leadership are vital to ensure the quality of healthcare (Macias-Konstantopoulos *et al.*, 2023).

An open organisational culture boosts staff engagement and learning, and also promotes effective reporting of incidents.

Continuous quality improvement enhances safer, patient-centred and sustainable healthcare services (McLaughlin *et al.*, 2022).

Structure of Component 2 Report



The report starts with background information on the Introduction, Literature review and understanding the context of healthcare quality.

It critically examines root causes, the theory of quality and the failures of policies.

The last portions are used to assess the effect and offer suggestions along with the conclusion.

Conclusion

There were several organisational and leadership failings as a result of which there were significant failures in healthcare quality.

Deteriorating government and poor policies slowed down the enhancement of control and effectiveness while creating patient harm.

Quality assurance continues to be a key component in providing safe, accountable, patient-centred health care, and sustainable quality assurance is necessary.



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*Thank
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