

THE BRISTOL INQUIRY THEN and NOW

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The Canadian Healthcare Safety Symposium: Healthcare and the Law



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BRISTOL THE BACKGROUND



- Paediatric Cardiac Surgery – 1980s to mid 1990s
- First Concerns about mortality – 86-7
- Whistleblower – early 90s
- General Medical Council – 97-98 : 3 doctors disciplined
- Government’s response - **Public Inquiry** (1998-2001) into the conduct of paediatric cardiac surgery at the Bristol Royal Infirmary 1984-95
- Established July 1998
- Chair, plus Panel of 3 – GP, Nurse/Administrator, Academic specialising in sociology and law relating to families
- Terms of Reference – to inquire, make findings as to adequacy of care, reach conclusions re action taken, **and** “...to make recommendations to help to secure high quality care across the NHS”.

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Bristol Royal infirmary inquiry

PURPOSES MY APPROACH


- TRUTH
- HEALING
- CATHARSIS
- LEARNING
- ACCOUNTABILITY
- PRESCRIBING

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SYSTEMS APPROACH Fundamental Basis of Inquiry



- Human Factors Analysis
- Systems Approach - how people behave in complex systems
- “the performance of organisations must be understood in terms of the complex interaction of factors which, only when taken together, explain success or failure. ... 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.”
- To understand is to learn is to prevent

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KEY FEATURES OF INQUIRY

- Accessibility and Setting
- Information Technology
- Evidence
- Experts
- Role of Legal Representatives
- Liaison



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REPORTS

Interim Report –*Removal and Retention of Human Material*, May 2000, 60 pages, 2 Appendices, 69 Recommendations

Final Report –*Learning From Bristol*, July 2001, 528 pages, 4 Annexes, c.12,000 pages, 198 Recommendations.

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AGENDA FOR REFORM

- Patient at the Centre
- Culture of NHS
- Respect and Honesty
- Leadership
- Competent Professionals
- Safe Care
- Quality and Standards of Care
- Empowerment of Patients and Public
- The Care of Children

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SAFE CARE

- Leadership and team-work
- Standards
- Metrics
- Reporting/Audit
- Information
- Publication of information
- Removal of Barriers, eg: litigation, "blame and shame", low priority, perverse incentives, structural upheaval

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SAFE CARE since BRISTOL

- Structures
- Regulation – Standards, Reviews Investigations
- Reporting
- Metrics
- National Campaign
- Government's Review – Darzi
- BUT ... progress slow: cultural change; operational embedding; limitations of data, especially in primary care, mental health, marginalised communities; structural changes; priorities/incentives not aligned



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