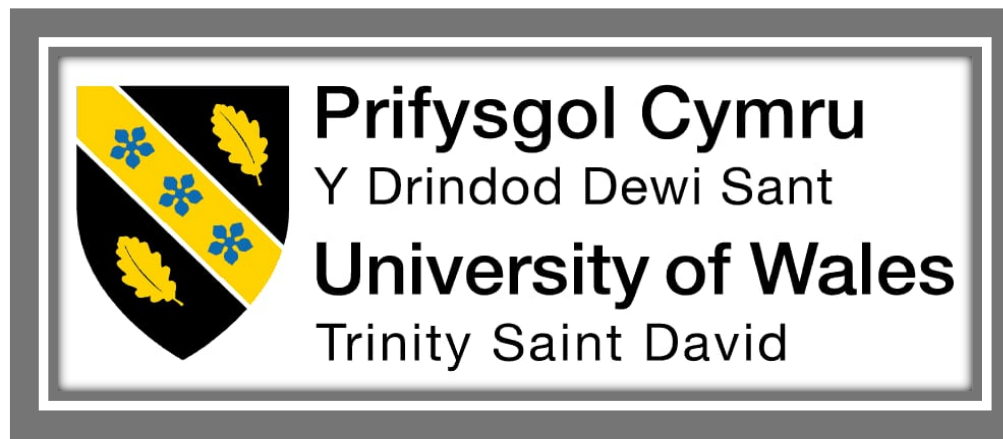




MSC IN PUBLIC HEALTH AND SOCIAL CARE IN PRACTICE

Module Code: LCHS7006

Module: Quality Assurance And Service
Improvement

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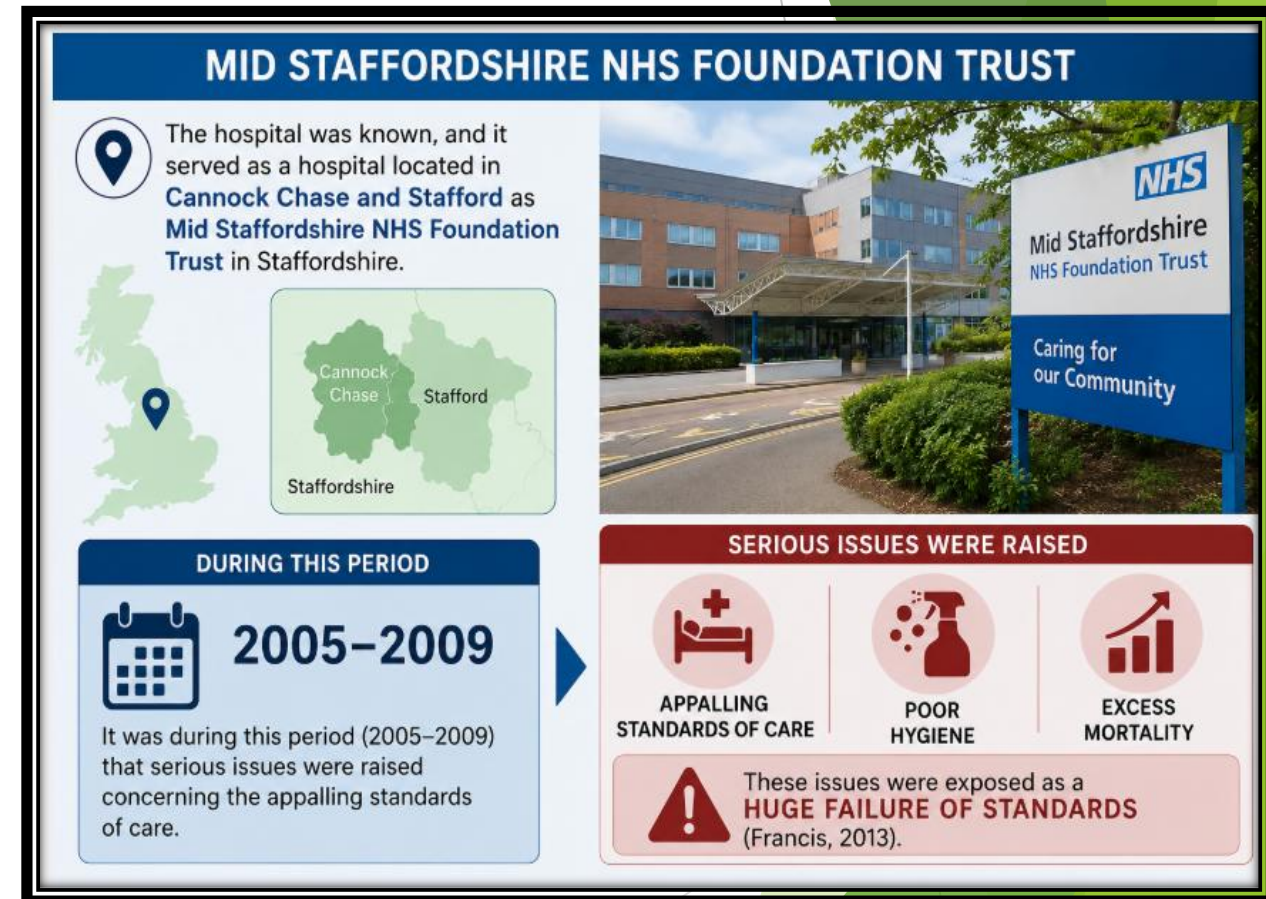
Student I.D.: 2529442

