Lessons from the Bristol Inquiry for education and training in the NHS

Brendan Hicks

The vast body of evidence, analysis and judgment within the Bristol Inquiry report gives rise to a host of recommendations for change. Most are relevant to health systems everywhere and to all parts of those health systems. Some raise issues which cry out to be addressed within the education, training and development of all health professionals.

INTRODUCTION

The Bristol Royal Infirmary Inquiry was set up to review the management of care of children receiving complex cardiac services at the Bristol Royal Infirmary between 1984 and 1995. For children under the age of 1 year, the mortality was twice the average for England. Some 30–35 children who died between 1991 and 1995 would probably have survived if they had been treated elsewhere. Yet by 1990 the available figures 'could have alerted the clinicians...to stop and take stock of their results'. A multiplicity of factors played a part in the tragedy. Some factors were financial or circumstantial, but many were related to professional attitudes and behaviours.

KEY LESSONS

The key lesson of section one of the Kennedy Report on the Bristol Royal Infirmary Inquiry (2001) is that what happened in Bristol could have happened anywhere in the NHS: we are talking culture, systems, fundamentals.

The lessons of section two, what should be done, are much more complex, with 198 recommendations, both explicit and practical. Even these draw as much on cultural issues and attitudes as on actions or processes or competence per se. So in teasing out ten discrete 'messages' or new objectives, one should not underestimate the profound nature of the changes we are being asked to pursue. Some of the objectives may look very familiar, but it is the depth and contexts of those objectives which will be new and challenging.

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BROADENING THE NOTION OF COMPETENCE

A key purpose of the recommendations is stated bluntly up front:

'To promote a new culture within the NHS: a three way partnership of respect, honesty and openness between — NHS and public — professionals and patients — professionals and professionals'.

This should be happening in the context of a professional style that acknowledges always the primacy of needs of patients generally as well as the patient who happens to be in front of us at the moment. Patient-centredness is after all not just a political slogan: it is what we all signed up to when we entered the world of health care.

The professions are being asked to do more than learn a few extra tricks of the communication trade when recommendations 1–38 range through partnership, information and communication. This communication is much richer than 'information' alone, that seeks what patients (or parents or families) want to know, that responds, that shares, that listens as much as talks, that sees 'consent' as a genuine dialogue between people — honest, respectful and vulnerable on both sides. Of course there are skills to be learnt, skills of awareness and perception, skills in exploring anxieties, handling issues honestly and sensitively, sharing the uncertainties and sometimes even the anguish. But also there are styles to be unlearnt.

Annex B of the report includes a provocatively thoughtful briefing paper from Jean Simons (2000), informed by her expertise in the support of parents and unwell children, which reminds us how the best of intentions may be ineffective or even damaging:

'…Although doctors thought in their interviews they were giving time and space for the patient to express their feelings, they were on the whole preventing the patient from doing so by their own need to give information they thought the patient needed to hear, changing the subject, offering premature inappropriate reassurance, and insisting on their agenda prevailing in the interview rather than partnering the patient in the discussion'.

Interestingly, a high quality of 'professional' communication comes naturally to trained patient volunteers: doctors and nurses and others have to unlearn habits of double-guessing 'what the patient wants', coming off the pedestal to talk with rather than at their patient partners. The problem is not one of arrogance, lack of caring, negligence or time. The solution is effective demonstration of our respect for our patients, singly and collectively, through the way we normally and naturally involve them and their families in their health and its management.

BROADENING THE NOTION OF PROFESSIONAL COMPETENCE

It is therefore not surprising that in chapter 25 of the report, concerned with this broader view of what it means to be a health professional, communication is named as the first

of six key developments in 'non-clinical' competence as promoted in the report (recommendations 57–63). Communication not only with patients and families, but with colleagues, and colleagues in the broader sense than 'the club' which contributed so much to the Bristol disaster. This is communication within units, between doctors and nurses and other health-care professionals, among whom must be counted health service managers.

The need for a sense of wholeness of the NHS generally and of 'units' locally is stressed, and indeed the second objective within non-clinical competence includes a deep understanding of, and commitment to, the values and principles which underlie the NHS, the organizational structure which sustains those principles, and the 'managing skills' that all professionals need to bring into play for the greater good of patients. It is suggested that these should be introduced early in training, and enhanced steadily thereafter by instruction and actual involvement at each new level of experience.

The report recognizes the fact that 'healthcare professionals…have always worked in teams of one sort or another…', but pushes for active further development of teamwork, making it less hierarchical and more flexible, and increasingly focused on the best care pathways for patients rather than the convenience of existing administrative arrangements or traditional work patterns.

'All prospective healthcare professionals…must receive *education and training* in the *meaning* of teamwork, how to work *effectively* in multidisciplinary teams, how to deal with the issues of *accountability* which arise in teams, and the role of teams in *providing* healthcare…also to be included in *specialist* training' (author's italics).

DEVELOPMENT OF TEAMWORK

Integral to this well-justified objective are recommendations 61, 62 and 64, expressed elsewhere in the report in the suggestion that:

'...the [undergraduate] education, [postgraduate] training and CPD [continuing professional development] of all healthcare professionals should include joint courses between the professionals…there should be more opportunities than at present for multi-professional teams to learn, train and develop together… Greater opportunity should be created for managers and clinicians to "shadow" one another to learn about their respective roles and work pressures'.

Existing curricula and pilot schemes which are testing these sorts of approaches are being received positively, even if evidence of benefit to patients and the most efficient way of delivering those benefits need to be explored further.

LEADERSHIP

A natural further objective arising from the preceding arguments must be good leadership, which must combine all the qualities and areas of competence discussed above. On this the report is direct and to the point:

'It is a mistake to expect that those who are skilled in one aspect of healthcare, or those who have risen to a certain level of seniority in their profession, will by that fact alone automatically make good leaders. Leaders must, to a large degree, be made. The skills of leadership can be taught, acquired and developed…'.

