Bristol Royal infirmary inquiry

The Bristol Royal infirmary inquiry: the issue explained

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The Bristol Royal infirmary inquiry is one of the most far-reaching and detailed investigations in to the NHS ever undertaken, addressing fundamental issues of clinical safety and accountability, professional culture in the health service, and the rights of patients.

Set up in 1998 to investigate the deaths of 29 babies undergoing heart surgery at the Bristol Royal infirmary in the late 1980s and early 1990s, the vast 529-page report effectively provided a blueprint for wider reform of the NHS.

It lifted the lid on an "old boy's" culture among doctors; patients being left in the dark about their treatment; a lax approach to clinical safety; low priority given to children's services; secrecy about doctor's performance, and a lack of external monitoring of NHS performance.

Warning that a scandal on the scale of Bristol could happen again, the report's author Professor Ian Kennedy QC demanded the NHS learn from the lessons of Bristol and act upon them.

"Changes are needed," he said when the report was published in July 2001.

Its recommendations include:

· Patients and the public should be more involved in decisions about their treatment and care

· A national director for children's services should be appointed to lead the development of child-centred healthcare

· The NHS must root out unsafe practices and learn from its errors

· Clinical negligence litigation, which cloaks adverse medical incidents in legal secrecy, should be abolished

· ; The introduction of appraisal, continuing professional development and revalidation for all healthcare professionals to ensure they keep their skills up to scratch

· Changes to the consultant contract to make them more accountable to the trust hospital that employs them

· The creation of national standards of care, both in clinical

to access information about the relative performance of hospitals, services or consultant unit

· An independent external monitoring service to identify good and failing hospitals.

The government responded positively to the report. At the time of its publication, it had already introduced several organisations in its NHS plan published a year previously, such as the commission for health improvement (CHI), which inspects NHS performance.

The NHS plan had heralded proposals to renegotiate the consultant contract and introduce annual appraisal for doctors. Earlier in 2000 the government had also begun to address the chronic underfunding of the NHS by announcing multi-billion pound increases for the NHS.

The national patient safety agency, which coordinates the reporting of medical errors, was announced a few weeks before the Bristol inquiry reported. The NHS and social care bill published a few months earlier contained measures to introduce patient advocacy services to trusts.

One the day of the report's publication, the health secretary, Alan Milburn, announced the appointment of Al Aynsley-Green, a professor at Great Ormond Street children's hospital as the national director of children's services.

A white paper on reform of medical negligence was promised for early 2002 and the creation of an independent office for information on healthcare performance, to collect and validate data on clinical performance, was announced.

The Bristol inquiry also helped spawn fresh health legislation. The NHS reform and health care professions bill introduced in November 2001 contains proposals that directly address the concerns of the inquiry report. These include giving more powers to CHI, setting up new patient representative bodies and creating a new national council for regulating healthcare professionals.

The government's formal response to the inquiry, published in January 2002, unveiled further measures to meet the Bristol recommendations, including plans to publish death rates for individual cardiac surgeons - the precursor of league tables of consultant performance in a wider range of speciaties.

A new council for the quality of healthcare will be created to coordinate the work of the various health quality and standards bodies, including CHI, the national institute for clinical excellence, the national patient safety agency and the national clinical assessment authority.

The government's response concludes: "Bristol was a turning point in the history of the NHS. We are determined that some good can come from the tragedy that took place there."

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