

RESPONDING TO LOCAL FAILURE

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Context

The Bristol Royal Infirmary (BRI) and the Bristol Royal Hospital for Sick Children (BRHSC) are two teaching hospitals associated with Bristol University's Medical School. Today, both are part of the University Hospitals Bristol NHS Foundation Trust (UHB). In the early 1980s, the Department of Health and Social Security (DHSS) initiated funding for Supra Regional Services (SRS) to concentrate resources and expertise in specialized medical fields throughout the UK. The goal was to enhance clinical performance when treating rare conditions through more cases and practice at designated locations. One of the services funded by the SRS initiative was Paediatric Cardiac Surgery (PCS), which was limited to babies under the age of one year. Bristol Hospitals were made one of nine designated centres for PCS across England in 1984, with BRI performing open-heart surgery and BRHSC performing closed-heart surgery on infants.

Failure

PCS services at UHB were formally stopped in 1995, when unexpectedly high death rates following cardiac surgery of babies under the age of one were detected. Although, initial concerns were expressed as early as 1990, they escaped the attention of Dr Ryolance, the chief executive at Bristol at the time. In 2001, a formal inquiry commission led by Ian Kennedy presented its final report "Learning from Bristol" revealing death rates as much as two times higher than expected in five out of seven years during the period from 1988 to 1994. The excessive death rates were attributed to several problems at the field level (i.e. the whole NHS) as well as the organisational level including process failures and cultural entrapment within the trust.

At the *field level*, the NHS experienced a far-reaching reorganisation during much of the 1980s and 1990s. This triggered resource and attention problems affecting the whole medical sector in the UK. Among others, UHB experienced a shortage in paediatrically trained nurses and cardiologists necessary for conducting operations, causing understaffed units and mounting quality concerns. These problems, however, escaped managerial attention as adequate standards and routines to monitor the quality of care within hospitals were still lacking within the NHS. At the time, no effective mechanisms were available to detect service failures, as

Domain

Public

Private

Non-profit

Commercial

Business: Hospital Services

Start up (0-1yr)

Growth (1-5 yrs)

Mature (5yrs +)

Micro (Staff <10)

SME (10 – 250 Staff)

Large (250+)

Regional

National

Multinational

Methods

Longitudinal

Cross-sectional

Access

Exemplar

Random

Innovation

Top Down

Bottom-up

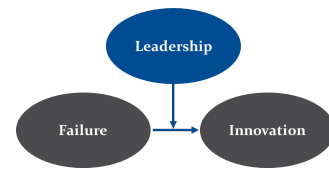
Product

Process

Organizational

Radical

Incremental



reflected in unexpectedly high death rates following open-heart surgery on infants.

At the *organisational level*, a number of additional shortcomings contributed to high infant death rates. First, building infrastructure and key care processes were inadequate considering the needs of very young patients. While the operating theatres and intensive care unit (ICU) were located inside the BRI hospital site, the wards for post-surgery care were situated at the BRHSC site. This meant that children leaving the ICU had to be taken to the BRHSC for residential care, although both facilities were located several hundred yards apart from each other. Further, no effective child-centred approach was applied at BRI, as neither an adequate paediatric ICU nor designated paediatric cardiac surgeons were available. Children were thus treated by staff specialised in adult care using facilities tailored to the needs of adult rather than infant patients. Second, the culture within Bristol hospitals was described as uncommunicative instead of open. It resembled a “club culture” or a culture of justification. Staff was not encouraged to share their problems and concerns were not to be taken to the chief executive. Weick and Sutcliffe (2003) in their post-report analysis highlight a pronounced tendency among staff and management for external rather than internal attribution. More specifically, they explain that BRI and BRHSC staff justified the poor performance with anomalies and particularly challenging cases instead of seeking to unearth internal shortcomings. The club culture entailed a marked concentration of power within a closed circle. As stated in the report, “[executives] were either part of the ‘club’ or treated as outsiders” unable to influence senior management. It was arguably this combination of poor communication, inadequate teamwork, weak processes (i.e. unacceptably long cardiac care waiting times) and an unsatisfying hospital layout (with two sites) that led to dramatically increased death rates following heart surgery of children under the age of one – a case of severe service failure today widely known as the “Bristol heart scandal”.

Innovation and Transformation

The commission in charge of the inquiry under the lead of Ian Kennedy developed far-reaching recommendations pertaining in particular to the organizational field (i.e. all NHS Hospital Trusts). The “Kennedy Report” published in 2001 contained recommendations pertaining primarily to standards of care, patient involvement and organisational culture within the acute care sector.

