The Bristol Heart Scandal and Its Consequences

M a r t i n E l l i o t t

37th Gresham Professor of Physic

Professor of Cardiothoracic Surgery at UCL

Consultant Paediatric Cardiothoracic Surgeon

&

co-Medical Director

The Great Ormond Street Hospital for Children

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You Expect

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You Expect

Experts

@ProfMJElliott

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You Expect

Experts

Facilities

@ProfMJElliott

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You Expect

Experts

Facilities

Care

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You Expect

- Experts
- Facilities
- Care
- Team

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You Expect

- Experts
- Facilities
- Care
- Team
- Truth

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You Expect

- Experts
- Facilities
- Care
- Team
- Truth
- Trust

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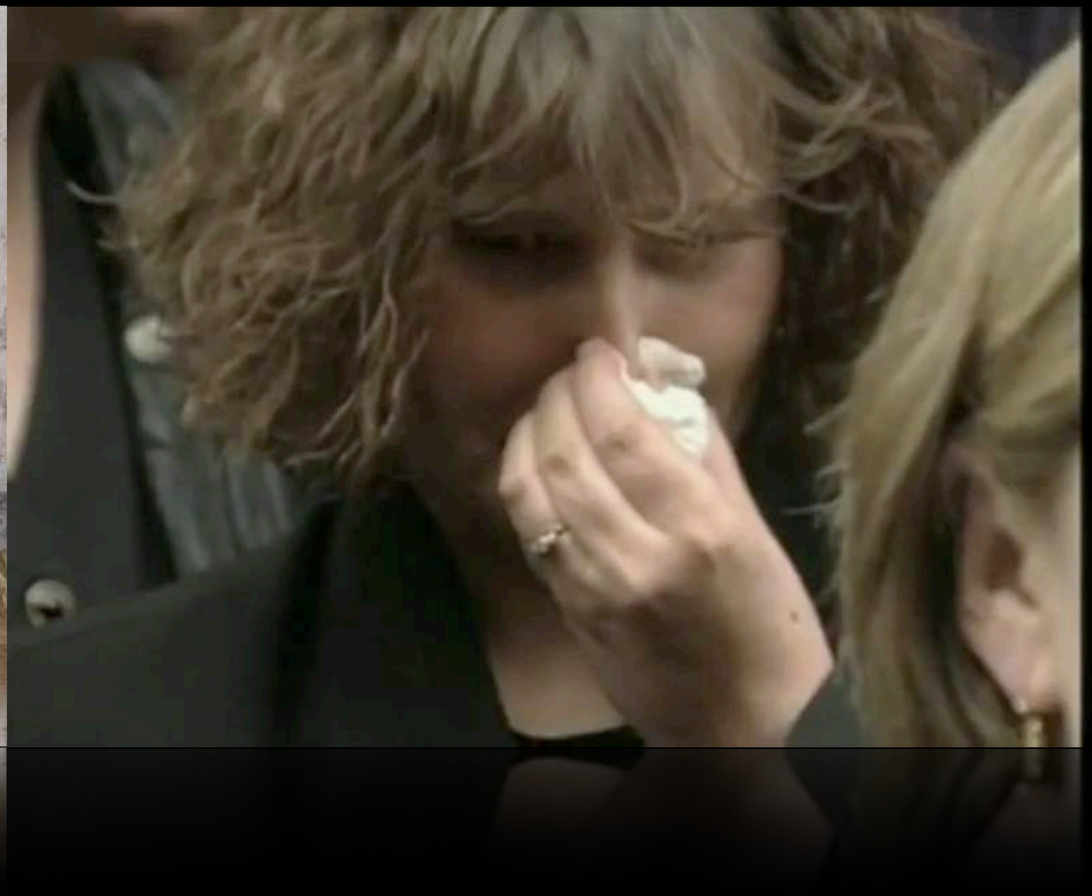

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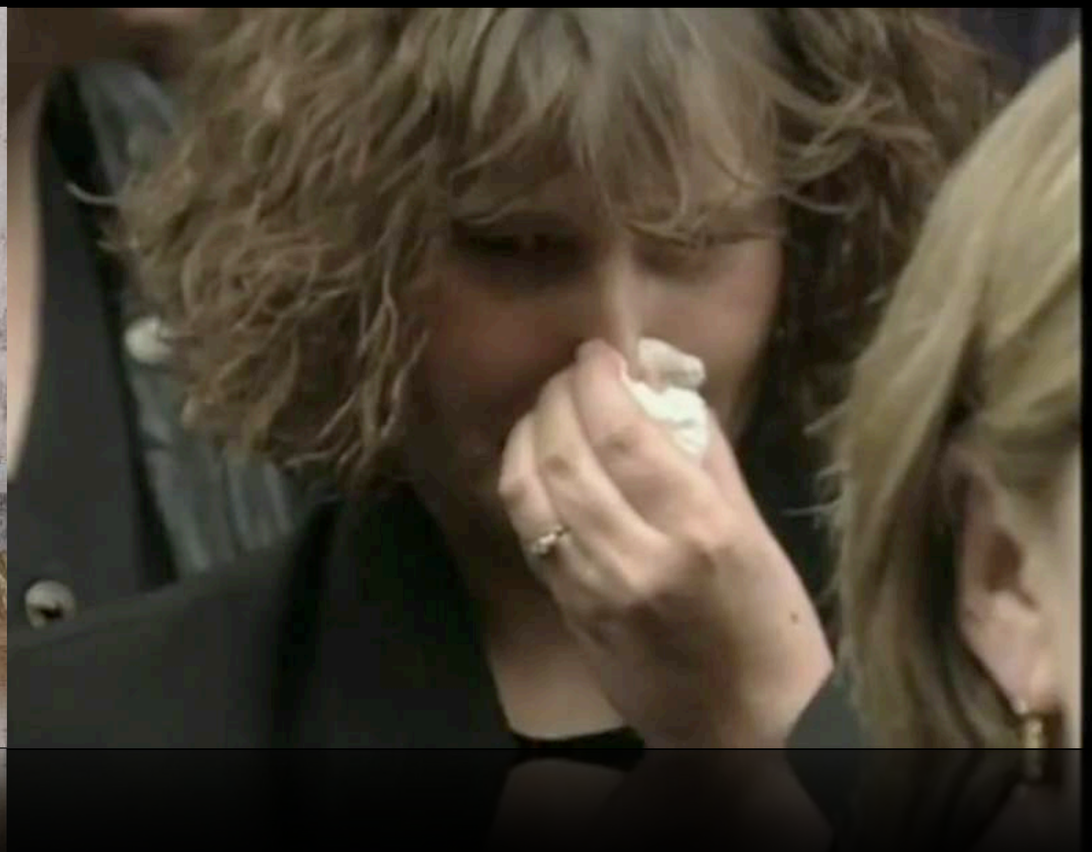

‘This is not a story of bad people, or those who did not care, or who wilfully harmed patients. Indeed they were dedicated and well motivated. But they lacked insight, their behaviour was flawed. There was poor teamwork and lack of leadership.’

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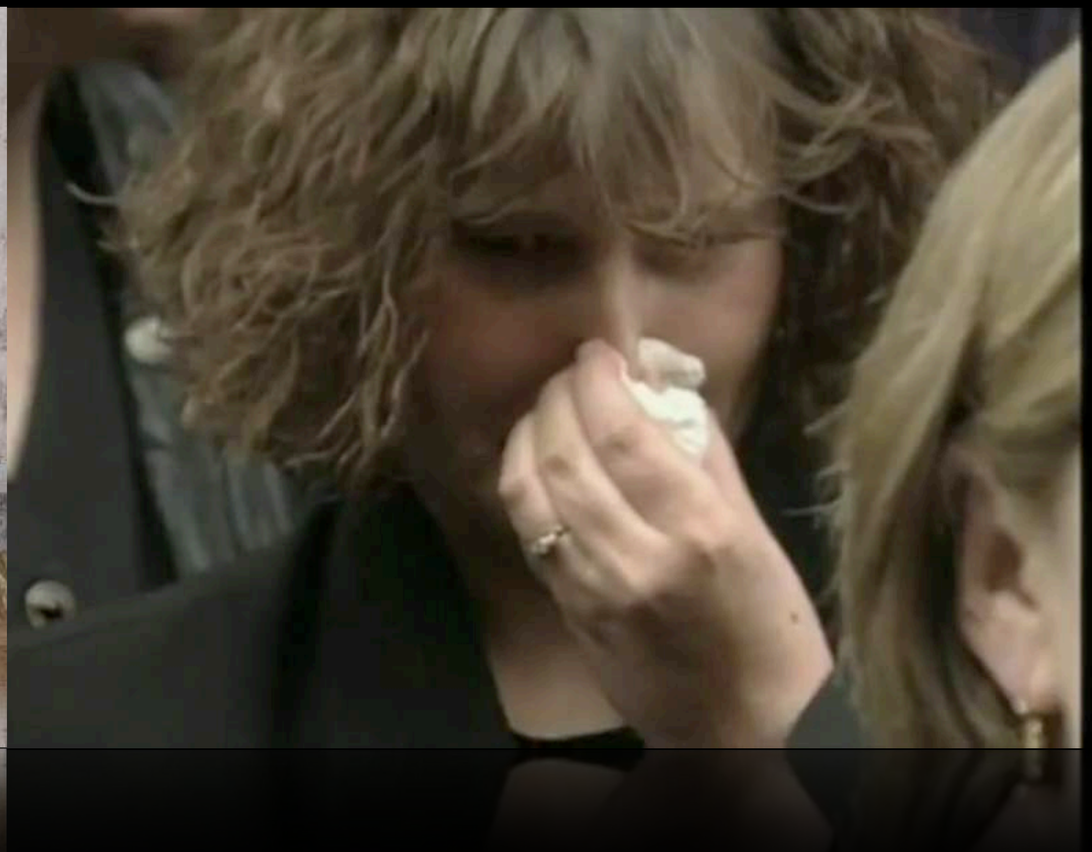

‘This is not a story of bad people, or those who did not care, or who wilfully harmed patients. Indeed they were dedicated and well motivated. But they lacked insight, their behaviour was flawed. There was poor teamwork and lack of leadership.’

It is a story of a breakdown of trust; of letting others down, and of terrible harm

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1970

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≈ 100
child
heart ops
per year

1970

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Mr James Wisheart

1970

1975

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Mr James Wisheart

investment from Avon Health Authority

1970

1975

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Mr James Wisheart

worst per capita provision in UK

BMJ

investment from Avon Health Authority

1970

1975

1984

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Mr James Wisheart

worst per capita provision in UK

BMJ

designated centre

investment from Avon Health Authority

1970

1975

1984

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Mr James Wisheart

1970

1975

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Mr James Wisheart

1970

1975

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Mr James Wisheart

Mr Janardan Dhasmana

1970

1975

1985

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Mr James Wisheart

Mr Janardan Dhasmana

100/year

435/year

1970

1975

1985

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1985 1988

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1985

1988

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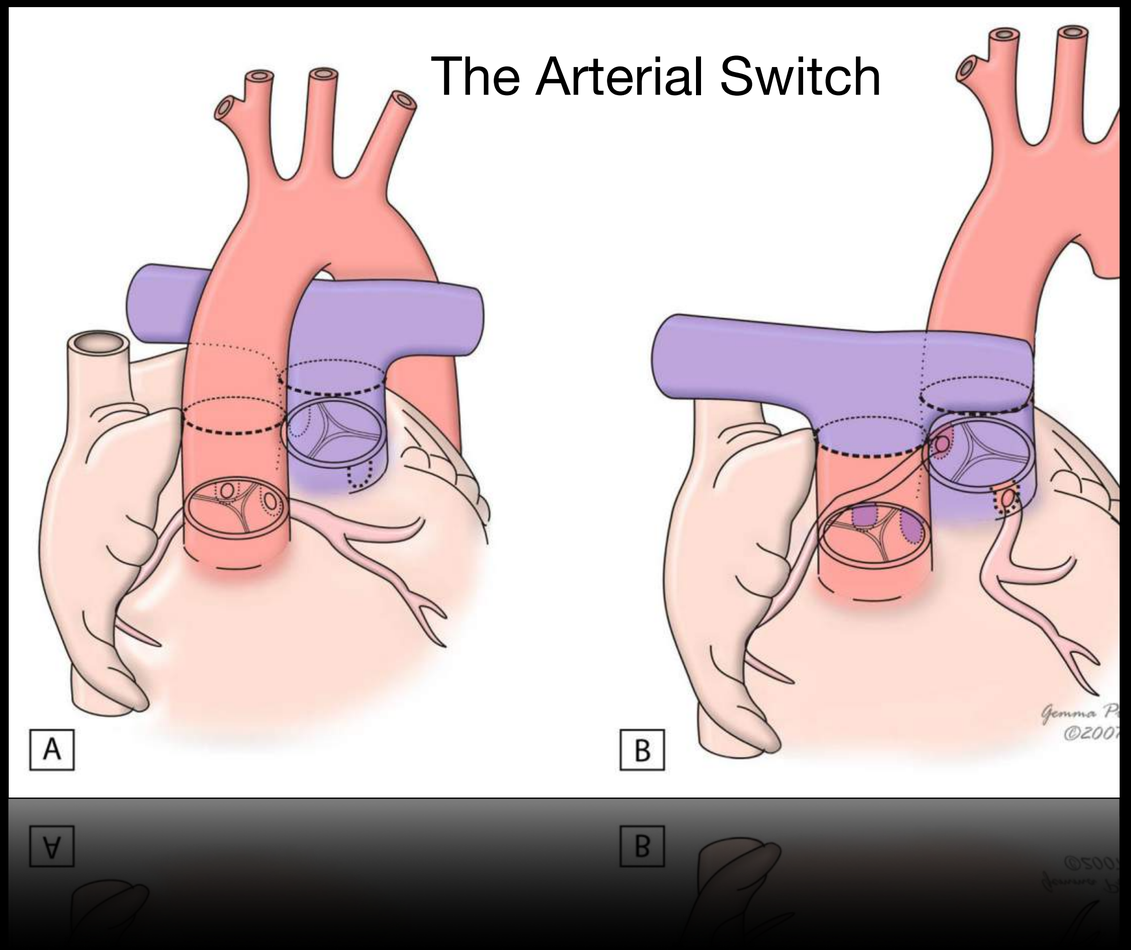
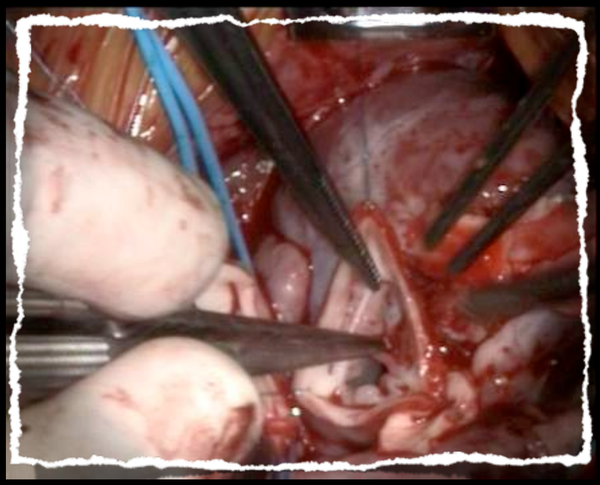
experience





