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Module: Quality Assurance and Service Improvements

Module code: LCHS7006

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Introduction: Quality Assurance and Service Improvements

Quality assurance refers to a set of systematic processes that ensure services meet established quality standards, safeguard patient safety, and promote continuous improvement through regular evaluation and monitoring (NHS, n.d.) (Klein *et al.*, 2009).

The importance of quality assurance



Safe:

Ensuring patient safety
(Atkinson *et al.*, 2010).

Effective:

Delivering reliable
care (Atkinson *et al.*,
2010).

Improvement:

Continuous monitoring
and improvement
(Atkinson *et al.*, 2010).

Systems and processes



Clinical audits and inspections (Atkinson *et al.*,
2010).



Patient feedback and reporting (Atkinson *et al.*,
2010).



Staff training and development (Atkinson *et al.*,
2010).

The Mid Staffordshire NHS Foundation Trust

Although primary responsibility lay with the hospital's board and healthcare professionals, it became clear that the entire supervisory system failed to identify and address the problems. In addition, a culture of fear, silence, and bullying prevented concerns from being raised and allowed unacceptable standards of care to continue (Francis, 2013a). (Powell, 2023).



(NHS, 2023)



(Telegraph, 2013)

High mortality rates and persistent complaints

- Between 2005 and 2009, serious failures in care occurred at Stafford Hospital despite appearing to meet standards (Francis, 2013a) (Powell, 2023).

Systemic failures

- The entire supervisory system failed to identify and address the problems (Francis, 2013a) (Powell, 2023) .
- Primary responsibility lay with the hospital's board and healthcare professionals (Francis, 2013a) (Powell, 2023) .

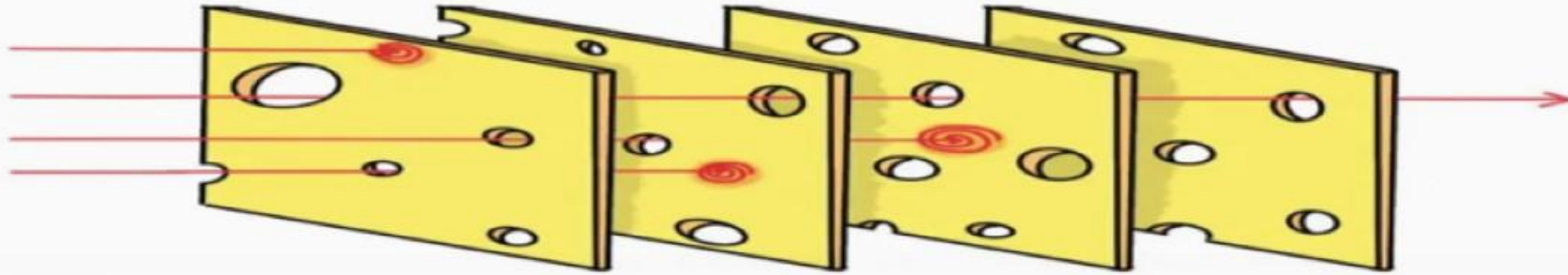
Culture of fear, silence and bullying

- A culture of fear, silence and bullying prevented concerns from being raised (Francis, 2013a) (Powell, 2023).
- This allowed unacceptable standards of care to continue (Francis, 2013a) (Powell, 2023).

Swiss Cheese Model

Model showing that accidents happen when multiple failures align and bypass system defences (Wiegmann et al., 2021).

The Swiss Cheese Model Explained



**Adverse
Event**

(Tapandesai, 2025)

Government policy
(Francis, 2013b).

Hospital leadership
(Francis, 2013b).

Staffing shortages
(Francis, 2013b).

Poor reporting systems
(Francis, 2013b).

Weak regulation
(Francis, 2013b).

Focus on targets and
cost-cutting (Francis,
2013b).

Ignored warnings and
complaints (Francis,
2013b).

Overworked and
understaffed (Francis,
2013b).

Missed safety concerns
(Francis, 2013b).

Failed oversight (Francis,
2013b).

