Briefing on the Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995

This briefing sets out the main general lessons emerging from the Bristol Inquiry. Although the origins of the Inquiry lie in events in a small part of one NHS hospital, the lessons drawn by the Inquiry team apply to the NHS as a whole. Put simply, the report aims to set out the way that the NHS should operate at the level of the trust or service and also how the individuals in it should perform their professional duties. It is written as a demand, on the behalf of patients, for change in the culture of the Service both within the NHS itself - how professionals behave towards each other - and also in the way that individual professionals treat their patients.

The report is long and the argument often dense and detailed. The recommendations alone cover 24 pages. This briefing therefore does not attempt to reproduce, in reduced form, the full range of its content. Instead, it focuses on some of the key themes and the main areas where the Inquiry calls for change.

Anthony Harrison
22 August 2001

Origins

The Inquiry was established to:

> Inquire into the management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995 and relevant related issues; to make findings as to the adequacy of the services provided; to establish what action was taken both within and outside the hospital to deal with concerns raised about the surgery and to identify any failure to take appropriate action promptly; to reach conclusions from these events and to make recommendations which could help to secure high-quality care across the NHS.

(The Bristol Royal Infirmary Inquiry, *Learning from Bristol*, CM 5207(1) - July 2001, p 1)

In this briefing we focus on the last elements of the terms of reference, the recommendations made to help secure high-quality care across the NHS as a whole.

We quote extensively from the report itself to convey both its passion and its sense of urgency. It is a crusading report, seeking, while recognising the constraints within which the Service operates, a radical change in the way that the NHS functions. Much of what it says is not new. It restates themes and arguments which patient groups and many professionals as well as recent government policy documents have put forward. But there is no one report which embodies the same passion for improvement across all the wide terrain it covers.

The Centrality of Culture

The report begins its analysis with the following general statement:

> *59. The culture of the future must be a culture of safety and of quality; a culture of openness and of accountability; a culture of public service; a culture in which collaborative teamwork is prized; and a culture of flexibility in which innovation can flourish in response to patients' needs. (p 13)*

The second part of the Report is devoted entirely to setting out how these requirements are best met and the changes needed to ensure that they are.

Underlying Themes

Although the report is long and complicated, three general ideas run through the whole of it.

The first is what we term the *systems view* of health care. The systems view starts from the perception that the various elements which delivery of health care requires must be viewed as a whole.

The main elements are the individual professions - others are the equipment, devices and drugs which health care requiries. From the systems viewpoint, the professions create arbitrary and harmful divisions between different parts of the service provided. The second general idea therefore is that the tribalism or separatism of the professions is part of the problem to be addressed.

The third is that services should be designed and delivered around the needs of the patient. The patient should not be in control, but rather in partnership with professionals.

How the NHS must change

The second half of the report amounts to a diagnosis of the current ills of the NHS, as far as patients are concerned. The analysis and the recommendations it leads to are aimed at *all* health professionals and *all* the organisations within which they work and are intended to improve the way that *all* clinical care is provided and *all* patients are treated.

The report's analysis starts out from the following key principles:

- **The complexity of the NHS as an organisation must be recognised.**

  10. .... Not only is the NHS highly complex in its processes and its organisation, but healthcare and medicine are constantly changing, as are patients' needs and expectations. It follows that this Inquiry's Panel cannot anticipate all the challenges which the NHS may face ten or even five years from now. Therefore our recommendations are intended to be realistic and workable in the near to medium term.

  The first theme of complexity and interconnections in the NHS runs through the whole report. No organisation and no profession should be 'an island': realisation of the principles which follow below require that all NHS professionals should share a joint vision of how the Service should work, not one exclusive to their separate professions - this is the second theme.

- **Patients must be at the centre of the NHS, and thus the patient's perspective must be included in the policy, planning and delivery of services at every level.**

This is the third theme. It stated as follows:

12. The NHS exists as a service to patients. Those whom it exists to serve are all of us, since we are all patients at some point in our lives. The legitimate needs of patients must be at the centre of the NHS and thus they are at the centre of our recommendations. (pps 255 and 257)

The rest of the report attempts to show what is required in terms of change in the way that professionals work to make it a reality.