1985

1988

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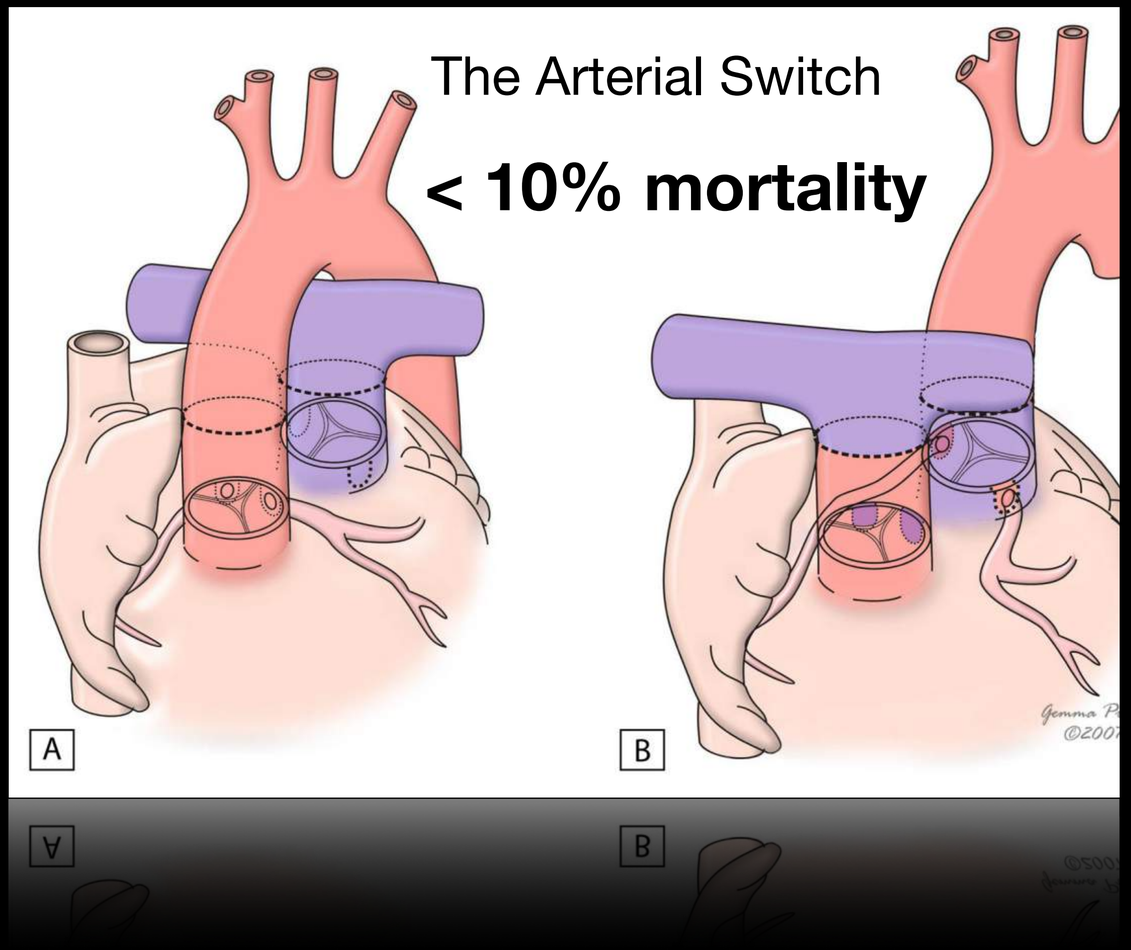
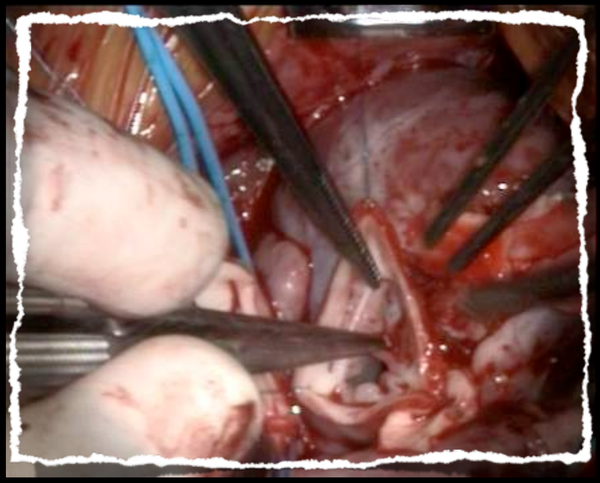
experience





1985

1988

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1985

1988

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Dr Stephen Bolsin

1985

1988

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Dr Stephen Bolsin

Bolsin immediately noticed that operations were taking much longer than he expected

1985 1988

Dr Stephen Bolsin

Bolsin immediately noticed that operations were taking much longer than he expected

Dhasmana carried out **38** switches, **20** died (**53%**)

1985 1988

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Mr James Wisheart

Asst Director of
Cardiac Surgery
Chairman of HMC

1989

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Bolsin audits results

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1994

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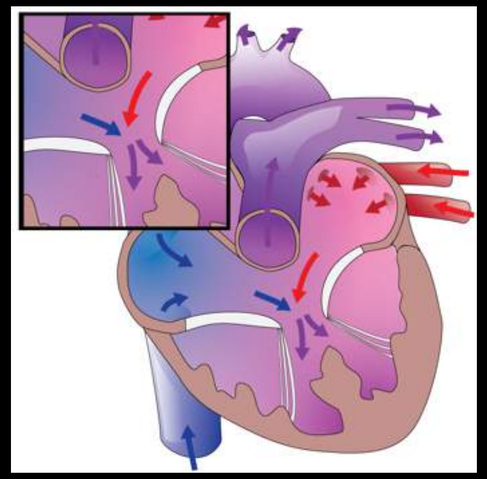

atrio-ventricular
septal defect

Asst Director of
Cardiac Surgery
Chairman of HMC

results under scrutiny

1989 1990

1994

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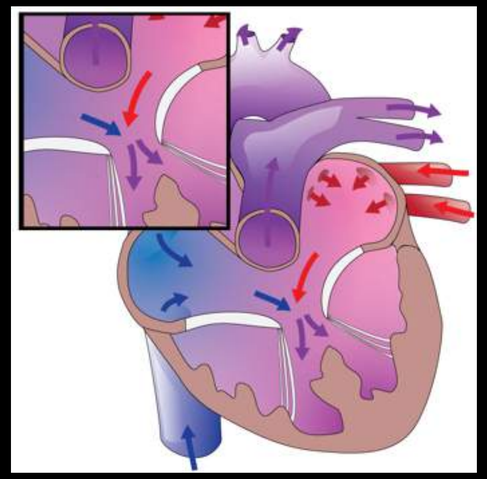
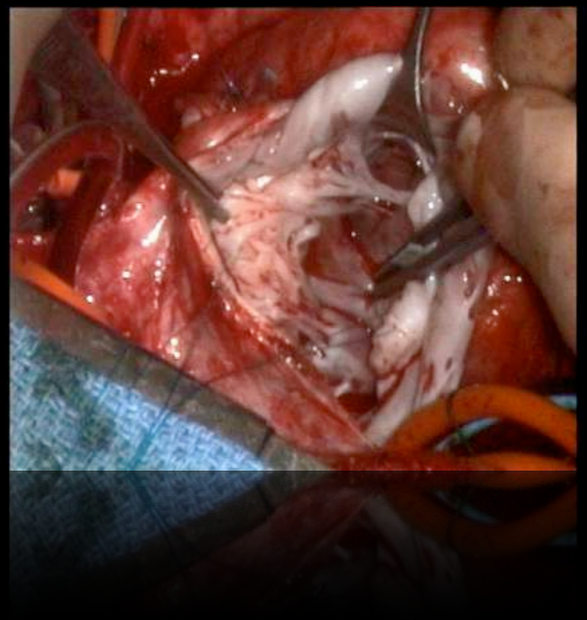


atrio-ventricular
septal defect



results under scrutiny

1989 1990

1994

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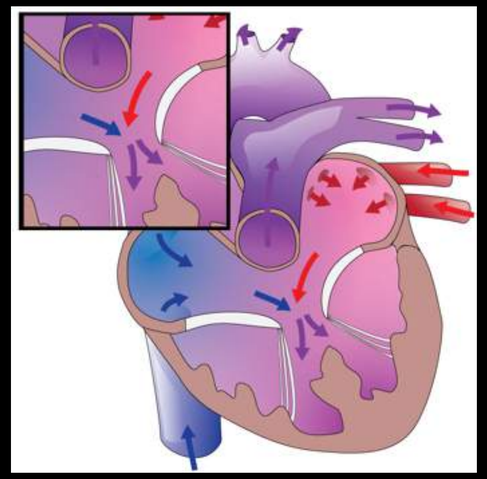
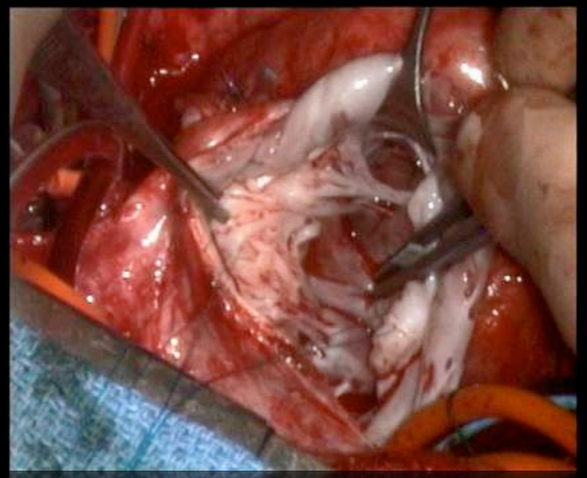


atrio-ventricular
septal defect



9/15 died (60%)

results under scrutiny

1989 1990

1994

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Chairman of HMC

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1994

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MJE approached to be new surgeon

1991

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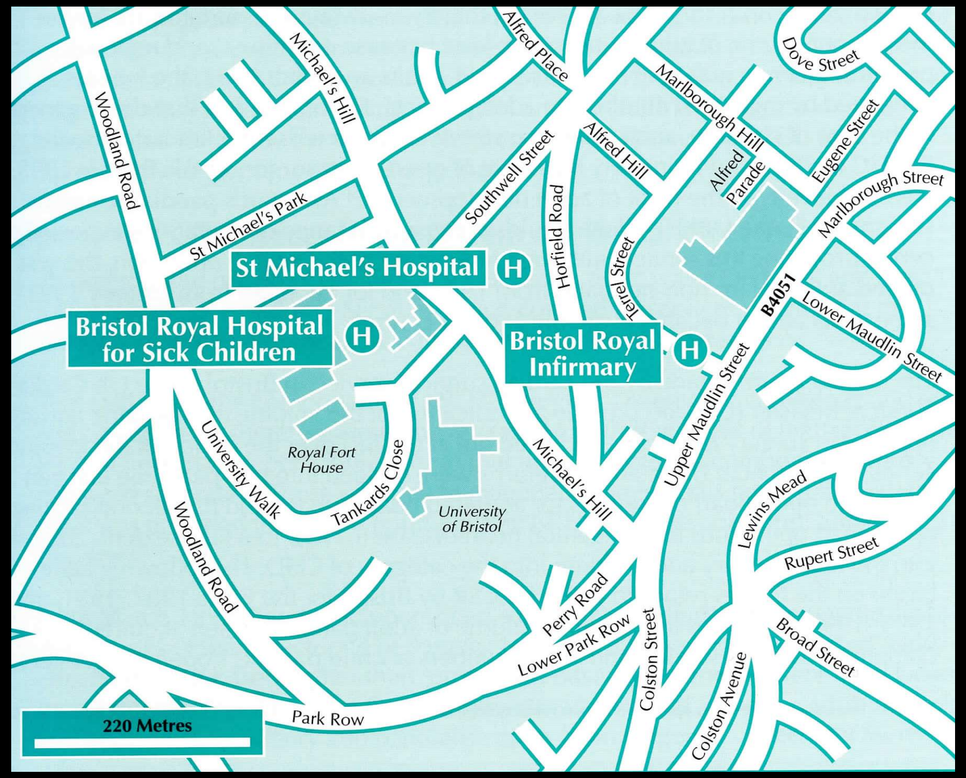
MJE approached to be new surgeon



1991

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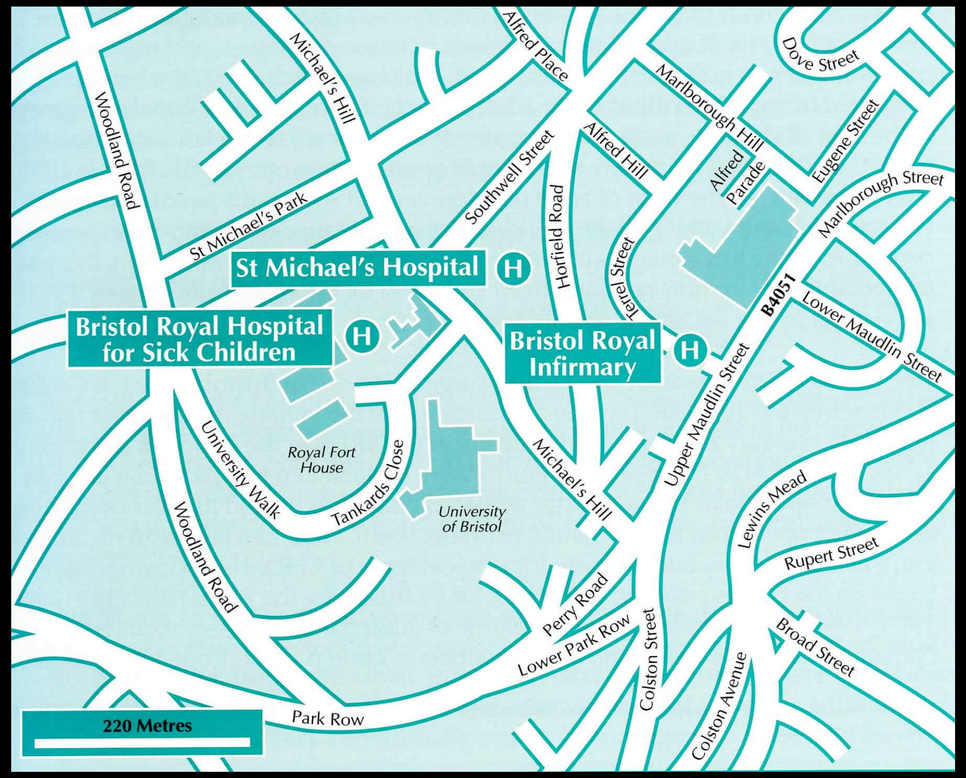
MJE approached to be new surgeon