Presentation date: 21st July, 2026

From Failure to Reform: The Mid Staffordshire NHS Crisis

INTRODUCTION

- ▶ The hospital was known, and it served as a hospital located in Cannock Chase and Stafford as Mid Staffordshire NHS Foundation Trust in Staffordshire.
- ▶ It was during this period (2005–2009) that serious issues were raised concerning the appalling standards of care, poor hygiene and excess mortality that were exposed as a huge failure of standards (Francis, 2013).
- ▶ This case is relevant as it demonstrates the potential for patient harm to continue through a weak Quality Assurance process across an organisation (Campbell, 2013).
- ▶ The reasons for the failure, theories about the failure, and reforms after the failure are discussed.



(Source: Self-developed)

OVERVIEW CASE STUDY

- ▶ Stafford Hospital was linked to the problems of neglect, poor hygiene and standards of emergency care between 2005 and 2009.
- ▶ Concerns were brought up but not acted upon on time by patient(s) and/or families.
- ▶ In 2010 and 2013, independent investigations identified hundreds of excess deaths that were associated with systemic deficiencies (Francis, 2013a).
- ▶ The 2013 Francis Report contained 290 recommendations which are impacting on an accountable and open culture across the NHS nationally (Holmes, 2013).

THE FRANCIS REPORT:

What's the big deal?
A question for all of us



What is it?

In 2010, the government commissioned Robert Francis QC to report on failings in care at the Mid-Staffordshire NHS Foundation Trust between 2005 and 2008. His report is lengthy and damning in equal measures. Stories of patients left in their own faeces, so thirsty they had to drink from flower vases and suffering without adequate pain relief made for difficult and distressing reading. Worse still, it became clear that these were not isolated incidents but that the culture at Mid-Staffs had insidiously become so damaged that such occurrences had become normal practice. Francis wants this to change, so do we.

Culture Change

One of the overwhelming messages of the report is the concept of the 'culture' within the Trust (and perhaps the wider NHS) and need for it to change. Too often the system makes it easier to comply with or ignore poor care, rather than highlight it. In other industries, speaking out about inadequacies or problems is encouraged and rewarded. Why do we fear doing it so much in the NHS? Francis wants this to change, so do we.

What's it got to do with me?

As trainee doctors working on the frontline we have a unique role. We see what happens day to day, and rotating through different hospitals throughout our training gives us the ability to make comparisons. We see the good, the bad and sometimes the downright ugly. The very nature of who we are, and why we became doctors in the first place, means we all go to work each day prepared to give everything we can and to strive towards excellence in patient care. But how many of us can say, hand on heart, that all the care we've ever seen delivered has always been good enough? Francis wants this to change, so do we.

Leadership?