- **The dedication and commitment of NHS staff is and must remain at the core of the service.**

13. *Whatever the changes in the NHS in the course of its history, there have been certain constants. Principal among these is the dedication and commitment of those who work in and for the NHS. We acknowledge and wish to harness these qualities. What we are seeking is an NHS which will marshal these qualities fully in the service of the public and of patients: to create a partnership in which all respect the needs and claims of others. (pps 256 and 257)*

The report's key insight, which also stems from its systems viewpoint is that however devoted professionals are, the service they offer can be poor. This apparent paradox rests on the view that working within the blinkers of individual professional roles can get in the way of a proper organisation and delivery of the service as a whole. Professional tribalism and rivalry and professional hierarchies are inimical to the culture which the report is trying to promote.

- **The quality of healthcare must include all aspects of care: clinical and non-clinical.**

14. *We are convinced that the only definition of quality in the context of healthcare which can be of real value has to be one which is all-embracing. A first condition for achieving quality in healthcare is that the service is safe. Once safety, as a fundamental prerequisite, has been addressed, attention must turn to the pursuit of quality. In essence, this involves identifying what will enable the NHS to meet its own high objectives and*

values. For us, this translates into the following concrete requirements. The quality of healthcare can only meet levels of which the NHS can be proud, if healthcare first encompasses the notions of respect for and honesty towards patients. It must recognise the emotional as well as the physical needs of patients (and their families). It must be delivered by competent staff who have suitable facilities and are always striving for improvement. It must be informed by up-to-date medical knowledge, including mechanisms for assessing the effectiveness and value of treatment. It must be safe, avoiding error and accident as far as is possible. It must be appropriate for and responsive to the needs of the patient, including being available when needed, in good time and accessible. Finally responsibility for the quality of healthcare services must rest with some identifiable person. That person now is the chief executive of each trust.

This definiiton of quality has important implications for professional training and development, to which we turn below. However, the systems viewpoint is also relevant here:

15. *A particular feature in our approach should be noted. Traditionally, analyses of the quality of healthcare have concentrated largely on the skills of the healthcare professionals who work in the NHS. More recently, attention has turned to the systems by which healthcare is delivered, focusing on such systems as those concerned with safety, standards, and the 'pathway' of patients' care as they move between GP and hospital. We go further. We are also concerned with the attitudes which those in the NHS bring to their work: how they relate to and respect the interests of patients. We are saying, in effect, that to secure care of high quality across the NHS, we can no longer overlook those elements of the service which go beyond technical skills and competence and beyond the systems in which they are practised. We have to care about attitudes, about respect and honesty, indeed about a partnership between patients and professionals. (pps 256, 257 and 258)*

- **Patients' safety must be the foundation of quality.**

The primary importance of safety has already been noted. In stressing it the report draws on work in the US and this country which has revealed - albeit on a sample basis - how many clinical errors occur in hospitals. In the past, when error has been discovered, the blame has tended to be put on one individual. Again the systems view clarifies the real isssues:

17. *As we set out in the introduction to Section One of our Report, throughout the Inquiry, both in its conduct and in framing our recommendations, we have been convinced of the value of what is known as the 'human factors' approach to understanding how people behave and function in complex systems. .... Thus, whatever the temptation to focus on the actions of individuals and to seek to blame someone when things go wrong, it is as important to pay attention to the system(s) in which those individuals find themselves. (pps 256 and 258)*

- **Systems of care, and facilities, as well as individuals, affect the quality of healthcare.**

The system approach is applied again:

21. *Throughout our Inquiry we have adopted an approach which looks beyond individuals to the systems within which they work. We do not reject the concepts of blame, or of individual accountability. When individuals are held accountable and shown to be guilty of misconduct, blame is both necessary and appropriate. What we reject is recourse to blame as a necessary, almost a reflex action, as if it were a solution in itself. (pps 256 and 259)*

- **Learning from error and mistakes, rather than seeking someone to blame, must be the priority in order to improve safety and quality.**

All systems will fail sometimes: when this happens the need is for failures to be recognised within a culture which embraces 'honest criticism'.

22. .... Our aim is to encourage change, with a view to empowering and assisting professionals within the NHS to serve those for whom it exists: the public. In doing so, criticisms may be made. But they are made constructively, to clear the air, to

offer a prospect of healing divisions, of rebuilding trust and starting again. *(pps 256, 259 and 260)*

- **Openness and transparency are as crucial to the development of trust between healthcare professional and patient, as they are to the trust between the NHS and the public.**

The openness theme is a (third) motif running through the whole report:

23. .... The NHS must let in and work with the public: it must celebrate its successes and make known its shortcomings. Of all our guiding principles, this is perhaps the most significant and the most difficult to put into action. *(pps 256 and 260)*

Against this background the report considers seven themes:

- NHS culture
- Respect and honesty
- Leadership
- Competent healthcare professionals
- Safety of care
- Care of an appropriate standard
- Public involvement through empowerment

In what follows we present some brief extracts from these sections.