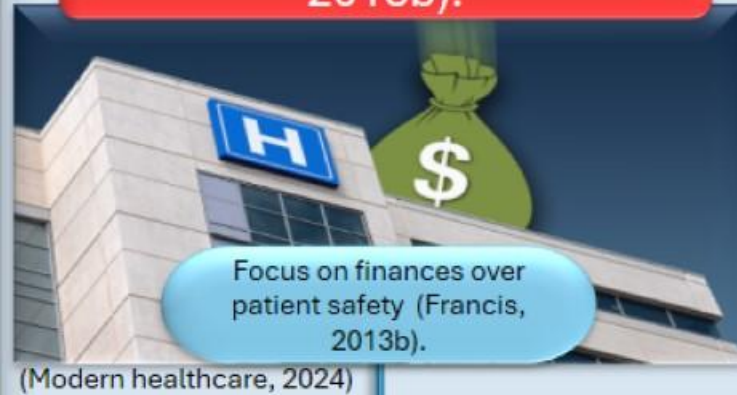
Failures in Multiple Defenses Led to Poor Patient Care (Francis, 2013b).

Root Cause Analysis

Root cause analysis is a method used to find the real cause of a problem (Tableau, n.d.).

In the Mid Staffordshire case, several key root causes were identified (Francis, 2013b).

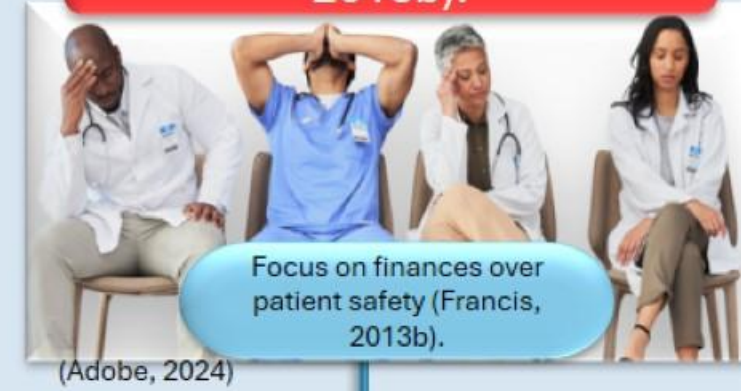
Leadership failure (Francis, 2013b).



Inadequate staffing (Francis, 2013b).



Poor Culture (Francis, 2013b).



Weak Governance (Francis, 2013b).



(Linkedin, 2021)

The Donabedian Model

The Donabedian Model evaluates healthcare quality through three components: Structure, Process and Outcomes (Robby et al., 2025).

Structure

The organisational environment in which healthcare services are delivered (Kunkel et al., 2007).



Inadequate staffing (Dziak, 2020).



Weak leadership (Dziak, 2020).



Poor Governance systems (Dziak, 2020).

Process

The delivery of care to patients (Kunkel et al., 2007).



Poor Patient Monitoring (Dziak, 2020).



Delays in treatment (Dziak, 2020).



Lack of communication (Dziak, 2020).



Hygiene failures (Dziak, 2020).

Outcomes

The results of healthcare services (Kunkel et al., 2007).



High mortality rates (Dziak, 2020).



Patient Neglect (Dziak, 2020).



Low patient satisfaction (Dziak, 2020).



Loss of public trust (Dziak, 2020).

Structural, Process and Outcome failures led to severe patient harm and loss of trust in the healthcare systems (Kunkel et al., 2007)

Policy issues affecting healthcare quality

Several policy-related issues contributed to the failures at Mid Staffordshire.

Target-Driven Culture



Pressure to meet waiting time targets and financial objectives (Phillips *et al.*, 2023).

(Googleepis, 2006)

Weak Regulatory Oversight



Failure to detect and respond to warning signs (Phillips *et al.*, 2023).

(Freepik, 2023)

Ineffective Whistleblowing Systems



Staff concerns about safety were ignored or discouraged (Phillips *et al.*, 2023).

(Gazette, 2019)