It is suggested that the new NHS Leadership Centre should '…take a firm grip on the myriad of existing programmes…'. Certainly in the field of leadership development within the principles of good teamwork for doctors and dentists, the medical schools and the postgraduate deans will want to look for a coherent multiprofessional context for the training they increasingly provide alongside or within those developments.

REFLECTIVE PRACTICE

The final competence to be pursued is that of clinical audit, at the level of personal practice, team function, and indeed a whole organization, extending seamlessly into national systems of quality assurance and development. In other sections of the report it is recognized that this is not only an important issue for education, training and the professional culture, but for the NHS as a whole, locally and nationally.

The NHS must be seen as an open organization and a safe environment for the recognition, reporting, recording and exploring of events that damaged or could have damaged patients, 'sentinel events' in the language of the report. The widespread scepticism at all levels of the NHS regarding talk of a 'blame-free culture' needs to be actively managed by demonstration of this good faith, again at every level. Some quite radical proposals are contained in recommendations 113–119, which include immunity from disciplinary action if untoward events are reported promptly (criminal offences excepted of course) and abolition of the clinical negligence system in favour of some form of 'no-fault compensation'.

FROM CLINICAL TO GENERIC

In these several ways, the report moves the whole area of generic or non-clinical skills up the agenda, and significantly broadens the NHS vision of what constitutes competence in health care, whichever profession. In the words of the report:

'...we argue that in the case of doctors and nurses, technical clinical skills are a necessary but not a sufficient qualification to practise as a healthcare professional… For the future we must expand our understanding of what constitutes professional competence'.

Few would disagree.

FROM GENERIC TO CLINICAL

There are many more pages in this report, and the 'technical clinical skills' so critical in the Bristol story naturally receive due attention. Particular messages emerge for CPD and medical education and training in

relation to new skills and how they should be acquired. Recommendation 99 suggests:

'Any clinician carrying out any clinical procedure for the first time must be directly supervised by colleagues who have necessary skills, competence and experience until such time as the relevant degree of expertise has been acquired'.

In the context of the inquiry, this directive has its origins in new procedures within the super-specialist area of innovative paediatric cardiac surgery, but the phrase 'clinical procedure' could include those which take place outside what is conventionally as seen as 'surgical'. The Royal Colleges will also be expected to organize or at least make possible the sharing of expertise and mentoring envisaged by Professor Kennedy and his team. Other important points are made in the report around adequate information being provided to those offered new treatments (or to their families or parents), meaningful consent, and the ethical committees. The relevance of this section of the report for all career grade professionals is evident, and it is not insignificant for the units and trusts which will need to build these arrangements into their clinical governance.

INDUCTION AND SUPERVISION

The broader impact for education and training generally lies in transferring this principle into the step-by-step progression through levels of training. Induction of 'new joiners' and their clinical and education supervision through every phase of training must surely be informed by the same standards, while recognizing the very exceptional emergency situation which would demand intervention on the good samaritan basis.

In general, a junior doctor should not be required to make critical clinical decisions or manage clinical procedures outside their current degree of expertise in the relevant area of practice unless they are supported and in a formal sense 'supervised' by a colleague or trainer with that expertise. One hastens to add that supervision in this sense does not necessarily require someone to be physically present, nor to prescribe an over-protective spoon-feeding approach to professional learning. Indeed, trainees must be ever more responsible for their professional self-awareness and good judgment as to when to seek advice or direct assistance. In doing so they have to respect the first duty of a doctor defined in *Good Medical Practice* (General Medical Council, 2001): 'Make the care of your patient your first concern', and in doing so 'Recognise the limits of your professional competence'. The same source reminds trainers, in their role as supervisors, that 'when you delegate care and treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved'.

CONTINUING PERSONAL AND PROFESSIONAL DEVELOPMENT

The final message that I would extract from this report embraces all the others, the expectation and indeed the unequivocal demand that continuing personal and professional development should be absolutely integral to professional life, should be in a formal sense mandatory, and should be supported by appraisal which in this report could be seen as both developmental and performance-related. This would be the basis for statutory revalidation.

More positively, and in the words of the report:

'Individual healthcare professionals, once qualified, need to be sufficiently *motivated* and have sufficient *incentive* to *maintain and develop* their competence… It is crucial therefore that the working life of healthcare professionals be so structured as to allow them to meet these requirements… Thus, the work environment in the NHS must *support and enable* the process of continuous learning, through well-planned strategies for continuing professional development' (author's italics).

O brave new world that has such people in it, or might in the future, and resources to match… HM

Conflict of interest: none.

Bristol Royal Infirmary Inquiry (2001) *Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995. Learning from Bristol.* Cmmd 5207. Stationery Office, London (www.bristol-inquiry.org.uk)

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Simons J (2000) Giving Information to Parents with an Unwell Child. Other expert papers presented to the Bristol Royal Infirmary Inquiry 10k. (http://www.bristol-inquiry.org.uk/final_report/annex_b/ab_idx10.html)

KEY POINTS

'The Bristol ten' for education and training

1. Respect and honesty: health-care professionals must work in true partnership with patients.

Broadening the notion of competence

2. Develop responsive communication skills.
3. Knowing the NHS: values and organization.
4. More effective teamwork, within and between teams.
5. Professionals must share learning and development.
6. Quality leadership is vital.
7. Reflective practice must take place on a personal, local and national level.

Assuring and sustaining competence

8. Doctors must be educated in handling innovation and new clinical skills.
9. Proper standards of induction and 'supervision' are needed.
10. Continuing personal and professional development and appraisal must be mandatory.