NHS Culture

Before the Bristol Inquiry began, three of the senior figures in the trust, its chief executive (who was also a doctor) and two surgeons had been struck off by the General Medical Council. Although the Inquiry did take evidence on their behaviour as individuals, the main focus of their analysis was the context within which they worked. The key conclusion, encapsulated in the following extract, is that even when individuals are dedicated to providing high quality care, the Service as a whole may perform badly.

16. .... *We cannot state this point too emphatically: healthcare professionals are virtually universally dedicated as individuals. But, as members of separate professions and of a large organisation, the NHS, they may not always act in the interests of patients as a whole. Their particular culture may even work against these wider interests. This is not because the professionals involved, be they managers, doctors, nurses or others, are bad people. It is merely that they have come to view*

the world in a particular way and, as a consequence, are unable to see the wider interests of patients as a whole (rather than the patient before them) and the wider picture of the NHS. (p 268)

This view leads to a series of proposals for change in the culture of the NHS. The key elements are:

- openness

The current NHS is characterised as defensive and secretive: the report argues that it must embrace a 'culture of openness between between professional and patient and profession and professional. Mistakes must be acknowledged: the culture must allow them to be discussed and dealt with.

- accountability

The current NHS culture is typified as one of uncertainty and obscurity as too who is responsible for what. Patients do not know to whom they shold go with a problem. The Inquiry concludes that responsibilities must be clearly articulated.

- patient safety

Safety is fundamental to achierving a high-quality service. The Inquiry states that it must be the responsibility of all staff to create a culture of safety.

- public service

The current NHS is seen as riven by the tribalism of professions which are often the first call on the individual's loyalty. The Inquiry argues that duties and allegiances to professional bodies must be aligned with those owed to employers (*ie* trusts) and to the public.

- teamwork

The report points out that teamwork is essential to break down professional tribalism. Patients do not belong to any one professional: they are the responsibility of all those who care for them. Multi-professional teamwork requires multi-professional collaborative effort.

Respect and Honesty

The need for openness has already been referred to. The report applies the theme to relationships with patients, in particular the information that is made available to them, how it is made available and how in particular the inherent risks of clinical care are made apparent.

> *18. In the light of the contributions to our seminar on empowering patients, we identify four fundamental principles which should in future underpin any policy aimed at meeting patients' needs for information. First, trust can only be sustained by openness. Secondly, openness means that information be given freely, honestly and regularly. Thirdly, it is of fundamental importance to be honest about the twin concerns of risk and uncertainty. Lastly, informing patients and in the case of young children their parents must be regarded as a process and not a one-off event.* *(p 286)*

These general requirements are then expressed in specific and practical terms:

> *49. .... It is equally important that trusts themselves provide access to a wide range of sources of information, not limited to resolving concerns or complaints, which will guide and assist patients in the course of their care. The key is to ensure that the sources of information which are intended for patients, for example, the hospital's website, the liaison service and the various contact points throughout the hospital, are integrated and complementary.* *(p 297)*

> *35. .... That said, healthcare professionals do not act alone; we were persuaded by the submission from the Royal College of Nursing that, in addition to those 'in the front line' who communicate with patients and serve as 'the companion on what is often a difficult and lonely journey', there should also be others who can provide support. Counsellors, patients' friends and others can play an invaluable role in giving and explaining information in a non-technical manner.*

> *36. The way forward lies in understanding that two quite distinct developments must take place. The first challenge is to foster, encourage and shape the attitudes of healthcare professionals, both as they enter and as they progress through the profession. The second challenge is to reinforce the attitudes of openness and preparedness to communicate by offering appropriate training in the relevant skills.* *(pps 292 and 293)*

Leadership

> *7. Reference to Bristol allows us to re-emphasise that leadership at a national level, most particularly through the DoH, crucially sets the context within whch leaders of trusts at the local level are able to carry out their responsibilities. With hindsight, it is possible to see that the absence, up to the late 1990s, of national leadership from government on the subject of the quality of clinical care had a role to play in the way in which events unfolded in Bristol. The quality of clinical care did not rank highly in the overall management of the NHS. Nor, until the Audit Commission was given a limited remit for the NHS in 1990, were there organisations external to the NHS which commented authoritatively upon matters touching on the quality of healthcare. But we should stress again that this was no conscious abdication of responsibility on the part of successive governments. Rather, it was an aspect of the unstated compact between government and the healthcare professions, particularly the medical profession, which had helped to see the NHS established in the first place. (p 305)*

Competent Professional

The 'systems' framework which forms the intellectual core of the report has implications for professional training. It leads to an emphasis on communications between professionals and between professionals and patients.