Inadequate Staffing Policies



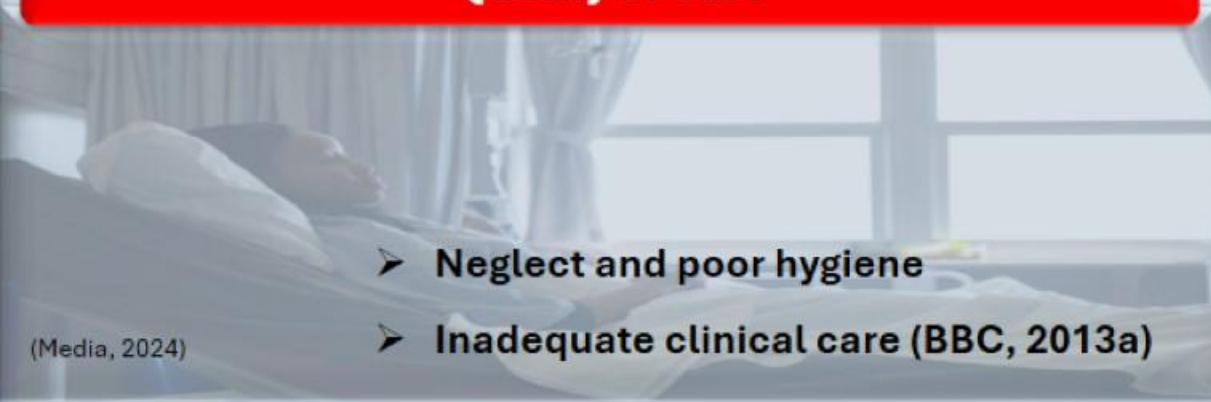
(Pinterest, 2016)

Lack of guidance on safe nurse to patient ratios (Phillips *et al.*, 2023).

Patient safety was not prioritised(Phillips *et al.*, 2023).

Impact on healthcare service provision

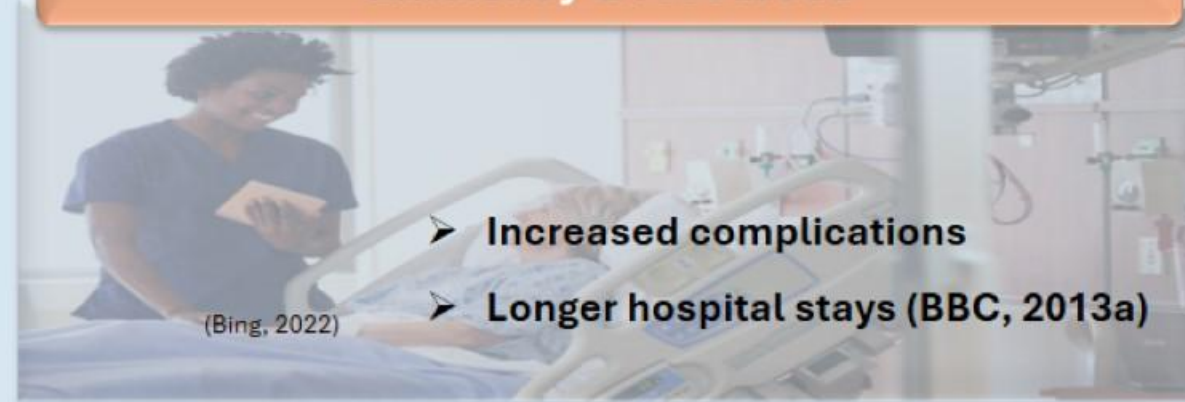
Quality of care



Impact on vulnerable groups



Efficiency & resources



Loss of public trust



Damaged public trust in the NHS (Francis, 2013c).

Recommendations

Improve Staffing levels

- More nurses
- Safe patient care (Choe, 2025).



(Freepik, 2025)

Strengthen Leadership and Accountability

- Better Management
- Clear responsibility (NICE,2018).



(Istockphoto, 2021)

Develop Safety culture

- Open communication
- Patient-first approach (NICE,2018).



(Cec health, 2020)

Improve Incident reporting

- Report errors quickly
- Learn from mistakes (NICE,2018).



(Vecteezy, 2024)

Effective Regulation and Monitoring

- Regular inspections
- Strong oversight (Choe, 2025).



(Vecteezy, 2025)

Support Whistleblowing

- Staff feel safe to speak
- Encourage reporting (NICE,2018).



(Visslan, 2023)

Component 2

- **Problem:** Failings at Mid Staffordshire NHS Foundation Trust (2005–2009) – poor leadership, understaffing, high patient mortality.
- **Analysis and tools:** Fishbone, 5 Whys, Donabedian, SWOT, Lean, Six Sigma.
- **Recommendations:** Improve leadership, governance, safety culture, and continuous monitoring.

Conclusion

The Mid Staffordshire scandal represents one of the most serious failures of quality management in UK healthcare, demonstrating how systemic issues poor leadership, understaffing, weak governance, and political pressures can cause harm to patients. Applying quality models such as the Swiss Cheese Model, Root Cause Analysis, and the Donabedian Model helps to understand its causes, and the lessons learned continue to influence NHS policies and practices.

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