6 BRISTOL ROYAL INFIRMARY INQUIRY

1.1 Introduction

A public inquiry set up to investigate the management of the care of children receiving complex cardiac services at the Bristol Royal Infirmary between 1984 and 1996. The Inquiry was chaired by Professor Sir Ian Kennedy. The report of the Inquiry was delivered in July 2001. The report can be viewed online.

The Inquiry was tasked with:

- Making findings as to the adequacy of the paediatric cardiac surgical services provided by Bristol Royal Infirmary;
- Establishing what action was taken both within and outside the hospital to deal with concerns raised and to identify any failure to take action promptly; and
- Reaching conclusions from these events and making recommendations to help secure high-quality care across the NHS.

The Inquiry found that the paediatric cardiac surgical service at Bristol Royal Infirmary was less than adequate. There was poor teamwork, with implications for performance and outcome including a significantly higher mortality rate for open-heart surgery. The systems and culture in place were such as to make open discussion and review more difficult. Communication between parents and some staff was poor. At national level, there was confusion as to who was responsible for monitoring quality of care, which a lack of any real system whereby an organisation took responsibility for keeping an eye on things.

The Inquiry made 198 recommendations. The Government responded to the report of the Inquiry, and the recommendations it made, in its January 2002 report titled '*Learning from Bristol: The Department of Health's Response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*'.

Methodology for review of recommendations from previous Inquiries

The Thirlwall Inquiry table has been updated (September 2024) as follows:

Exclusions:

a. The two inquiries relating to Wales: Ely Hospital (1967) and Cwm Taf Hospital (2019 and 2022).
b. The Independent Inquiry into Child Sexual Abuse (2022)

Approach:

1. Desktop review by separate teams at the Department of Health and Social Care and NHS England
2. Allocating responsibility as follows:
   a. NHS England for itself and legacy bodies; and
   b. DHSC for itself and wider health family, where possible.
3. A recommendation-by-recommendation approach was undertaken with updates provided to different degrees of detail.
   a. In general, more detail from 2013 (date of establishment of NHS England) onwards; and
   b. On any inquiries referred to in the Sir Robert Francis KC's Expert Review[1] and
   c. Less detail on recommendations which are considered to have been superseded, with a summary of the current position provided.
4. A third assessment category has been applied to reflect those recommendations where implementation is ongoing. Definitions are included at the end of the update. The Department of Health and Social Care and NHS England are clear that these judgements on implementation do not mean that effectiveness is either consistent or at the same level.
5. The separate review teams were in agreement on the implementation positions and so this table is provided jointly, with no areas of disagreement noted.

The legislation and organisational landscape of the NHS has changed significantly since the Bristol report was published and as such many of the immediate actions taken in response to the recommendations have now been superseded as has the organisational landscape to which the recommendations refer. In many cases, the actions to implement the recommendations have been incorporated in standard practice and procedure.

Type of Recommendation	No.	Details of Recommendation	Implementation	Source	Extent of Implementation	Updated notes on Implementation (DHSC and NHS England)	Reviewed extent of Implementation
Regulation and oversight of NHS managers	**91**	Managers as healthcare professionals should be subject to the same obligations as other healthcare professionals, including being subject to a regulatory body and professional code of practice. (July 2001)	The Government agreed in part with this recommendation. In its January 2002 response, the Department of Health said it did not think it practicable to establish self-regulation for senior managers. The Department agreed that the standards expected of senior managers should be explicit, and it favoured a code of conduct, stronger performance management and tighter contracts.	The Department of Health's Response to the BRI Inquiry, January 2002.		The new government manifesto includes a commitment to introduce professional standards for NHS managers and bring them into regulation. The department is currently exploring options for taking this work forwards. The NHS Leadership Competency Framework for Board members (2024)[183] supports the recently refreshed Fit and Proper Persons[184] regime. An independent evaluation is planned for 2025. NHS England is also developing a management and leadership framework, which will include a Code of Practice for all leaders and managers.	Superseded
Improving NHS culture and governance	**92**	Where clinicians hold managerial roles which extend beyond their immediate clinical practice, sufficient protected time in the form of allocated sessions must be made available for them to carry out that managerial role. (July 2001)	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that under its proposals for a new consultant contract, consultant's job plans would specifically address the time commitments needed for managerial duties.	The Department of Health's Response to the BRI Inquiry, January 2002.		Please see our response to Recommendation 91 (consultant contract) above. The 2003 consultant contract specifies that the job plan sets out the consultant's managerial responsibilities. Similarly, managerial responsibilities are factored into the NHS Agenda for Change banding (for most other professions).	Implemented – Closed
Regulation and oversight of NHS managers	**93**	Any clinician, before appointment to a managerial role, must demonstrate the managerial competence to undertake what is required in that role: training and support should be made available by trusts and	The Government agreed with this recommendation. In its January 2002 response, the Department of Health said that clinical director and medical director development programmes would be rolled out from January 2002.	The Department of Health's Response to the BRI Inquiry, January 2002.		Please also see our response to Recommendation 91 (Leadership competency framework). The new government manifesto includes a commitment to introduce professional standards for NHS managers. Since November 2014, providers of health and social care registered with Care Quality Commission, including Trusts — have been required to comply with the requirements in Regulation 5[185] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (known as the Fit and Proper Person Regulation) In August 2023, NHS England published a strengthened Fit and Proper Person Test Framework[186] in response to the 2019 Kark Review to introduce:	Implemented – Ongoing

[183] NHS England » NHS leadership competency framework for board members
[184] NHS England » NHS England fit and proper person test framework for board members
[185] Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)
[186] NHS England » NHS England fit and proper person test framework for board members