- skills in communicating with patients and with colleagues;
- education about the principles and organisation of the NHS, how care is managed, and the skills required for management;
- the development of teamwork;
- shared learning across professional boundaries;
- clinical audit and reflective practice; and
- leadership. (p 325)

The report makes a large number of recommendations on the content of professional training. Two of the central ones are aimed, again, at reducing professional tribalism:

The need for training in the principles and organisation of the NHS:

> *14. .... aaaBy learning about the NHS, future healthcare professionals become aware from the outset that the NHS is a service* both *for the* particular patient *currently needing care,* and *for the* generality of patients. *This opens the way to an understanding of the challenges and dilemmas faced by those who are responsible for running and managing the service for the benefit of all and who, therefore, must serve both patient and patients.* (p 327)

The need for professionals to train together:

> *19. .... the benefits of bringing together undergraduate students from different disciplines to be educated together should be explored with vigour. Our preference, in time, would be to go further. While recognising the challenge it represents, we urge that thought be given to creating an undergraduate first year of entry which is common to all, whatever discipline they may wish ultimately to pursue....* (p 329)

A third strand of this part of the report is the need to maintain professional competence during a working life. It points out different professions take different approaches: some recognise the problem others do not. The report states:

> *51. .... We believe that the formal systems and resources to support professionals in maintaining their competence need to be part of a comprehensive framework whereby the NHS* and *all the healthcare professions, jointly, embrace three separate but interconnected practices:* continuing professional development, periodic appraisal and revalidation. (p 339)

Safety of Care

The need for an emphasis on safety has already been noted and also the need for a culture which allowed professionals to acknolwedge mistakes.

> *17. Perhaps the most fundamental feature of a culture of safety is the need for the hospital to create an open and non-punitive environment in which it is safe for healthcare professionals to report adverse events, safe to admit error, safe to admit when things have almost gone wrong and safe to explore the reasons why. Adverse events, especially clinical errors, very often go undetected and unreported because of fear: the fear healthcare professionals have of being blamed and perhaps more fundamentally, the fear of what it will mean for them to acknowledge that through their conduct a patient has actually been harmed, the last thing they intended. This goes beyond a fear for job or reputation.* *(p 360)*
>
> - *Concern for the safety of patients should be embedded in the NHS as a whole, and be the responsibility of everyone who works in a trust.*
> - *There must be an awareness and understanding of safety and an appropriate means of managing issues relating to safety at all levels of the NHS.*
> - *Human fallibility is an inescapable reality: thus, systems are needed to anticipate all types of adverse event, to eradicate them where possible and mitigate their effects.*
> - *A mindset of constant vigilance is crucial.*
> - *Fear is the enemy of safety: an open and non-punitive environment, in which it is safe to admit and report adverse events, especially errors, is fundamental.*
> - *Adverse events offer an opportunity to learn and to make changes for the better, not an occasion merely to punish and forget.* (p 360)
>
> *22. .... The first can be called the myth (or imperative) of infallibility.* (p 363)
>
> *23. Secondly, in the particular case of errors, quite apart from any errors of their own, healthcare professionals find it difficult to speak up about the errors of others.* (p 363)

> *24. Thirdly, fear of exposure and blame, whether in the press or through litigation, with the consequent loss of standing, career prospects, or even livelihood, is a further powerful inhibiting factor.* (p 363)

The report also argues for two other changes:

- research into the extent of adverse events and near misses
- a national reporting system
- better design of buildings, equipment and pharmaceuticals

The creation of the National Safety Agency (check) is a response to the second of these.

Care of an Appropriate Standard

The report records the gradual emergence at national level of a concern about standards of care and the recent policy responses. But while these are welcomed, the report sees a need for bringing the various elements together:

> *54. At the national level, we are convinced that it would be of benefit to the quality of healthcare if the monitoring of clinical performance were brought together and co-ordinated by one body. This would include the co-ordination of national audits and the validation and presentation to the public of information about performance in relation to national standards. It would also include filling the gap which we referred to earlier, the absence currently of a mechanism for survillance, to review trends in performance over time and between trusts. We propose that all of these activities should be brought together under an independent office for Monitoring Healthcare Performance which should be part of CHI [Commission for Health Improvement]. (p 397)*

Public Involvement

The report acknowledges that there has been no shortage of attempts to involve patients and the public in the NHS. It identifies four critical areas:

