
QUALITY ASSURANCE AND SERVICE IMPROVEMENT

Case study :
Mid Staffordshire
NHS Foundation Trust
Scandal (2005 – 2009)

LCHS7006

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(Failings at Mid Staffordshire Hospital, 2009b)



(Trust, 2026)

INTRODUCTION

- The Mid Staffordshire scandal is one of the most serious failures of patient care in NHS history.
- It showed how poor leadership, weak governance, and inadequate staffing caused avoidable harm.
- This case helps us see why quality checks and ongoing improvement are important.
- . The Francis Inquiry report (2013) pointed out significant problems in culture, leadership, and patient safety.

Francis (2013)

BACKGROUND OF THE CASE

2005, 2009

Poor quality of care were reported across Mid Staffordshire NHS Foundation Trust.

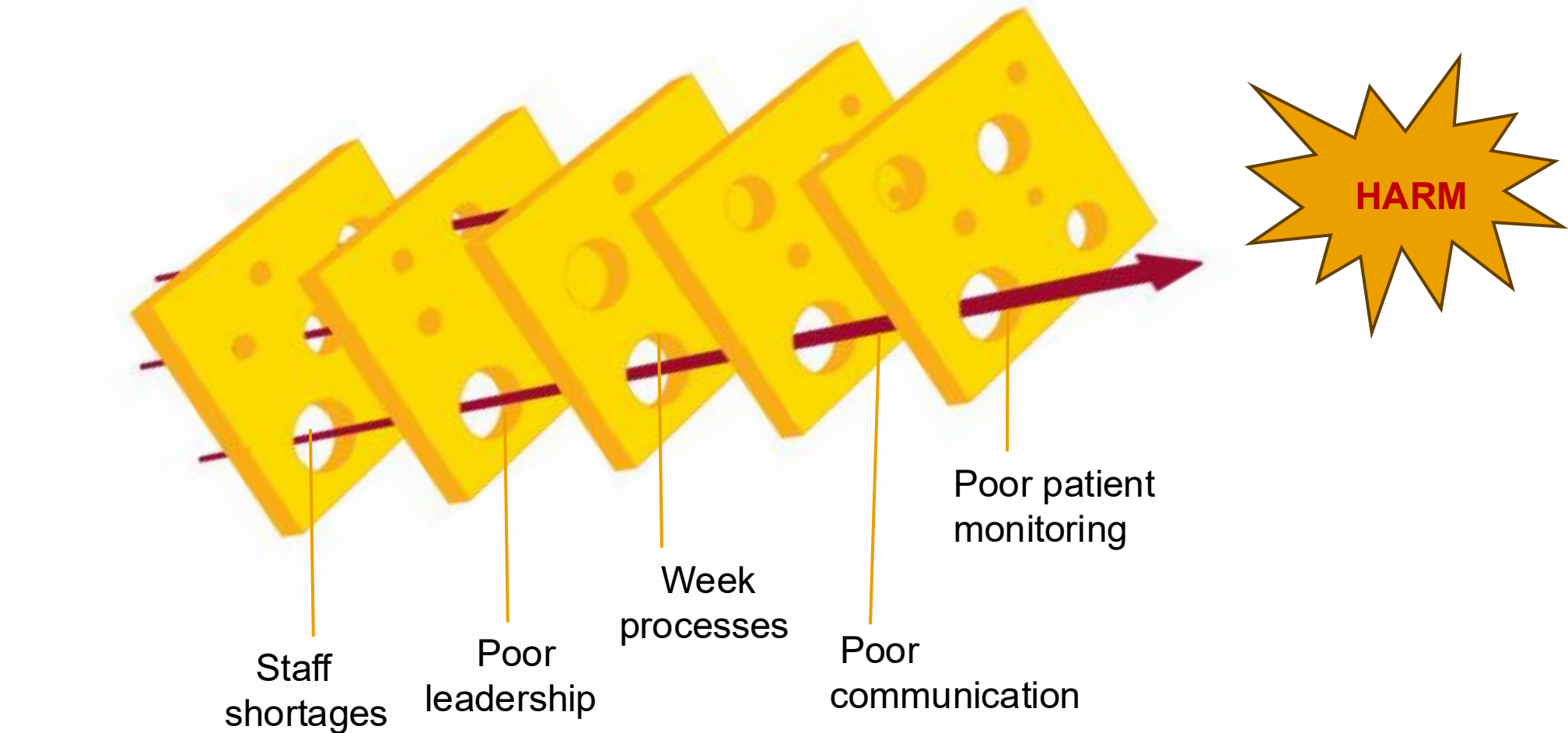
Patients experienced neglect, dehydration, poor hygiene standards and delays in clinical care.

2013

The Francis Report found a culture of poor care and a
Absence of compassionate care.

Francis (2013b)

SWISS CHEESE MODEL (ROOT CAUSE ANALYSIS)





ROOT CAUSE ANALYSIS (FISHBONE DIAGRAM)

POLICY ISSUES

Multiple policy weaknesses contributed to the crisis:

- * Too much emphasis on financial performance
- * Weak implementation of NHS quality standards
- * Poor regulation before Care Quality Commission reforms
- * Ineffective whistleblowing systems
- * Limited patient involvement in quality improvement

(Care Quality Commission (CQC), 2024)



(National Health Service, 2015)



(Care Quality Commission - Harley Street Clinic Surrey, 2024)

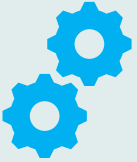
IMPACT ON HEALTH SERVICE QUALITY

QUALITY



- * Increased patient harm and death
- * Reduced safety and trust
- * Poor patient experience and dignity

EFFICIENCY



- * Increased complaints and investigations
- * Higher legal and compensation costs
- * Longer hospital stays and readmissions

EQITY



- * Vulnerable patients received worse care
- * Loss of public confidence in the NHS

(Skills for Health, 2018)



(Donabedian, 1988)

RECOMMENDATION FOR IMPROVEMENT



("Different Types of Doctors | Trinity School of Medicine," 2024b)

- Strengthen leadership and accountability.
- Improve staffing levels and staff well-being.
- Promote a culture where staff can speak up
- regular Root Cause Analysis for incidents
- Improve training and education.
- Enhance incident reporting and learning
- Carry out regular quality audits and monitoring.

(NHS England, 2019)



CRITICAL REFLECTION

The Mid Staffordshire scandal demonstrates that healthcare failures are rarely caused by a single mistake. Instead, they arise from multiple organisational weaknesses, including ineffective leadership, poor governance and a culture that discourages transparency. Healthcare organisations should prioritise patient safety over financial performance and promote continuous learning to prevent similar incidents

Francis (2013), (Reason, 2000)

IMPACT ON STAKEHOLDERS

WHO WAS AFFECTED?

- * Patients: Increased harm and reduced trust.
- * Families: Emotional distress and loss of confidence.
- * Healthcare staff: Low morale and increased stress.
- * Hospital: Reputational damage and financial consequences.
- * NHS: National policy and regulatory reforms.

Francis (2013)



(Troy, 2022)

CONCLUSION

The Mid Staffordshire scandal caused unnecessary harm and suffering.

Organisational weaknesses, not just individual errors, led to patient harm.

Learning from this case helps create safer, more compassionate and effective healthcare services.

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