The report challenges each one of us to think about the elusive concept of 'clinical leadership'. Not just leadership at the board or executive level, but at every level. We all have a responsibility to our patients, whether we are cleaners or porters, doctors or nurses, managers or senior executives. Leadership isn't something you need to go on a course or read a book to learn; it's something we do every day without realising, and a set of skills we need to identify and develop. We can't just blame senior executives within hospitals for the failings – it's time to accept that we all have a role, and that we all have a responsibility for improving the future.

EASIER SAID THAN DONE?

We don't think so. Here are 3 things you can start doing today:

1. Speak: Easier said than done? But we are the future of the NHS and making it better for our patients is in our hands. Do you remember when you didn't used to wash your hands between patients? Of course not. But it didn't use to be the norm, just as having the confidence to speak out isn't now. But we can make it change. If something we see isn't right, we need to start speaking up. And keep speaking until someone listens.

2. Act: We need to stop treating audits and quality improvement projects as 'Oh fillers!' We're full of ideas and enthusiasm for how we can make things better on the wards, and it's such a waste if we don't put them to use. We need to stop seeing managers as the enemy; we all want the same thing: better patient care. Next time you walk past them in the corridor say hello. If you don't know who they are go and find out.

3. Lead: We're all responsible for the whole system, not just the patient in front of us now. We need to start working out ways to solve the problems – improving the system rather than just working around the glitches. We don't need to wait until we are consultants before we stand up and lead. It's about us setting the right example, and us creating the culture that we want to work in.

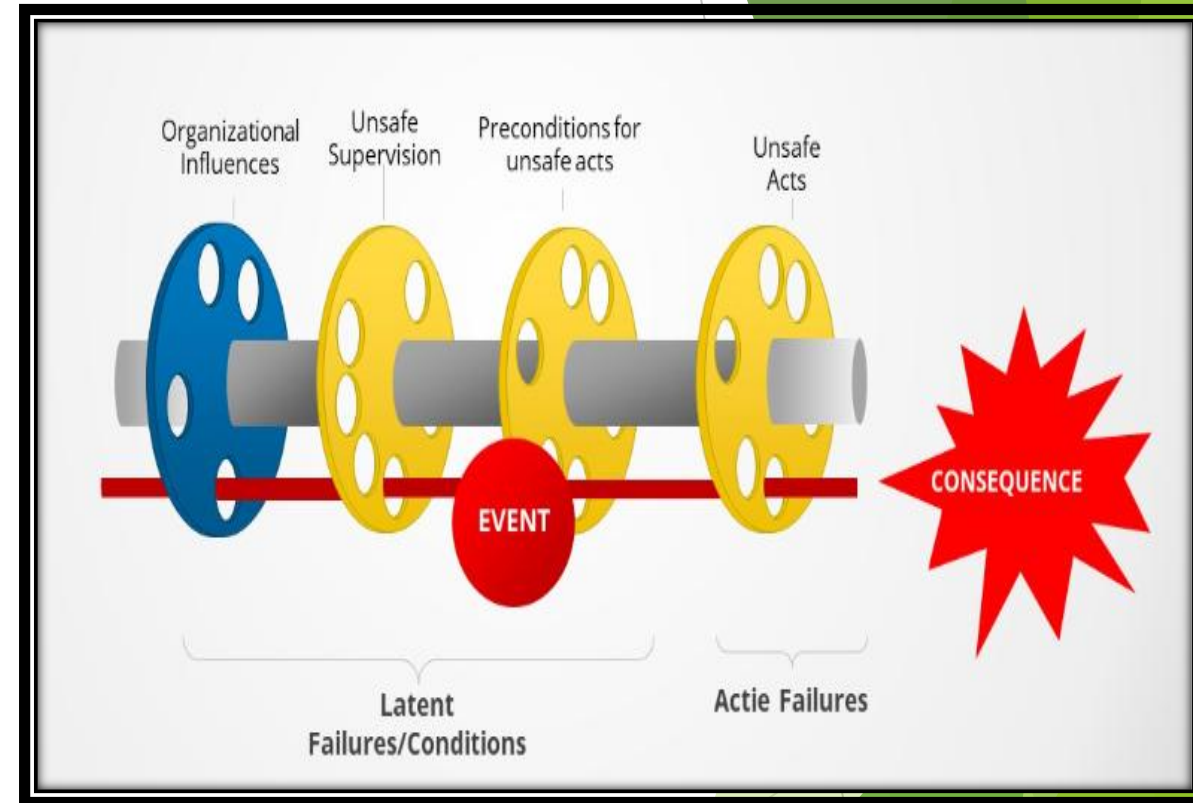
Find out more at: <http://www.fmlm.ac.uk/francis>
FMLM trainee members