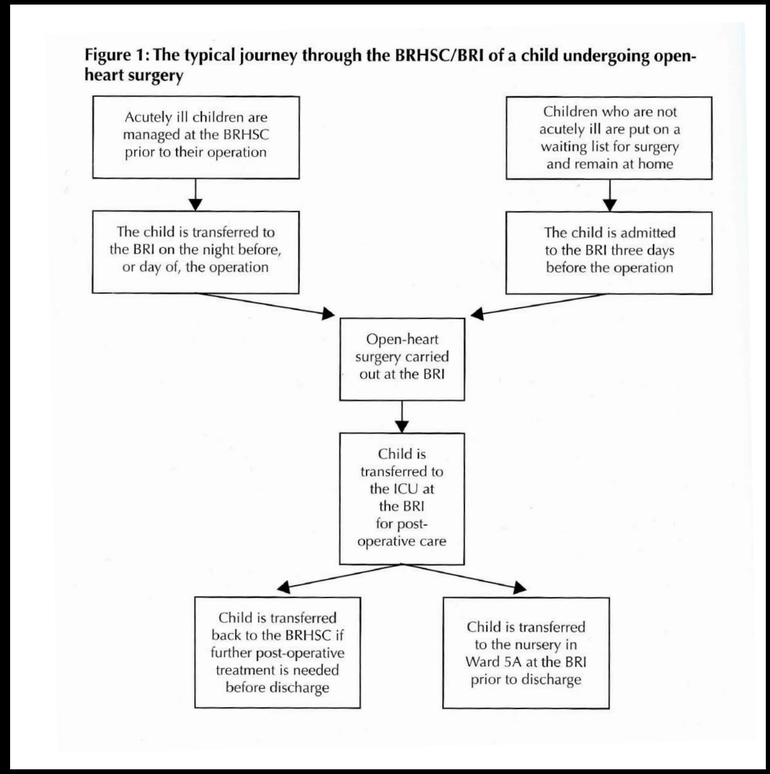


Figure 1: The typical journey through the BRHSC/BRI of a child undergoing open-heart surgery

1991

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MJE approached to be new surgeon

1991

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MJE approached to be new surgeon

NO

1991

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MJE approached to be new surgeon

“the split-site working and poor operating and ICU facilities are inefficient, archaic, inhibitory to progress and potentially dangerous”

1991

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MD of BRI

Bolsin audits results

1991 1992 1993

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MD of BRI

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MD of BRI

‘The Killing Fields’

Bolsin audits results

1991 1992 1993

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martin.elliott@gosh.nhs.uk

MD of BRI

‘The Killing Fields’

‘The Departure Lounge’

Bolsin audits results

1991 1992 1993

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MD of BRI

Dr John Roylance
CEO of BRI

‘The Killing Fields’

‘The Departure Lounge’

Bolsin audits results

1991 1992 1993

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Dr John Roylance
CEO of BRI

‘The Killing Fields’

‘The Departure Lounge’

Bolsin audits results

1991 1992 1993

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Bolsin informs DoH

1990 1991 1992 1993 1994 1995

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MD of Frenchay Hospital
Reports Anxieties to
Royal College of Surgeons

1990 1991 1992 1993 1994 1995

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1990 1991 1992 1993 1994 1995

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Stops doing switches

Anaesthetists and Prof of Surgery shown audit

1990 1991 1992 1993 1994 1995

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martin.elliott@gosh.nhs.uk

1990 1991 1992 1993 1994 1995

@ProfMJElliott

martin.elliott@gosh.nhs.uk

1994
Royal College of Surgeons
issues positive report

1990 1991 1992 1993 1994 1995

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Bolsin’s audit given
to DoH official,
who does not read it

1990 1991 1992 1993 1994 1995

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1995

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Joshua Loveday

1995

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Joshua Loveday

Dhasmana is encouraged to operate by his colleagues

1995

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Joshua Loveday

Dhasmana is encouraged to operate by his colleagues

He does operate, against the advice of DoH

1995

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Dhasmana is encouraged to operate by his colleagues

He does operate, against the advice of DoH

Joshua dies on the table

1995

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Dhasmana is encouraged to operate by his colleagues

He does operate, against the advice of DoH

Joshua dies on the table

Bristol Heart Babies Action Group

1995

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Bristol Heart Babies Action Group

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Bristol Heart Babies Action Group

1995

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Dr Stewart Hunter   Prof Marc de Leval

Bristol Heart Babies Action Group

1995

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Dr Stewart Hunter   Prof Marc de Leval

“the data available to us was weak, but there was considerable confusion in the organisation of ICU, and generally poor communication. The unit needs strengthening with new appointments”

Bristol Heart Babies Action Group

1995

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1995

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Wisheart stops operating
and
resigns as medical director

1995

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1995 1996 1997

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1995 1996 1997

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1995 1996 1997

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Bolsin resigns from NHS
and goes to Australia

1995 1996 1997

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GMC
begins
investigation

1995 1996 1997

@ProfMJElliott

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GMC
begins
investigation

Wisheart
retires

1995 1996 1997

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GMC
hearing
begins

1998

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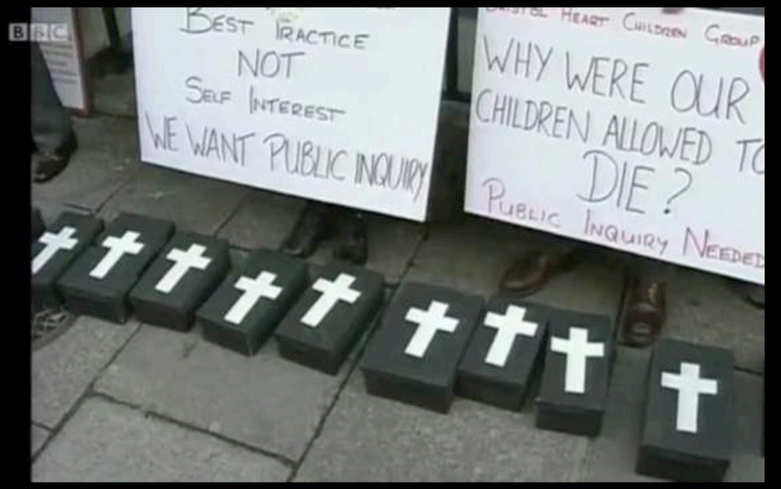

GMC
hearing
begins

1998

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surgeon
&
medical director

doctor
&
CEO

surgeon

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&
medical director

doctor
&
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&
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doctor
&
CEO

surgeon

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GMC hearing

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GMC hearing

“you murderer”

GMC hearing

“you murderer”

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struck off

struck off

suspended

@ProfMJElliott

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struck off

struck off

suspended

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struck off

struck off

suspended

- Frank Dobson announces Public Inquiry
- GMC guidelines issued
- litigation expected for 119 deaths and 47 cases of brain damage
- merit award system changed

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Where were the rest of the doctors?

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Mr Roger Henderson QC

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Mr Roger Henderson QC

"The reason that no cardiologist and no anaesthetist was in the frame was that the case which was unwieldy enough as it was would have become wholly unmanageable and hopelessly prolonged had any of them been charged. It took long enough as it was but would have taken even longer had others been charged".

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Mr Roger Henderson QC

"The reason that no cardiologist and no anaesthetist was in the frame was that the case which was unwieldy enough as it was would have become wholly unmanageable and hopelessly prolonged had any of them been charged. It took long enough as it was but would have taken even longer had others been charged".

"Again to try to avoid undue complexity and increased time, to focus on only two types of cardiac problem; eg ignoring cases of truncus arteriosus etc".

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Sir Robert Francis QC

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Sir Robert Francis QC

“Felt like emigrating after the hearing”

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Sir Robert Francis QC

"Felt like emigrating after the hearing"

"The apotheosis of the blame culture; someone had to be seen to pay"

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The data available to the GMC

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The data available to the GMC

Voluntary, unvalidated mortality data from UK Cardiac Surgical Register
paid for by the surgeons themselves

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The data available to the GMC

Voluntary, unvalidated mortality data from UK Cardiac Surgical Register
paid for by the surgeons themselves

- varying accuracy of reporting
- no risk stratification
- procedure based

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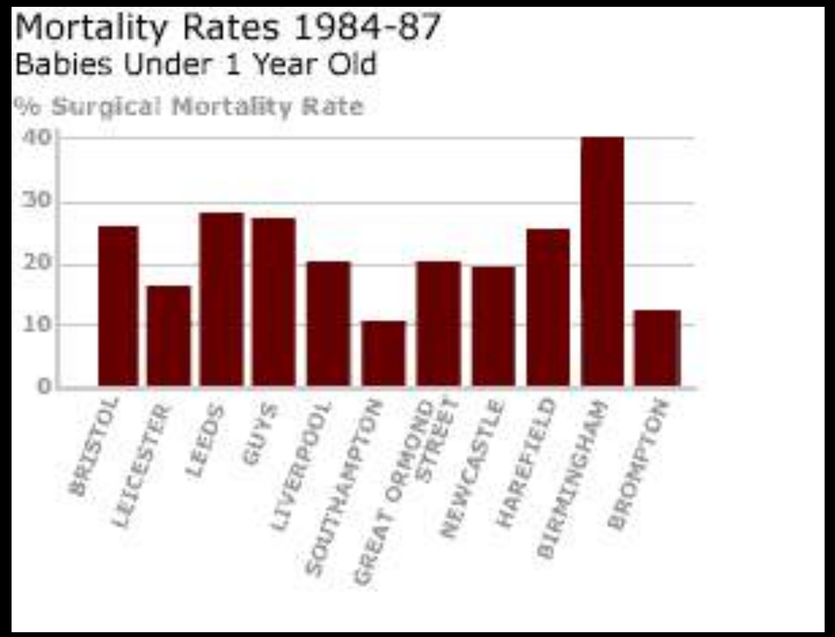

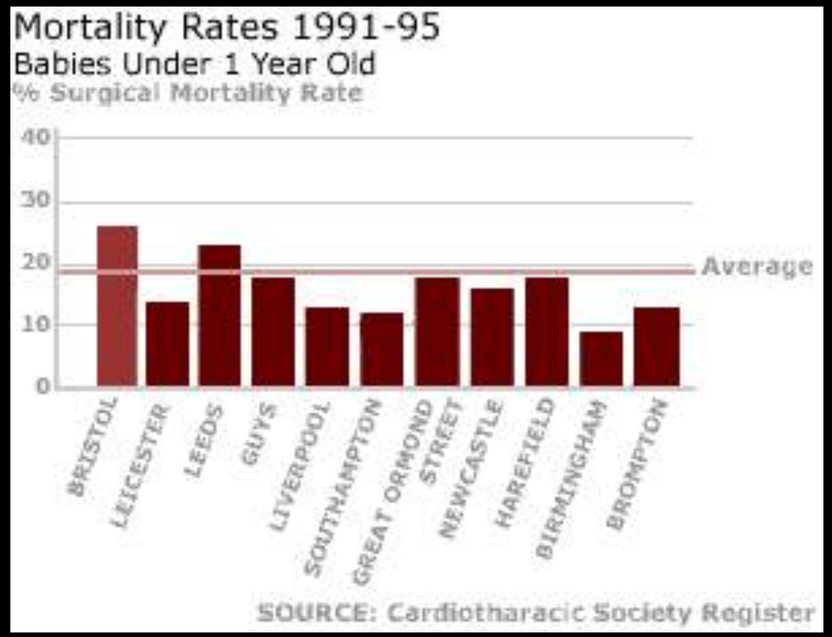

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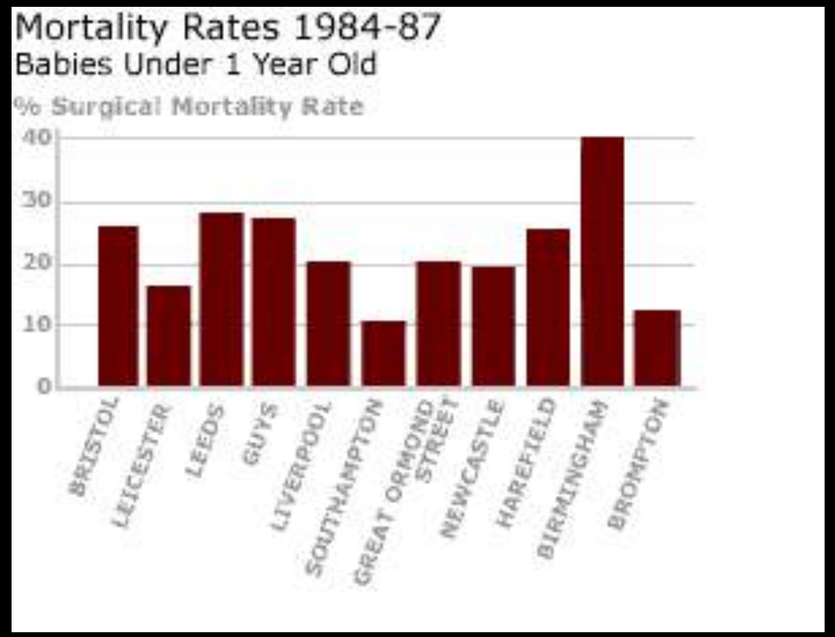
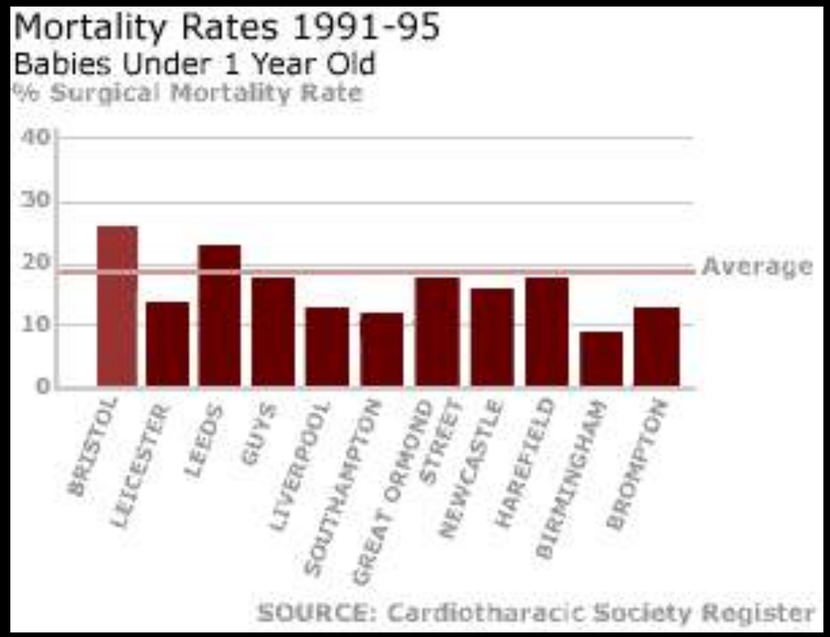


Bristol was not improving
at the same rate
as others



- varying accuracy of reporting
- no risk stratification
- procedure based

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BMJ. 1998 Jun 27; 316(7149): 1917–1918.