As for *standards of care*, the report called for an independent system to monitor care quality across the entire NHS. This would require not only appropriate process and outcome metrics

Failure

- Caused externally
- Caused internally

- Step1 Invent
- Step2 Select
- Step3 Implement
- Step4 Capture

Transformation

- Internal to Organisation
- External to Organisation
- Delivered by Organisation
- Delivered by Others

Role of Leadership

- Strategic Recovery
- Employee-led Recovery
- Field-level Response

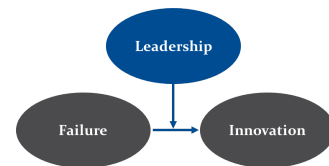
- New Leader Engaged
- Existing Leader

- Recovery Strategy Published
- Recovery Led by Operational Activity

- Strategy Announced
- Recovery Evolved

Learning outcomes

- Inadequate (clinical) leadership can be a key contributing factor to failure
- Failure can trigger profound and lasting changes at the field level



comparable across service providers but also unprecedented data collection and analysis efforts. Similarly, a regulatory authority would need to be in place to oversee NHS trusts and intervene in case of sustained failure to meet national standards. Moreover, the systematic reporting of adverse events as a means to learn from clinical errors, near misses and incidents and prevent their future occurrence moved into the foreground.

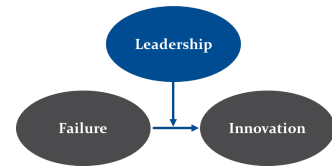
With regards to *patient involvement*, the commission advocated a renewed emphasis on the patient and her idiosyncratic needs. This holds first and foremost for children, which need to be treated in dedicated facilities and by adequately trained clinical staff, if they are to obtain the best possible care. The call for a stronger patient orientation, however, was more general in that it pertained to all patients irrespective of their age. More specifically, an agenda for greater patient information, consent, choice and feedback as essential constitutive elements of every treatment experience was outlined, eventually triggering the birth of the world's largest patient survey programme to solicit systematic feedback from patients about their entire treatment experience from admission to discharge.

As for *organisational culture*, the report called for 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” (Kennedy Report p. 13) needs to be created. This requires not only good communication between staff, patients and executives, but also an environment that is open, encouraging and non-punitive as well as a wider adoption of multidisciplinary teamwork.

Jointly, these recommendations have fundamentally transformed the NHS and the way it is governed. The outcome metrics (e.g. Patient Satisfaction Score), oversight bodies (e.g. Healthcare Commission) and patient involvement mechanisms (e.g. NHS Choices) that were created in the wake of the Bristol heart scandal have since then been – and continue to be – emulated across the world, fuelled by a growing recognition of the need to reward service providers for the care quality in addition to care quantity.

Leadership

Leadership played a pivotal role in explaining both the emergence of clinical failure at the local level and the far-reaching responses taken at the national level. As for the local level, Dr Roylance, a medical doctor serving as UHB's CEO at the time, introduced 13 separate directorates inside UBHT each led by medical professionals with little – if any – prior management experience. The unintended consequence was a system of isolated units or “silos”, which were characterised by a concentration of power at the top (club culture) and a lack of intra- as well as inter-directorate collaboration. This had notable negative side effects in the operating room, where staff members were hesitant to engage in multidisciplinary teamwork and to share problems with their respective superiors – activities that were particularly vital in the field of paediatric cardiac surgery. As for the national level, the Bristol heart scandal acted as a catalyst for profound structural changes. Strong political and academic leadership was essential at numerous stages of the transformation process. Sir Ian Kennedy, who chaired not only the public inquiry into the Bristol heart scandal but also the newly established regulatory authority until 2009 known as the Healthcare Commission, in particular was relentless in his efforts to identify root causes, to propose often evidence-based corrective actions and take the lead in implementing them at the system level.



Data

This case study relies on data collected as part of the formal inquiry published in 2001 and mandated by the Secretary of State for Health in the UK. The report was based on written evidence by 577 witnesses and more than 900,000 pages of documents.

Further Reading

Secretary of State for Health (2001). *Learning from Bristol: The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995*. London.

Weick, K.E. and Sutcliff, K.M. (2003). Hospitals as Cultures of Entrapment: A reanalysis of the Bristol Royal Infirmary. *California Management Review* 45 (2): 73-84.