(Source: Fmlm, 2026)

Swiss Cheese Model

- ▶ Write the words Root Cause Analysis on the chalkboard. Write on the chalkboard Root Cause Analysis.
- ▶ The Swiss Cheese Model describes how several gaps in safety measures can converge to create the chance for harm to enter the system (Wiegmann *et al.*, 2022).
- ▶ There were significant gaps across four areas in Mid Staffordshire, organisational, leadership, staffing and governance, which converged (Trekels and Telzer, 2025).
- ▶ Often, preventable harm was caused by cost-cutting, by remote managers, understaffing and/or poor governance.



(Source:Investigations, 2026)

ELABORATE THE THEORIES OR MODELS

- The report is going to base itself on various healthcare safety and quality models to help understand the poor care patients experienced at Mid Staffordshire NHS Foundation Trust. The models can be used to explain that it was not one person's one mistake that caused the problem. Rather it was due to a combination of issues that occurred within the organisation, such as weak monitoring, inappropriate policies, limited staffing and poor leadership.

Root Cause Analysis

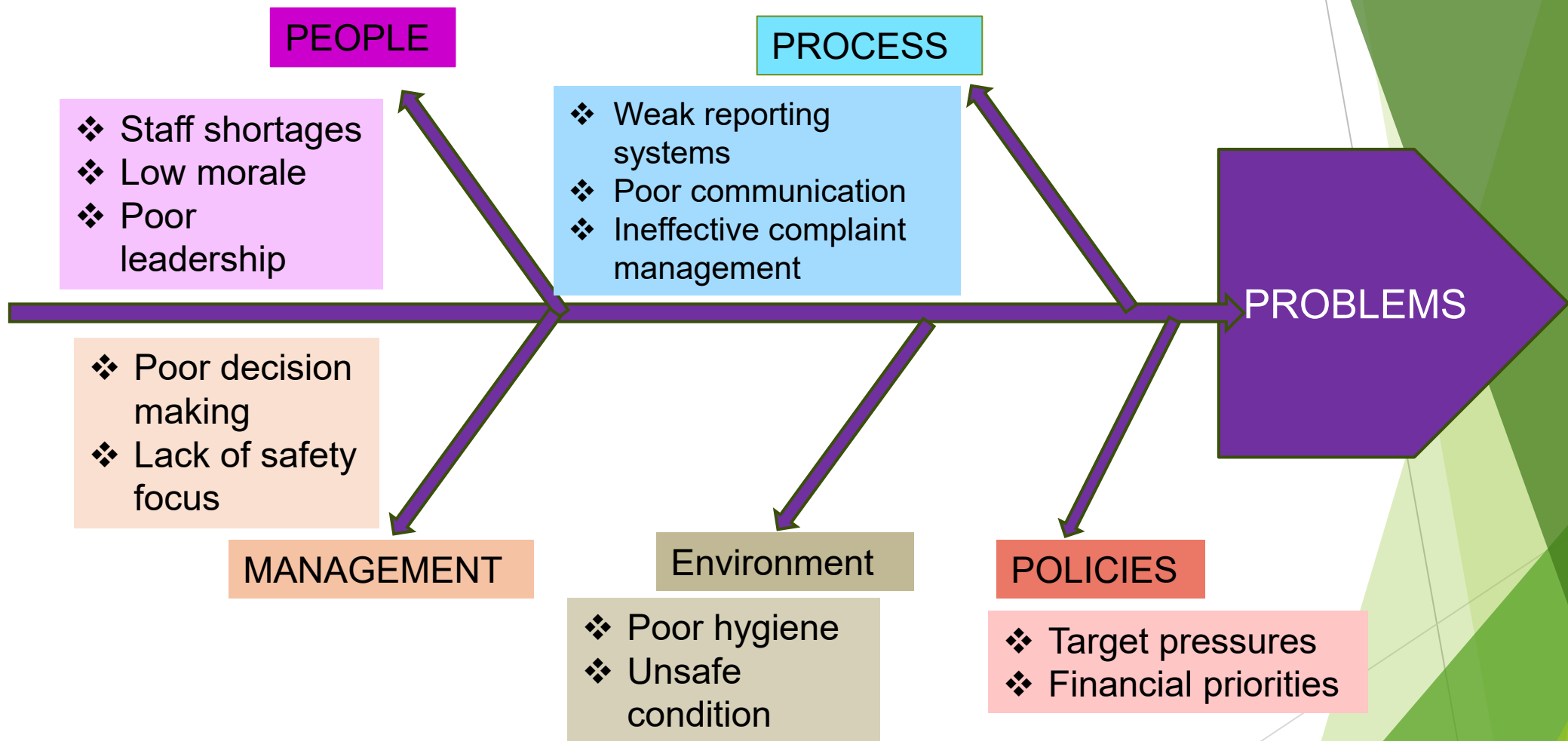
The Fishbone Analysis

Systems Theory