- planning and development of services
- operation and delivery of services
- assuring the competence of healthcare professionals
- protection of vulnerable groups

It sets ten principles:

- Patients and the public are entitled to be involved wherever decisions are taken about care in the NHS;

- The involvement of patients and the public must be embedded in the structures of the NHS and permeate all aspects of healthcare in the NHS;

- Information;

- Healthcare professionals must be involved in the process;

- Honesty about the scope of involvement;

- Transparency;

- Effectiveness;

- Training, development and preparation;

- Funding;

- Involving different groups;

(pps 408-410)

> *30. Accordingly, we are of the view that, on balance, the priority should be that the public's interests are embedded into all the organisations and institutions concerned with quality of performance within the NHS. In this way the public is 'on the inside', rather than 'on the outside'. Moreover, in wider constitutional terms, it leaves the field clear to democratically elected politicians to be, as they must be, the final arbiters of the wider public interest, able to weigh both competing priorities within the NHS, and the relative claim of the NHS as against those of other sectors of public service.* (p 411)

Recommendations

In making its recommendations, the report returns to the 8 themes set out above. Because of their number, we cannot simply reproduce the recommendations here. In this section therefore we highlight a smal number to re-emphase the general themes set out above.

Patient and Professionals

1. In a patient-centred healthcare service patients must be involved, wherever possible, in decisions about their treatment and care.

2. The education and training of all healthcare professionals should be imbued with the idea of partnership between the healthcare professional and the patient.

3. The notion of partnership between the healthcare professional and the patient, whereby the patient and the professional meet as equals with different expertise, must be adopted by healthcare professionals in all parts of the NHS, including healthcare professionals in hospitals. (p 438)

Leadership

The Inquiry recommends that the regulation of all professionals should be brought together under one umbrella body and that a similar umbrella organisation should be created to bring together the work of all the regulators of healthcare standards and institutions. The first of these has already been accepted by the Government in the form of ADD

Competent Professionals

57. Greater priority than at present should be given to non-clinical aspects of care in six key areas in the education, training and continuing professional development of healthcare professionals:

    - skills in communicating with patients and with colleagues;

    - education about the principles and organisation of the NHS, and about how care is managed, and the skills required for

management;

- the development of teamwork;
- shared learning across professional boundaries;
- clinical audit and reflective practice; and
- leadership. (pps 444 and 445)

Safety

As noted, the report endorses the creation of the National Patient Safety Agency and the introduction of a national reporting system.

It adds that:

120. The proposed National Patient Safety Agency should, as a matter of urgency, bring together managers in the NHS, representatives of the pharmaceutical companies and manufacturers of medical equipment, members of the healthcare professions and the public, to seek to apply approaches based on engineering and design so as to reduce (and eliminate to the extent possible) the incidence of sentinel events. (p 451)

Care of an Appropriate Standard

The report aims again at unification here, first in organisational terms and then in terms of the standards themselves:

122. One body should be responsible for co-ordinating *all* action relating to the setting, issuing and keeping under review of national clinical standards: this should be NICE, suitably structured so as to give it the necessary independence and authority.

123. One the recommended system is in place, only NICE should be permitted to issue national clinical standards to the NHS. (p 452)

The report also recommends the creation of a new organisation to deal with all clinical information.

146. The monitoring of clinical performance at a national level should be brought together and co-ordinated in one body: an

independent Office for Information on Healthcare Performance. This Office should be part of CHI.

147. The Office for Information on Healthcare Performance should supplant the current fragmentation of approach through a programme of activities involving the co-ordination of the various national audits. In addition to its other responsibilities, the new system should provide a mechanism for surveillance whereby patterns of performance in the NHS which may warrant further scrutiny can be identified as early as possible. (p 455)

As noted the Government has accepted this recommendation.

Public Involvement through Empowerment

158. Organisations which are not part of the NHS but have an impact on it, such as Royal Colleges, the GMC, the Nursing and Midwifery Council and the body responsible for regulating the professions allied to medicine, must involve the public in their decision-making processes, as they affect the provision of healthcare by the NHS. (p 456)

130. There must be a single, coherent, co-ordinated set of generic standards; that is standards relating to the patient's experience and the systems for ensuring that care is safe and of good quality (for example corporate management, clinical governance, risk management, clinical audit, the management and support of staff, and the management of resources). Trusts must comply with these standards. (p 453)

The Government Response

The Government issued a short initial response on the occasion of the publication of the report. A fuller response is expected in the autumn.