All changed, changed utterly

British medicine will be transformed by the Bristol case

Richard Smith, Editor

BMJ

BMJ

Richard Smith, Editor

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BMJ. 1998 Jun 27; 316(7149): 1917–1918.

All changed, changed utterly

British medicine will be transformed by the Bristol case

Richard Smith, Editor

BMJ

- mandatory individual mortality reporting
- RCS rapid response group
- 12 x increase in the suspension of doctors
- 18/199 cardiac surgeons under investigation

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Sir Ian Kennedy QC

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Sir Ian Kennedy QC

“It would have been much better to hold the public inquiry **before** any involvement of the GMC.

The **wider brief and more effective and open process** was better suited to explore the complex issues involved and to hear in detail the harrowing tales of the families involved”.

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£15,000,000

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Respect and Honesty

Involving patients

Keeping them informed

Improved communication

Improved support services

Better consent Processes

Easier patient feedback

Better complaint responses

No-fault compensation system

A Health Service that is well led

Improved regulation of quality and safety

Better and clearer local management, including of doctors

Sir Ian Kennedy QC

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Sir Ian Kennedy QC

“There were no agreed national standards as to what amounted to good quality care for paediatric cardiac surgery - no agreed measure or benchmark”.

“There was confusion in the NHS from top to bottom as to where responsibility lay for monitoring the quality of paediatric cardiac surgery”.

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Sir Ian Kennedy QC

theguardian

'There's no incentive to admit error, only to cover up'

In an exclusive newspaper interview, Clare Dyer talks to Ian Kennedy, the law professor who headed the inquiry into the heart-surgery baby scandal at Bristol Royal Infirmary

Clare Dyer

Tuesday 24 July 2001 15.30 BST

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“Doctors, surgeons battling against difficult circumstances, with inadequate resources in a **culture where the finding of scapegoats appears to be put before the finding of solutions**”

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BMJ. 2001 Jul 28; 323(7306): 179–180.

One Bristol, but there could have been many

Radical change is essential but hard to achieve

Richard Smith, editor

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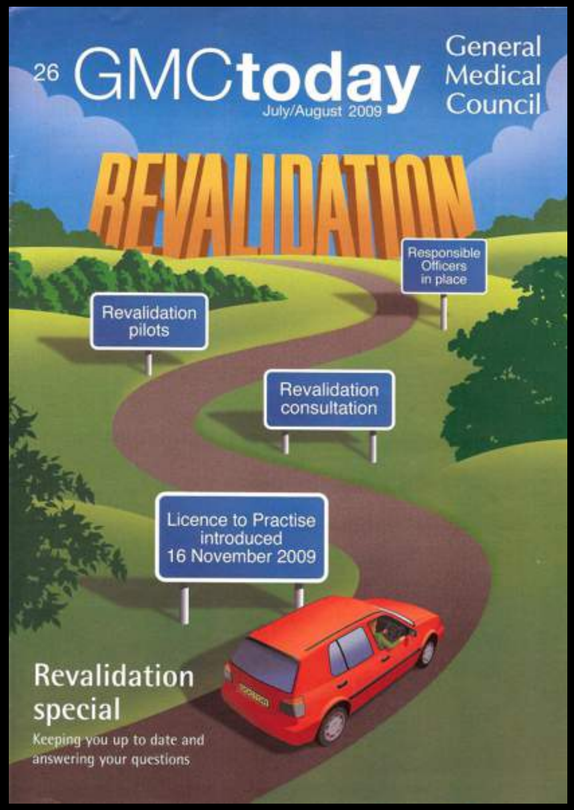

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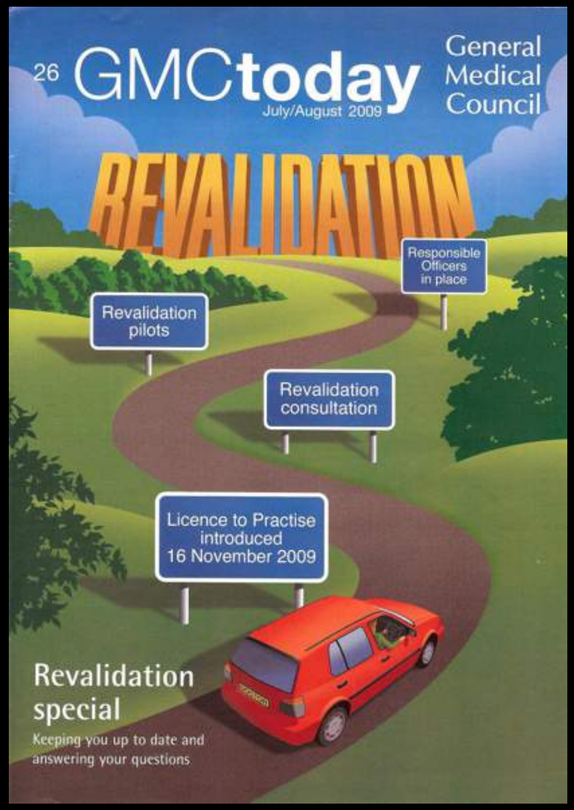

120 doctors have had their licences revoked since 2012

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Sir Ian Kennedy QC
on Children's Heart Surgery in General

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Sir Ian Kennedy QC
on Children's Heart Surgery in General

there were too many cardiac surgery centres in the UK, and complex surgery should be done in centres of excellence, and not in centres which do not meet a defined minimum number of procedures.

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Sir Ian Kennedy QC
on Children's Heart Surgery in General

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"Considerations of ease of access to a hospital should not be taken into account when considering whether cardiac surgery should be undertaken there".

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health care is an **information economy**

data

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Prof Jim Monro
on behalf of
STCVS of GB

2003

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Prof Jim Monro
on behalf of
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what is the optimum
size and volume?

2003

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on behalf of
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Recommended in 2003 that a unit should do no less than 300 relevant operations per year.

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At the time that would have meant that 50% of the units in the UK would have closed.

no change in NHS governance, and no action taken

2003

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Realpolitik

2001 2003

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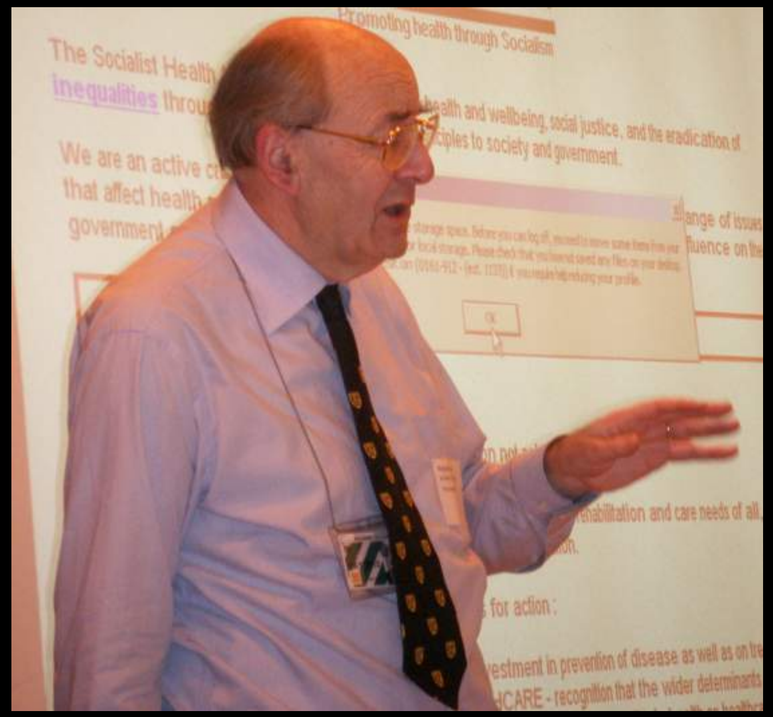
Realpolitik



Richard Taylor MBE FRCP

2001 2003

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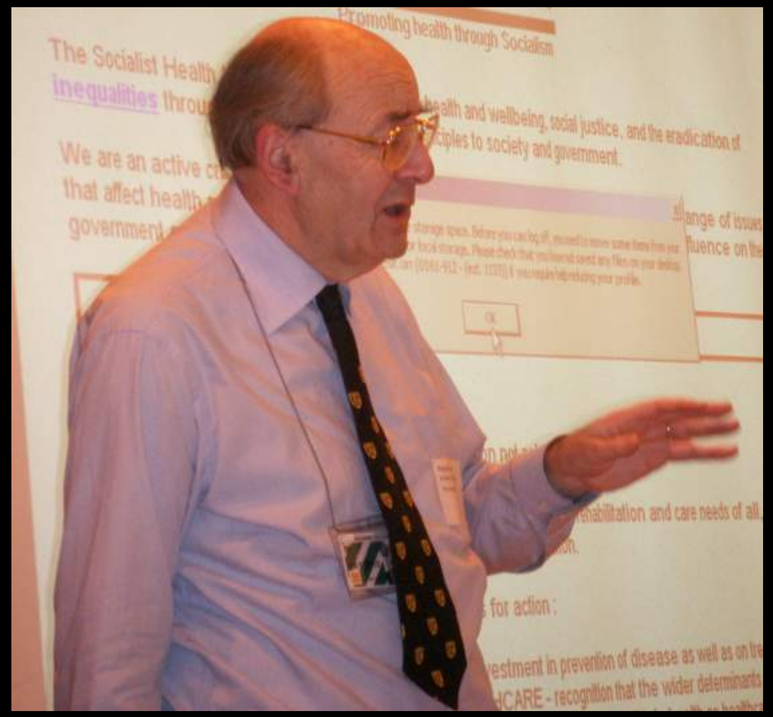
Realpolitik



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won over sitting labour junior minister,
with a majority of 18,000

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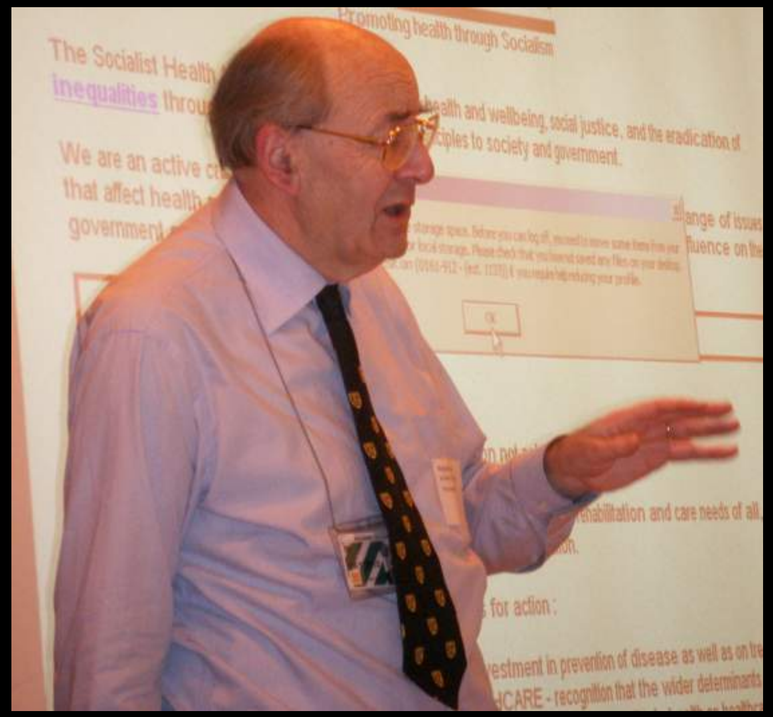

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The Kidderminster Effect

2001 2003

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Realpolitik

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Realpolitik

The majority of my profession was very anxious for change

2004

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Realpolitik

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Roger Boyle

Sheila Shribman

2006

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Roger Boyle

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Consensus meeting; the then current configuration was '**unsustainable**'

2006

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Consensus meeting

ALL units sent representatives

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Consensus meeting

ALL

ALL agreed that the number of units should fall from **11 to 7**

2006

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Consensus meeting

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ALL recognised that their unit might be a ‘victim’

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ALL agreed on the need for change

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ALL agreed that the number of units should fall from **11 to 7**

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ALL agreed on the need for change

2006

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Roger Boyle

Sheila Shribman

The Royal College of Surgeons called for concentration of expertise

2007

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2008

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Sir Bruce Keogh
Medical Director
NHS England

2008

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The Safe & Sustainable Review

Sir Bruce Keogh
Medical Director
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2008

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The Safe & Sustainable Review

Sir Bruce Keogh
Medical Director
NHS England

"failure to reorganise paediatric cardiac services would be
a stain on the soul of the speciality"

2008

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The Safe & Sustainable Review

Sir Bruce Keogh
Medical Director
NHS England

31 surgeons, of which 10 purely paediatric,
in 11 centres doing a total of 2300 cases per year

2008

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The Safe & Sustainable Review

Sir Bruce Keogh
Medical Director
NHS England

31 surgeons, of which 10 purely paediatric,
in 11 centres doing a total of 2300 cases per year

Some centres were doing < 100 cases,
and only had 2 surgeons

2008

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The Safe & Sustainable Review

Sir Bruce Keogh
Medical Director
NHS England

Centralisation was Working

2008

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Who makes the decision?