The Donabedian Mode

FISHBONE ANALYSIS

- ❑ It is also known as **ISHIKAWA DIAGRAMS** (The name of the creator is Kaoru Ishikawa- a Japanese organizational theorist and a professor in the engineering).
- ❑ They are a visual tool that helps individuals and teams capture and understand the root causes to a specific problem.
- ❑ Fishbone analysis is a graphing tool for organising the causes of a problem into categories (people, processes, policies, management.(Kumah *et al.*, 2024).
- ❑ Some wards at Mid Staffordshire were overstaffed, while others were understaffed, and leadership was weak in certain areas, resulting in unsafe care (Sakdiyah *et al.*, 2022).



(Source: Self-developed)

The Donabedian Model

Structure

- Staffing
- Leadership
- Resources

Process

- Care delivery
- Communication
- Monitoring

Outcomes

- Patient harm
- Mortality
- Loss of trust

❖ Donabedian's model relates these three factors, structure, process and outcome, to evaluate healthcare quality (White *et al.*, 2022).

❖ Mid Staffordshire was poorly structured, had bad processes, and terrible outcomes.

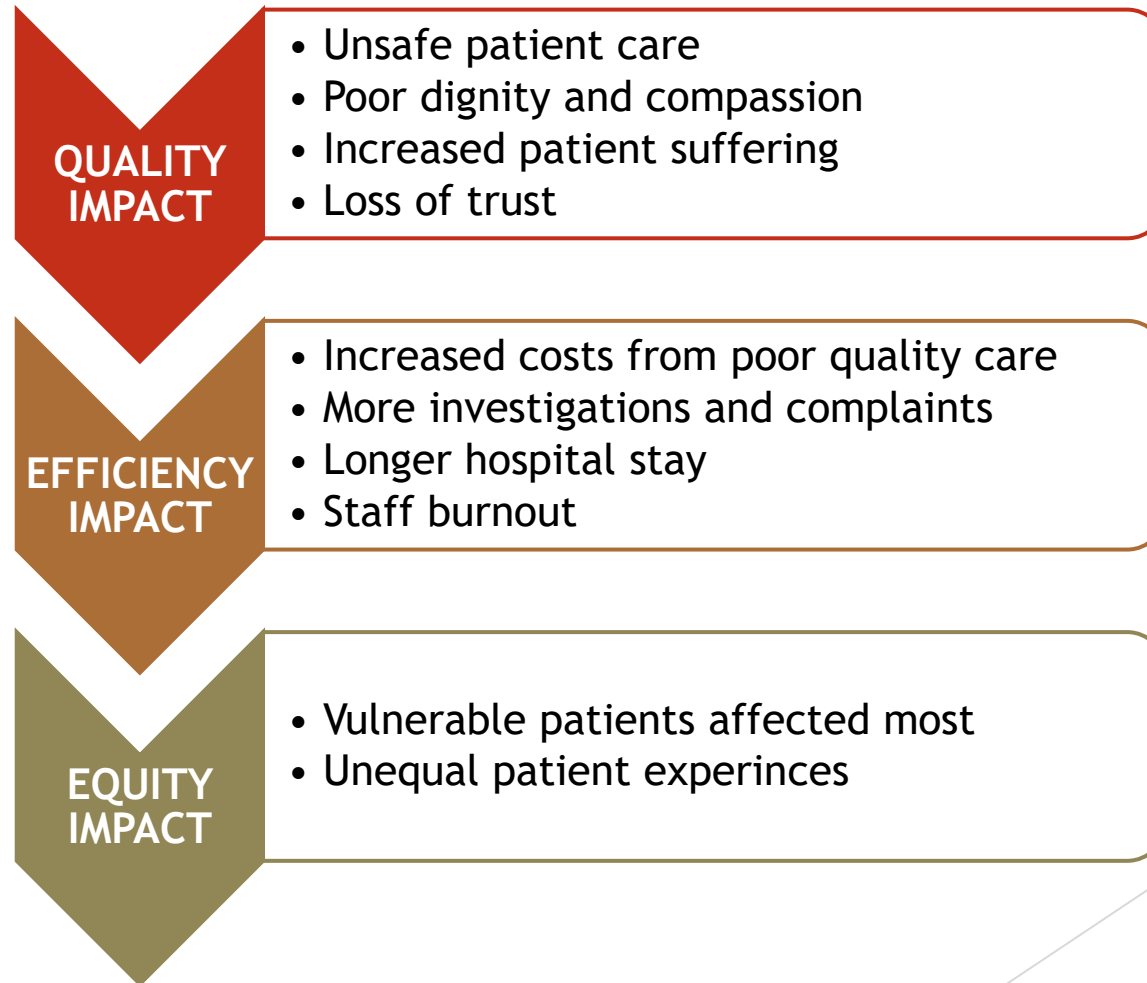
Policy Issues Behind the Mid Staffordshire NHS Foundation Trust Failures

POLICY ISSUE	HOW IT CREATED PROBLEMS	EFFECT ON HEALTHCARE SERVICES
Focus on NHS targets	Managers focused more on achieving targets and meeting numbers rather than improving patient care.	Patients received less attention, and the quality of care and compassion reduced.
Pressure to become a Foundation Trust	The hospital focused on saving money and improving financial performance, leading to cost-cutting decisions.	Fewer staff were available, increasing workload and reducing the quality of care.
Weak regulation and monitoring	Regulators did not identify and respond to warning signs such as complaints and high mortality rates quickly enough.	Unsafe care continued, putting patients at risk.
Lack of safe staffing rules	The hospital reduced staff numbers without considering the impact on patient safety.	Staff became overwhelmed, and some patients experienced delays or missed care.
Poor culture of reporting problems	Staff concerns were not always listened to or acted upon.	Problems remained hidden and opportunities to improve patient safety were missed.
Limited focus on patient experience	Patient feedback, dignity, and individual needs were not given enough importance.	Patients felt ignored, leading to loss of trust and confidence in healthcare services.

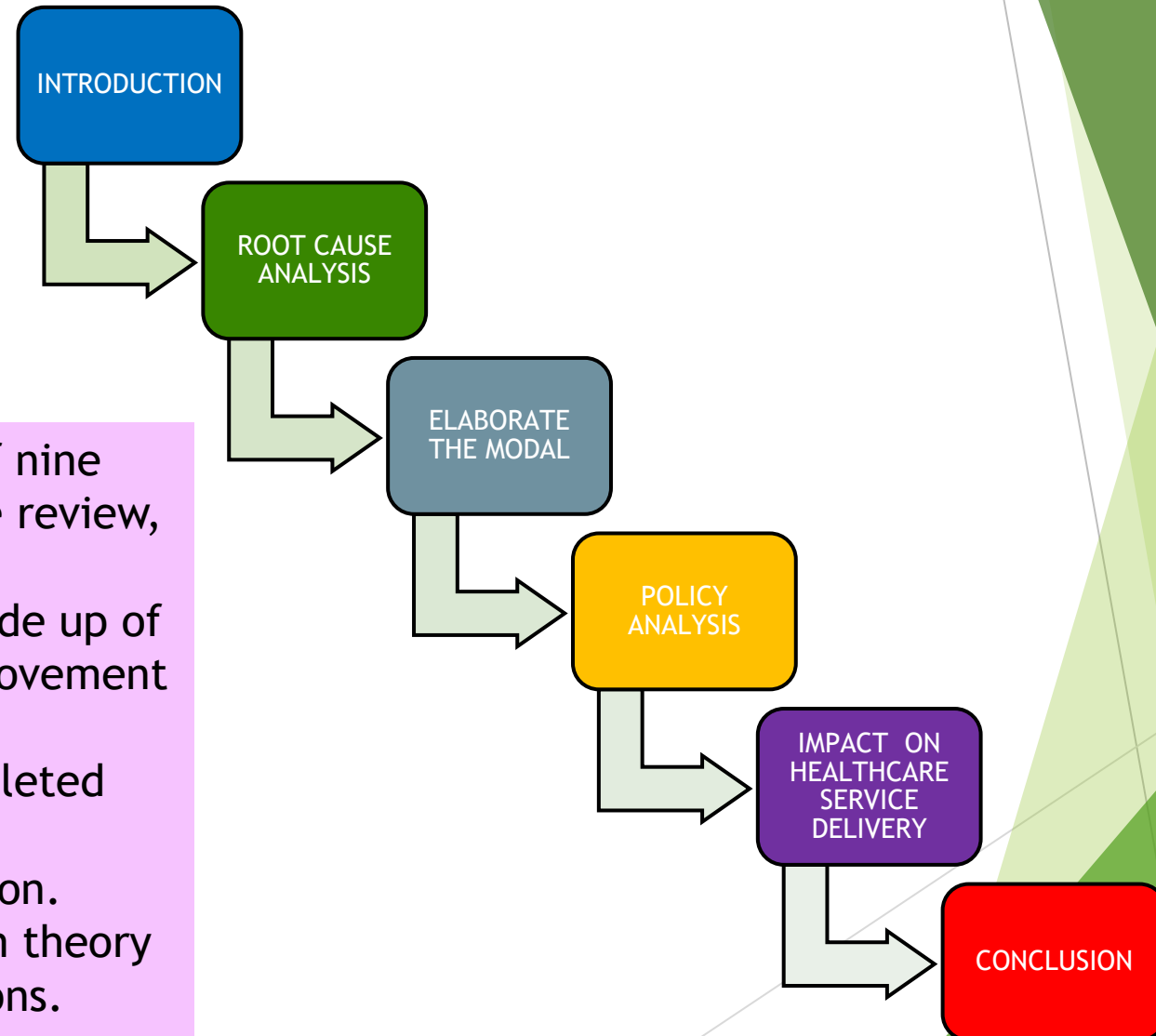
IMPACT ON SERVICE DELIVERY

- ▶ Clinical outcomes and patient safety were significantly compromised, and the patient's lifetime consequences of the experience were great (England, 2022).