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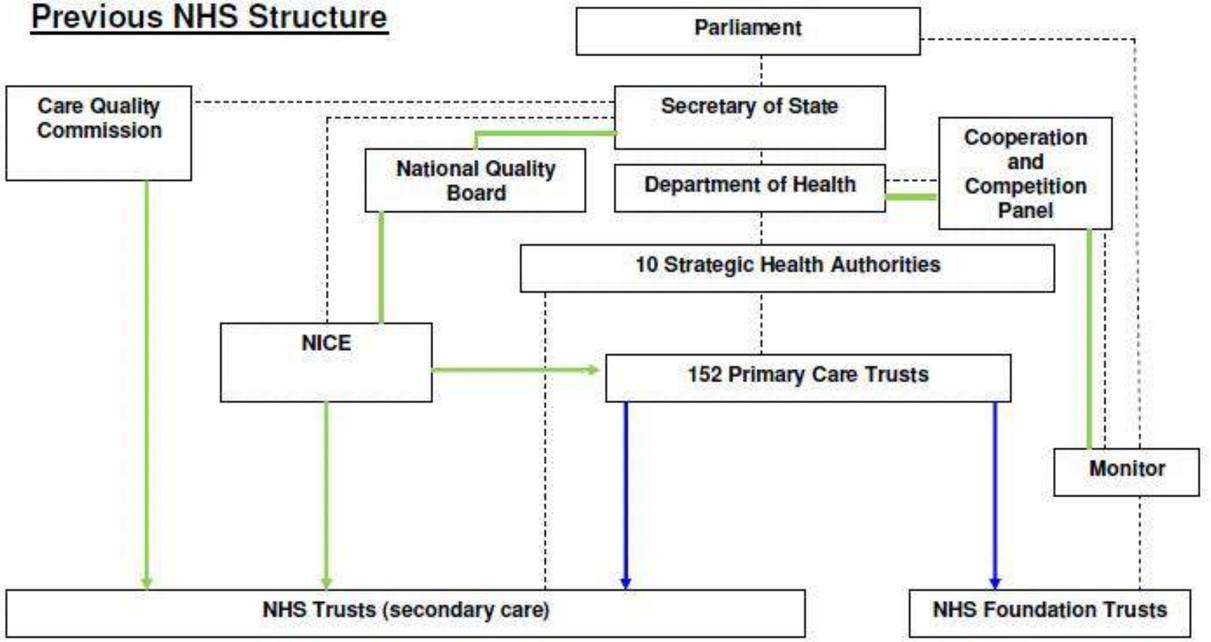
Previous NHS Structure



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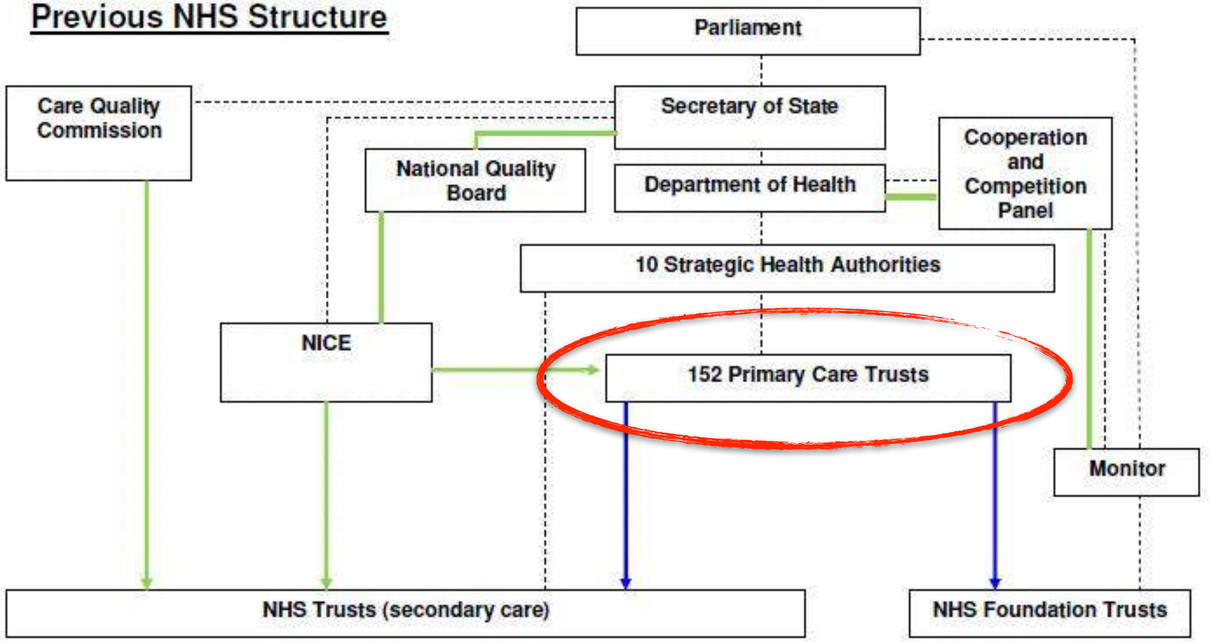

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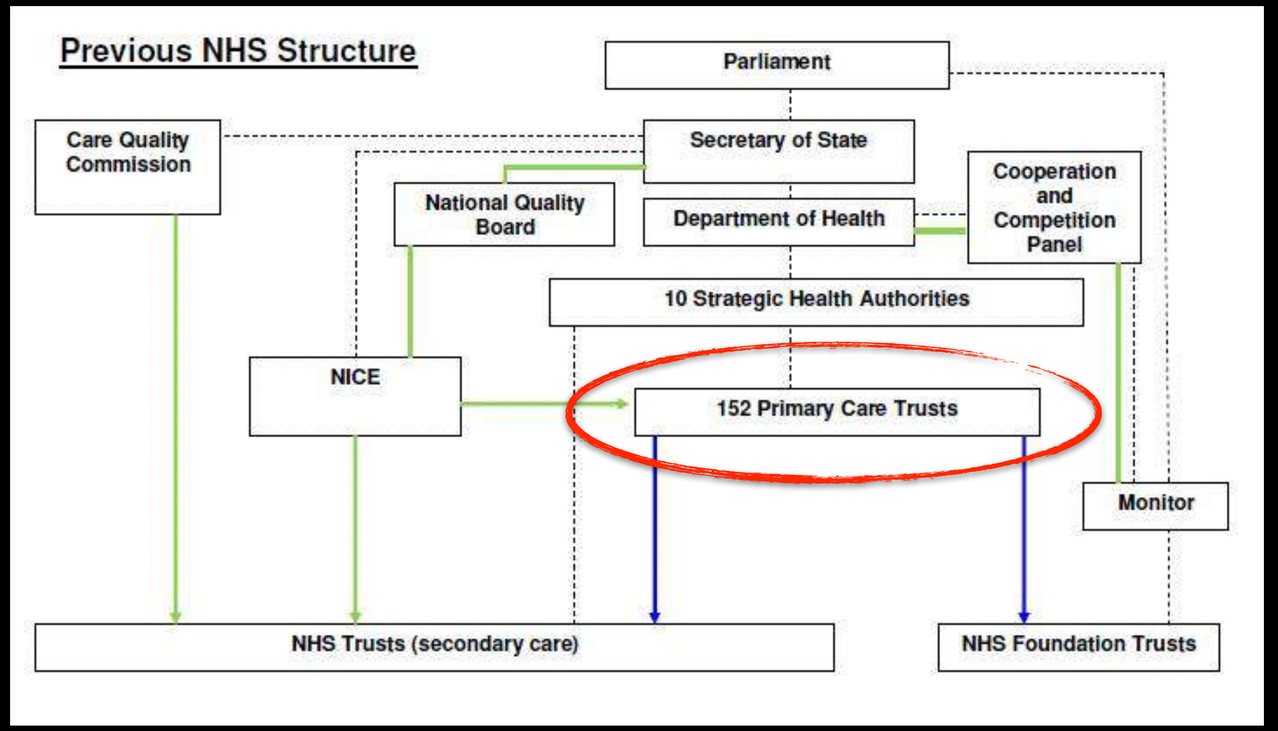

Joint Committee of PCTs (JCPCT)

Steering Group

Standards Group

Admin Team

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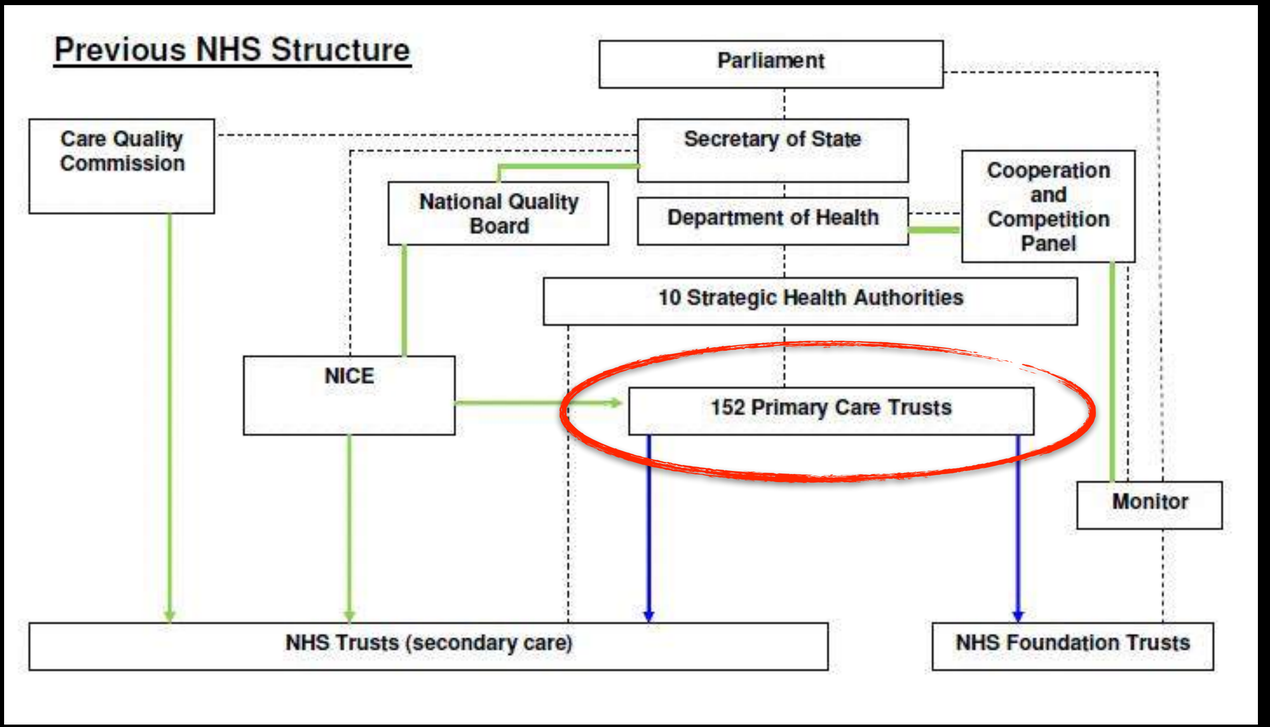

Joint Committee of PCTs (JCPCT)

Steering Group
Standards Group
Admin Team

External Advisors

KPMG (demographics, etc)
Ipsos Mori

Review Group

Sir Ian Kennedy
Prof James Monro

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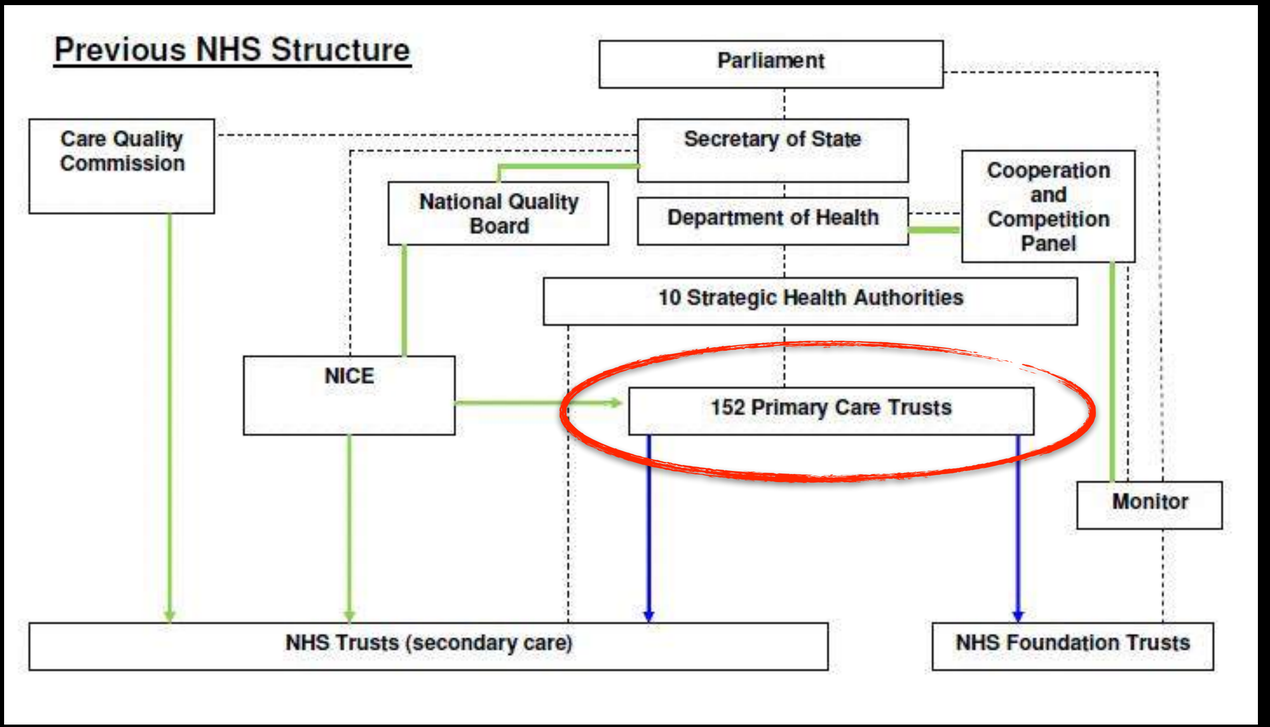