- ▶ This had a significant negative impact on staff morale, the public and the reputation of the organisation.
- ▶ In addition to these, the scandal also led to a rise in the cost of healthcare because of litigation, special measures, and improvement programmes (Elkomy *et al.*, 2023).
- ▶ In addition to impacting patients, it was felt by the whole NHS system.

Demonstrating The Impact Of These Root Causes And Policy Issues



REPORT STRUCTURE



- ❖ The written report is made up of nine sections: introduction, literature review, and case study background.
- ❖ The core analytical parts are made up of root cause analysis, quality improvement theory, and policy analysis.
- ❖ The Component 2 report is completed with Impact assessment, recommendations and a conclusion.
- ❖ This is a mechanism to shift from theory to evidence and finally to solutions.

CONCLUSION

- ▶ Mid Staffordshire demonstrates a breakdown in systems of care in terms of culture, leadership and staffing and identifies how this could compromise patient welfare.
- ▶ It is important that the same principles of vigilance, transparency and accountability are upheld at all levels for effective quality assurance.
- ▶ There needs to be a continuous drive to ensure that the momentum for reform continues within NHS organisations and that next time there is no large-scale failure.
- ▶ This episode of the case remains a seminal moment for the NHS, and in the broader context of healthcare governance.



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Thank You

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