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Professional Comms Team

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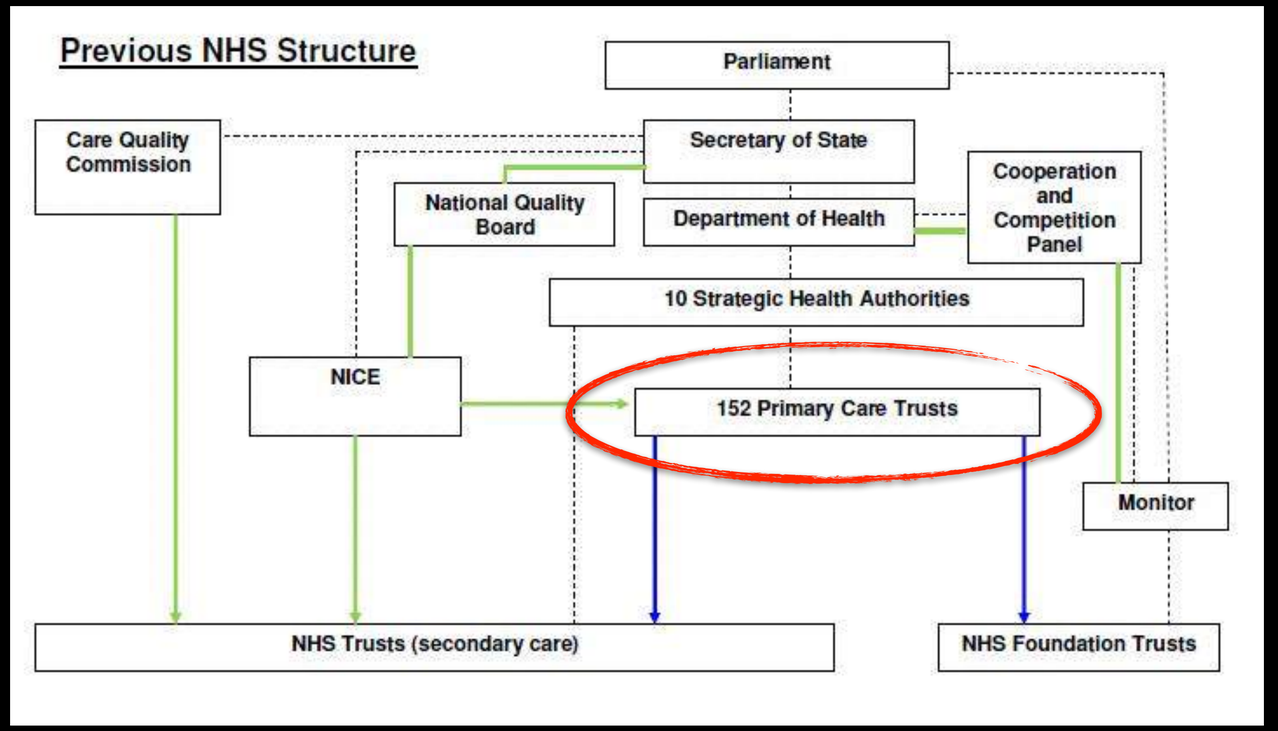
Local
Oversight
& Scrutiny
Committees



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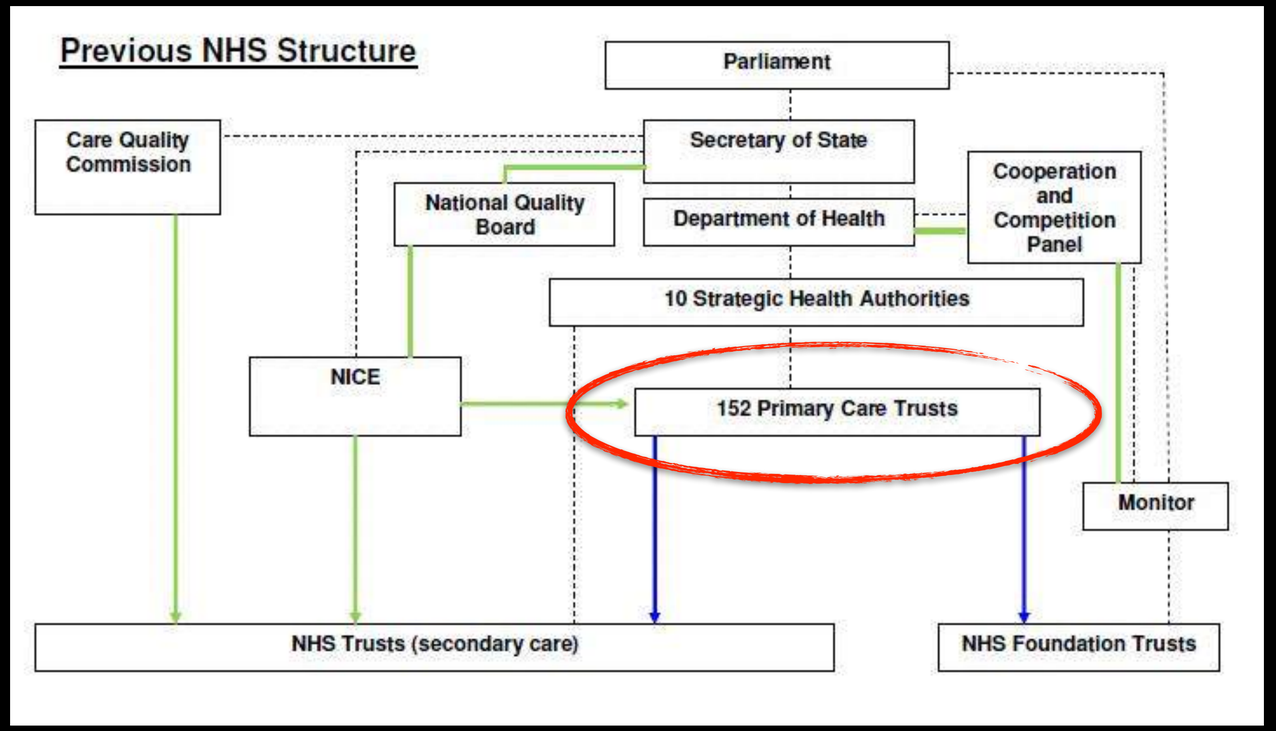
Local Oversight & Scrutiny Committees



Judicial Review of Process

Joint Committee of PCTs (JCPCT)

Steering Group
Standards Group
Admin Team

External Advisors

KPMG (demographics, etc)
Ipsos Mori

Review Group

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Prof James Monro

Professional Comms Team

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The Need for Change; Children's heart surgery was becoming increasingly complex

- Services had developed on an ad hoc basis; there was a need for a planned approach for England and Wales
- **Surgical expertise (31 surgeons) was spread too thinly** over 11 surgical centres
- Some centres were reliant on one or two surgeons and **could not deliver a safe 24h emergency service**
- **Smaller centres are vulnerable** to sudden and unplanned closure
- Current a**rrangements were inequitable** as was too much variation in the expertise available from centres
- **Fewer surgical centres were needed** to ensure that surgical and medical teams were seeing a sufficient number of children to maintain and develop their specialist skills
- Available research evidence identified **a relationship between higher-volume surgical centres and better clinical outcomes**
- Having a larger and varied caseload would mean that **larger centres are best placed to recruit and retain** new surgeons and plan for the future
- The delivery of non-surgical cardiology care for children in local hospitals was inconsistent; strong leadership was thought to be required from surgical centres to develop expertise through **regional and local networks**
- **Increasing the national pool of surgeons was not considered the answer**, as this would result in individual surgeons performing fewer surgical centres and increase the risk of occasional surgical practice

The 'Need for Change Document' also predicted significant benefits if the change was carried through:-

- **Better result**s in the surgical centres with fewer deaths and complications following surgery
- **Better, more accessible diagnostic services** and follow up treatment delivered closer to home within regional and local networks
- **Reduced waiting times** and cancelled operations

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- **Reduced waiting times** and cancelled operations
- **Improved communication** between parents and all of the services in the network that see their child
- **Better training for surgeons** and their teams to ensure the sustainability of the service
- A trained **workforce expert in the care and treatment of children** and young people with congenital heart disease
- Centres at the forefront of modern working practices and innovative technologies that are **leaders in research and development**
- A network of specialist centres **collaborating in research and clinical development**, encouraging the sharing of knowledge across the network

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ALMOST THE SAME AS KENNEDY A DECADE EARLIER

Secretary of State's criteria for reconfiguration of NHS services

- support from GP Commissioners
- strong public and patient engagement
- a clinical evidence base
- developed and supported patient choice

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Secretary of State's criteria for reconfiguration of NHS services

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unique and complete support from all professional and national lay bodies

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The Largest and Most Extensive Public Consultation in NHS History

£6,000,000

75,000 responses

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£6,000,000

4 months in 2011

Videos laying out case

234 page, multilingual publication

Website with FAQs

Ipsos Mori questionnaire

‘Town-Hall’ meetings

Focus Groups

75,000 responses

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Kennedy and Monro Review

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Kennedy and Monro Review

visited and scored all centres against the newly defined standards

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Kennedy and Monro Review

visited and scored all centres against the newly defined standards

"During the current assessment process I and my colleagues on the panel found many examples of commendably high commitment and dedication by talented NHS staff delivering congenital cardiac services.

But we **found exemplary practice to be the exception** rather than the rule.

Mediocrity must not be our benchmark for the future."

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The Decision

The Decision

made 4th July 2012 (in public) againts a decision making business case

@ProfMJElliott

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The Decision

made 4th July 2012 (in public) agains a decision making business case

de-designate Leeds, Leicester, Oxford and Royal Brompton

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The Decision

made 4th July 2012 (in public) agains a decision making business case

de-designate Leeds, Leicester, Oxford and Royal Brompton

reduce the number of centres to **7**

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The Decision

made 4th July 2012 (in public) agains a decision making business case

de-designate Leeds, Leicester, Oxford and Royal Brompton

reduce the number of centres to **7**

Title: Treating CHD
Source: ***The Times (London, England)***. (July 6, 2012): Opinion and Editorial: p20.
Document Type: Brief article, Letter to the editor
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http://www.thetimes.co.uk
Full Text:

Sir, This week marked an important turning point in the future care of children with congenital heart disease (CHD) in England. We strongly believe that the decision taken by the Joint Committee of Primary Care Trusts (**JCPCT**) will improve clinical outcomes and help to save more children's lives in the future.

Maintaining the status quo was simply not an option. For too long surgical expertise has been spread too thinly across too many hospitals, and services need to be better co-ordinated to deliver expert care closer to where families live. The decision will mean that children's heart surgery will be provided in fewer larger centres with the expertise and volume of cases to ensure that outcomes for children improve. New congenital heart networks of care will be developed to ensure that services for children are more joined up, meet new national quality standards and deliver better monitoring of outcomes, allowing for services to be continually reviewed and improved.

We have stood firmly behind this review as we believe it will create a more sustainable service that is safe for the future.

It is vital that we now move forward and make sure that the process of change is embraced with no delays. Our organisations will help to ensure these changes are implemented so that children have access to world-class care in the future. professor terence stephenson Academy of Medical Royal Colleges dr peter carter Chief Executive and General Secretary, Royal College of Nursing dr hilary cass President, Royal College of Paediatrics and Child Health professor norman williams President, Royal College of Surgeons james roxburgh President, Society for Cardiothoracic Surgery in Great Britain and Ireland dr tony salmon President, British Congenital Cardiac Association

Wholehearted support from the Presidents of ALL the Royal Colleges

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de-designated units fought back

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de-designated units fought back

Judicial Review from the Brompton

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lost on appeal, legal cost to NHS £2,000,000

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Judicial Review from the Leeds SoS Ltd

won on legal technicality, appeal planned

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de-designated units fought back

Jeremy Hunt instructed
the Independent Reconfiguration Panel
to review the process

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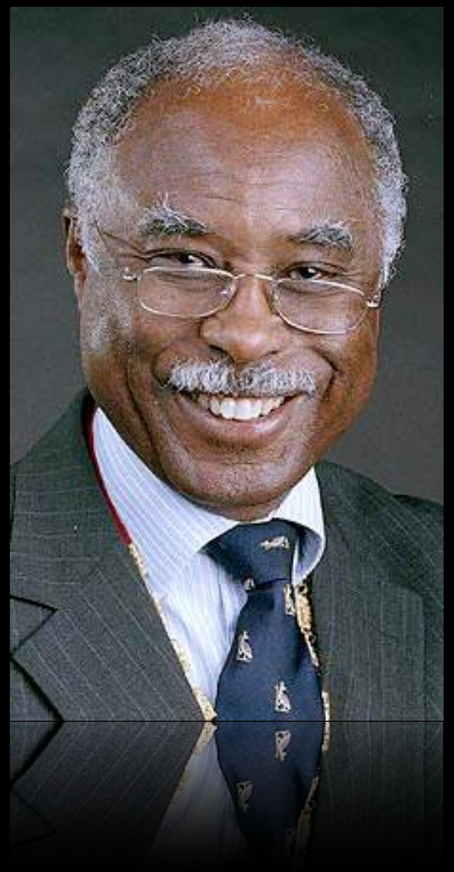

The **IRP**, Chaired by Baron Ribeiro

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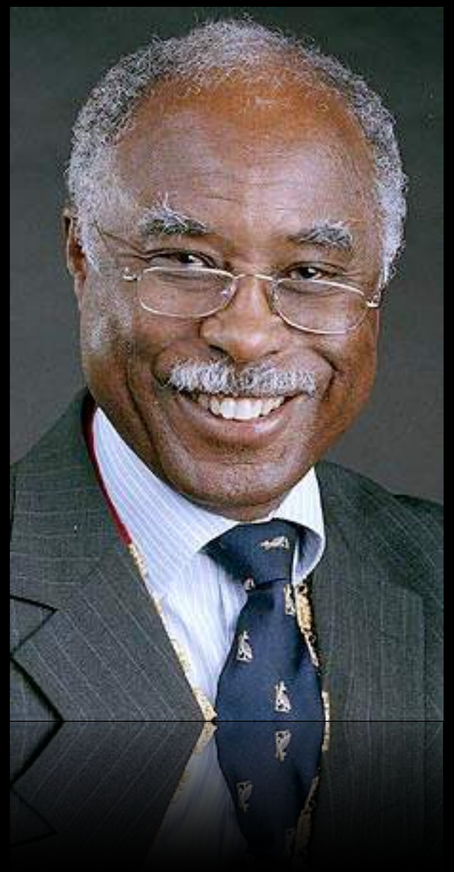

The **IRP**, Chaired by Baron Ribeiro

experts in hospital reconfiguration
NHS managers
public engagement specialists
no experts from the specialty

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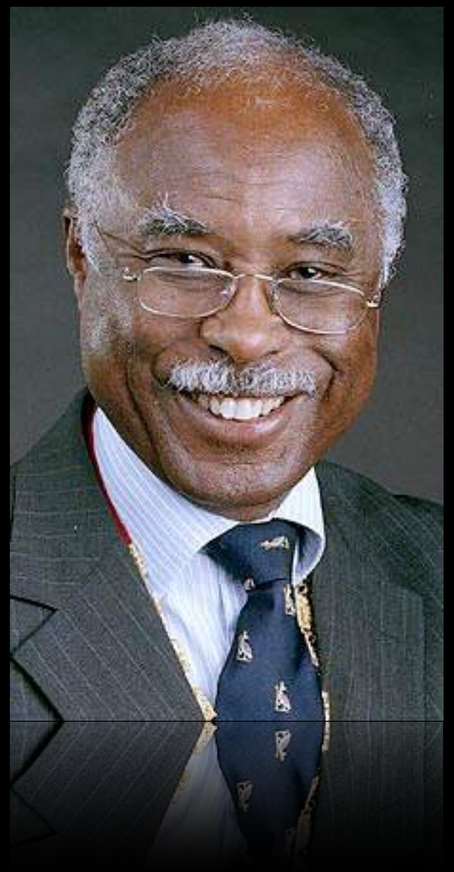

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5 month Review

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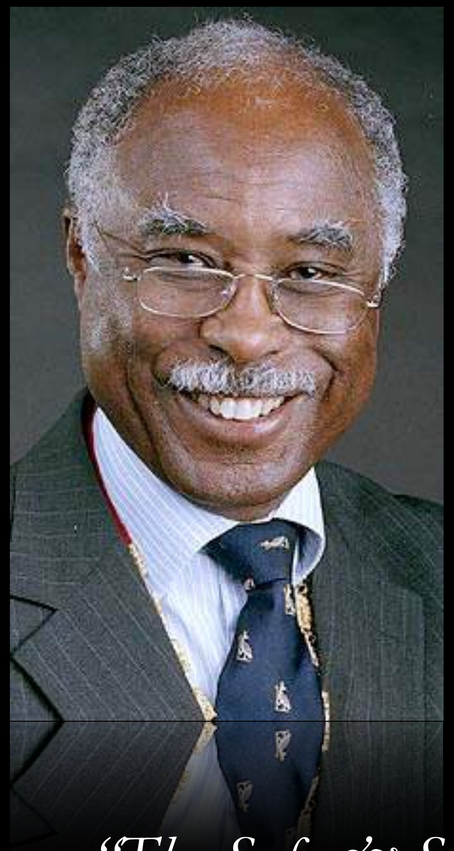

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5 month Review

"The Safe & Sustainable review was based on a flawed analysis of the impact of incomplete proposals"

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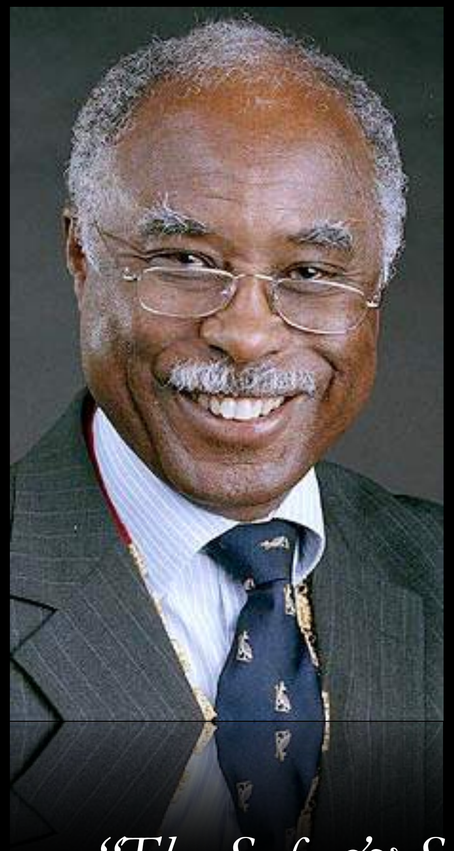

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5 month Review

"The Safe & Sustainable review was based on a flawed analysis of the impact of incomplete proposals"

"I therefore accept their recommendation that the proposals cannot go ahead in their current form and am **suspending the review today***"*

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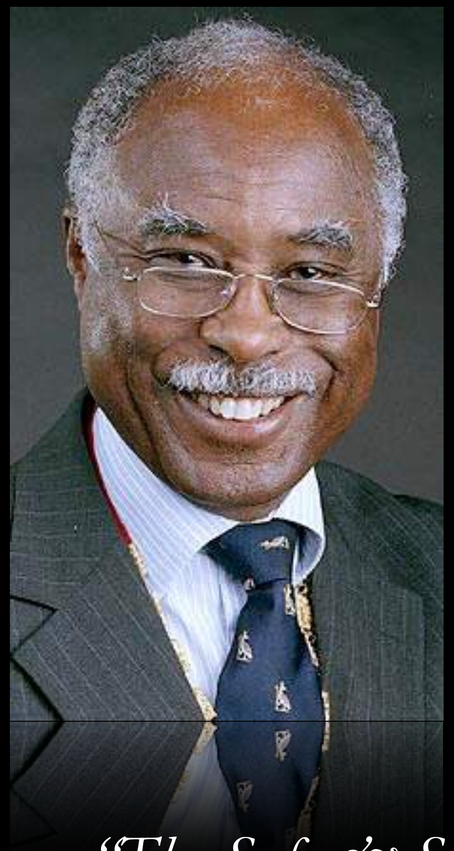

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no experts from the specialty

5 month Review

12 years after Kennedy

"The Safe & Sustainable review was based on a flawed analysis of the impact of incomplete proposals"

"I therefore accept their recommendation that the proposals cannot go ahead in their current form and am **suspending the review today***"*

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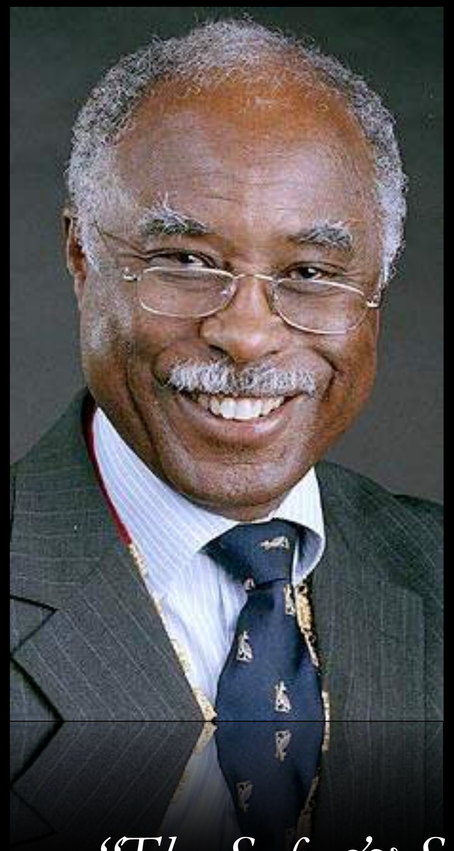

The **IRP**, Chaired by Baron Ribeiro

experts in hospital reconfiguration
NHS managers
public engagement specialists
no experts from the specialty

5 month Review

12 years after Kennedy

"we need to get on with this"

"The Safe & Sustainable review was based on a flawed analysis of the impact of incomplete proposals"

"I therefore accept their recommendation that the proposals cannot go ahead in their current form and am **suspending the review today***"*

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A New Review

http://www.england.nhs.uk/2013/06/28/john-holden/

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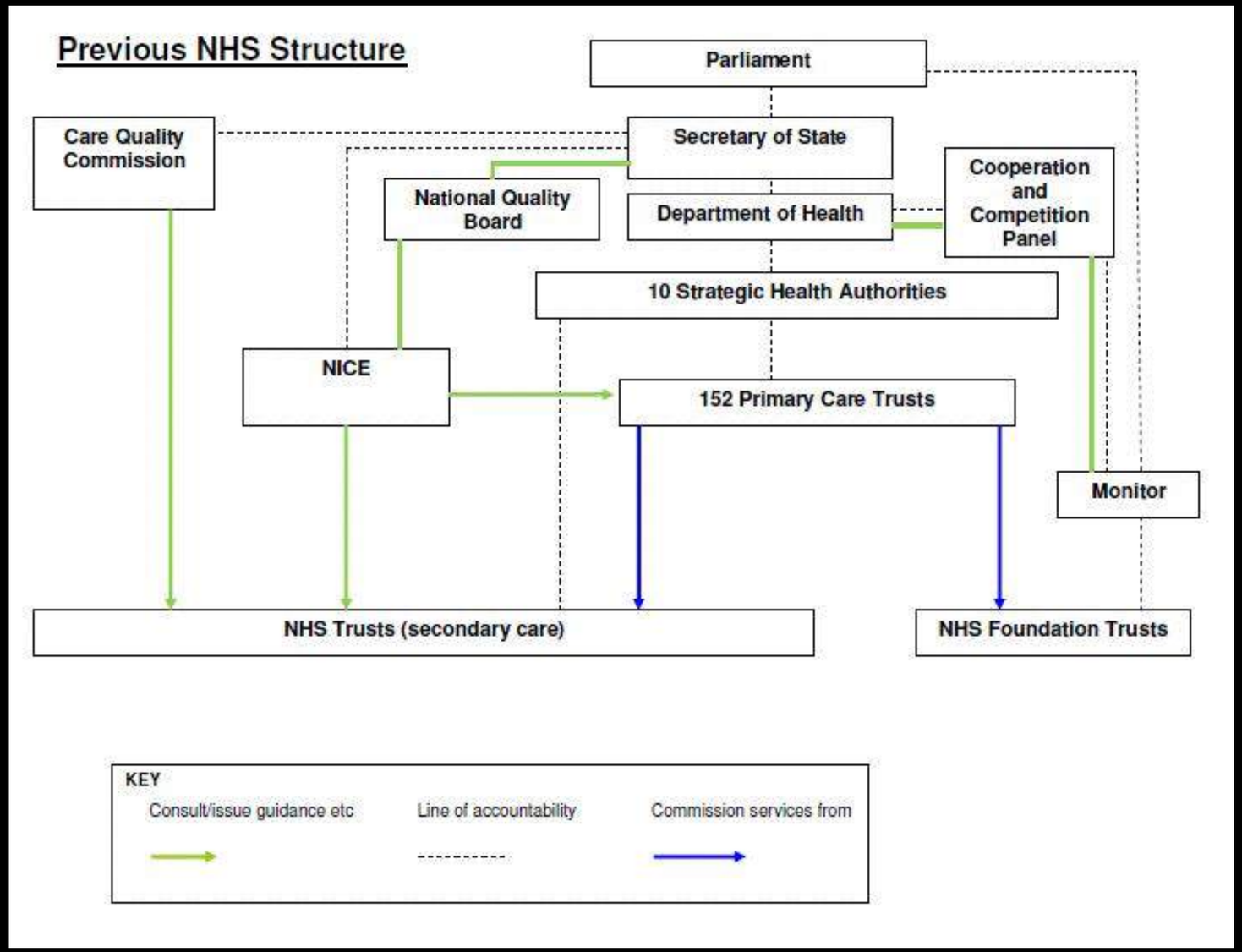

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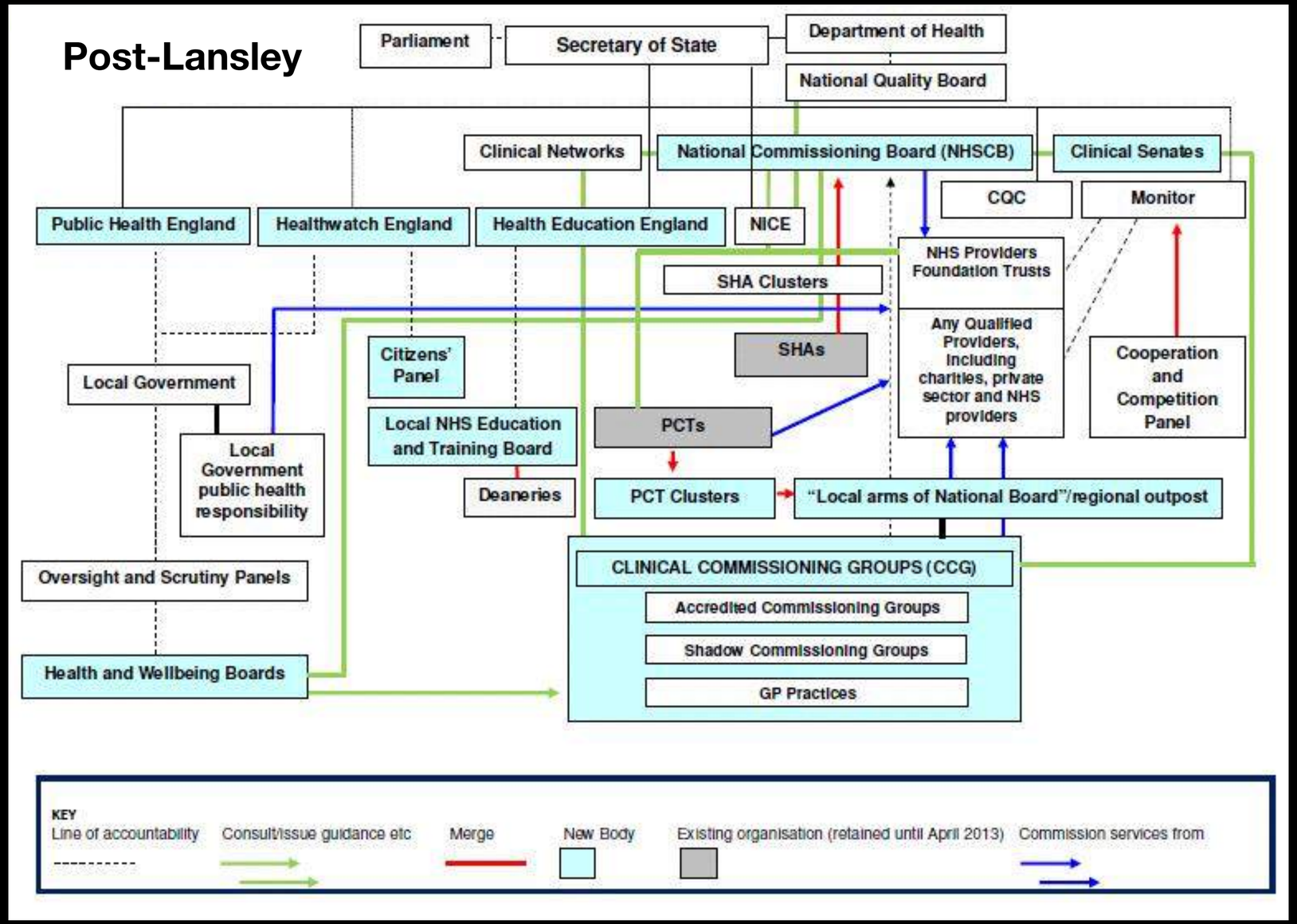
Post-Lansley



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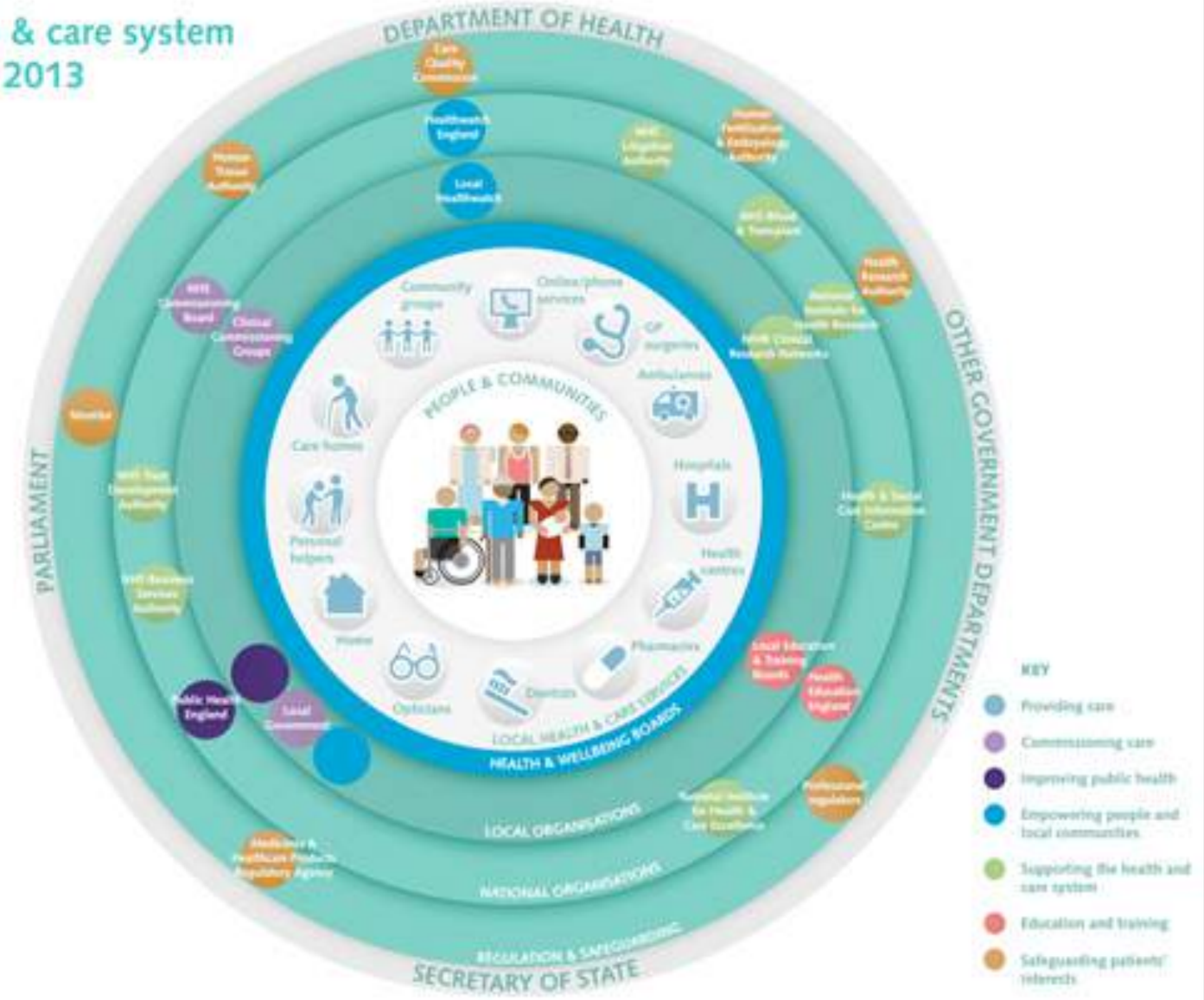
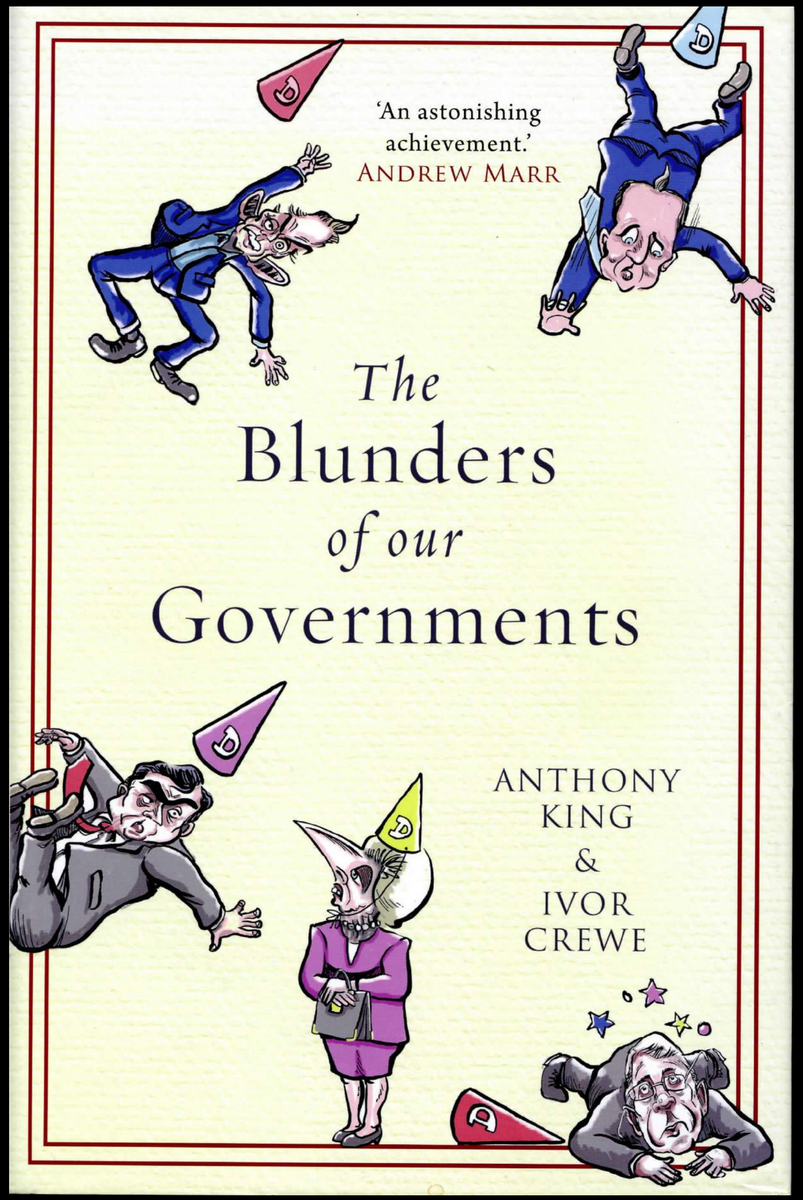
The health & care system from April 2013





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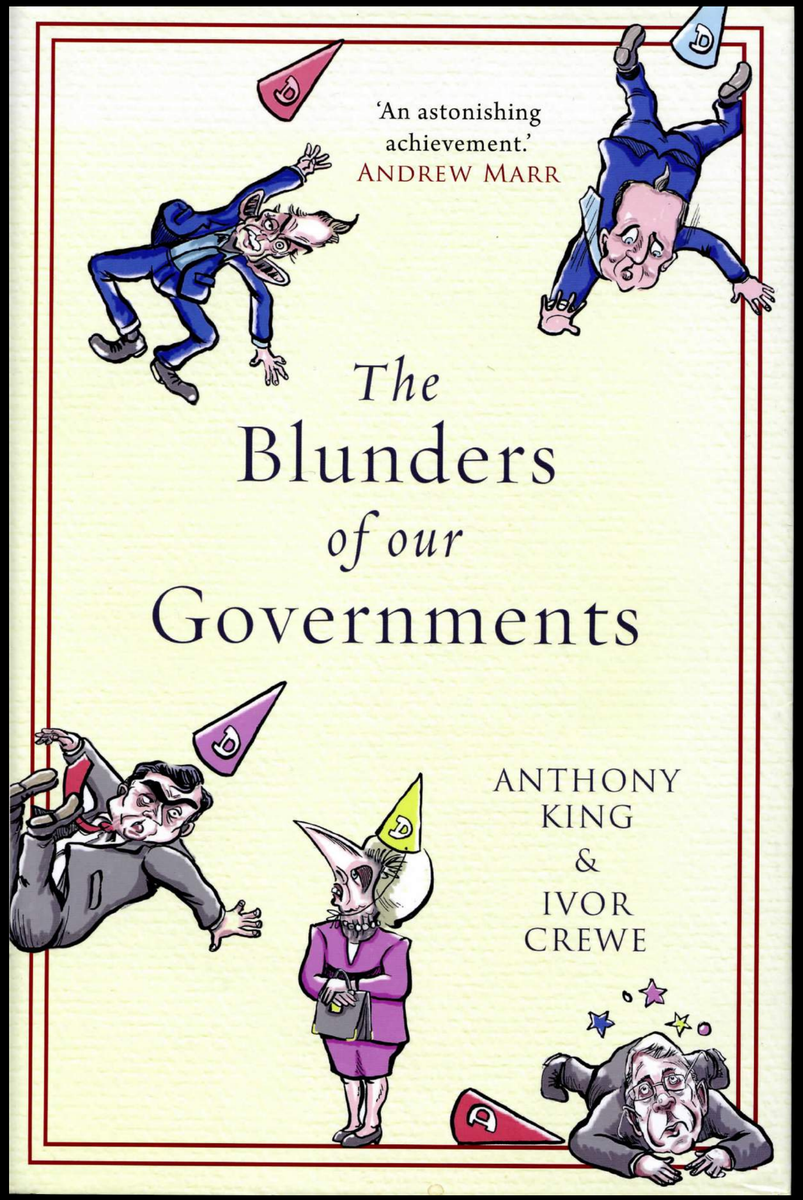

- Cultural Disconnect
- Group Think
- Prejudice and Pragmatism
- Operational Disconnect
- Panic, Symbols and Spin

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were we guilty?

- Cultural Disconnect
- Group Think
- Prejudice and Pragmatism
- Operational Disconnect
- Panic, Symbols and Spin

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health care is an **information economy**

data

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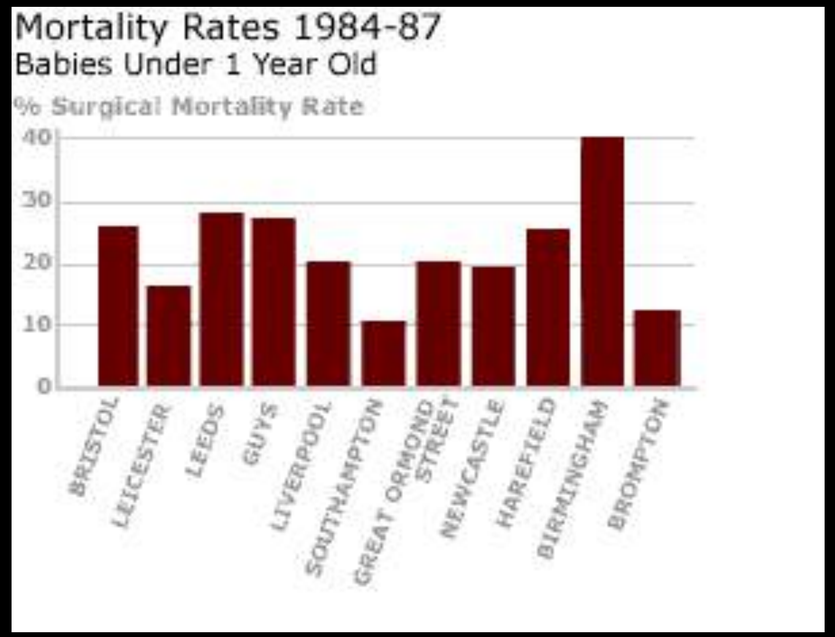
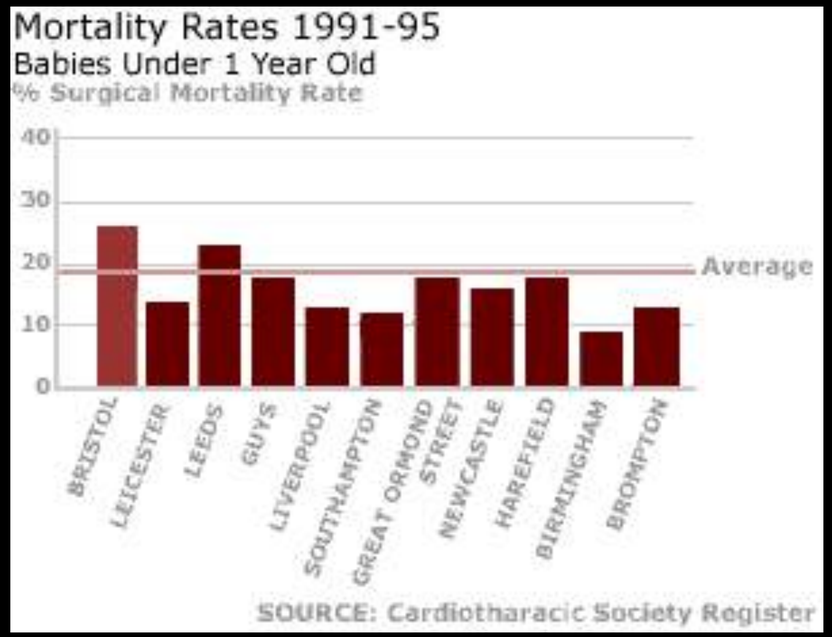
The data available to the GMC

Voluntary, unvalidated mortality data from UK Cardiac Surgical Register
paid for by the surgeons themselves





- varying accuracy of reporting
- no risk stratification
- procedure based

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Thousands of Diagnoses, Thousands of Terms

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Thousands of Diagnoses, Thousands of Terms

1

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Thousands of Diagnoses, Thousands of Terms

1

there is so much to put right

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Thousands of Diagnoses, Thousands of Terms

1

there is so much to put right

so many risk factors

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Thousands of Diagnoses, Thousands of Terms

1

there is so much to put right

so many risk factors

weight, prematurity, genetics

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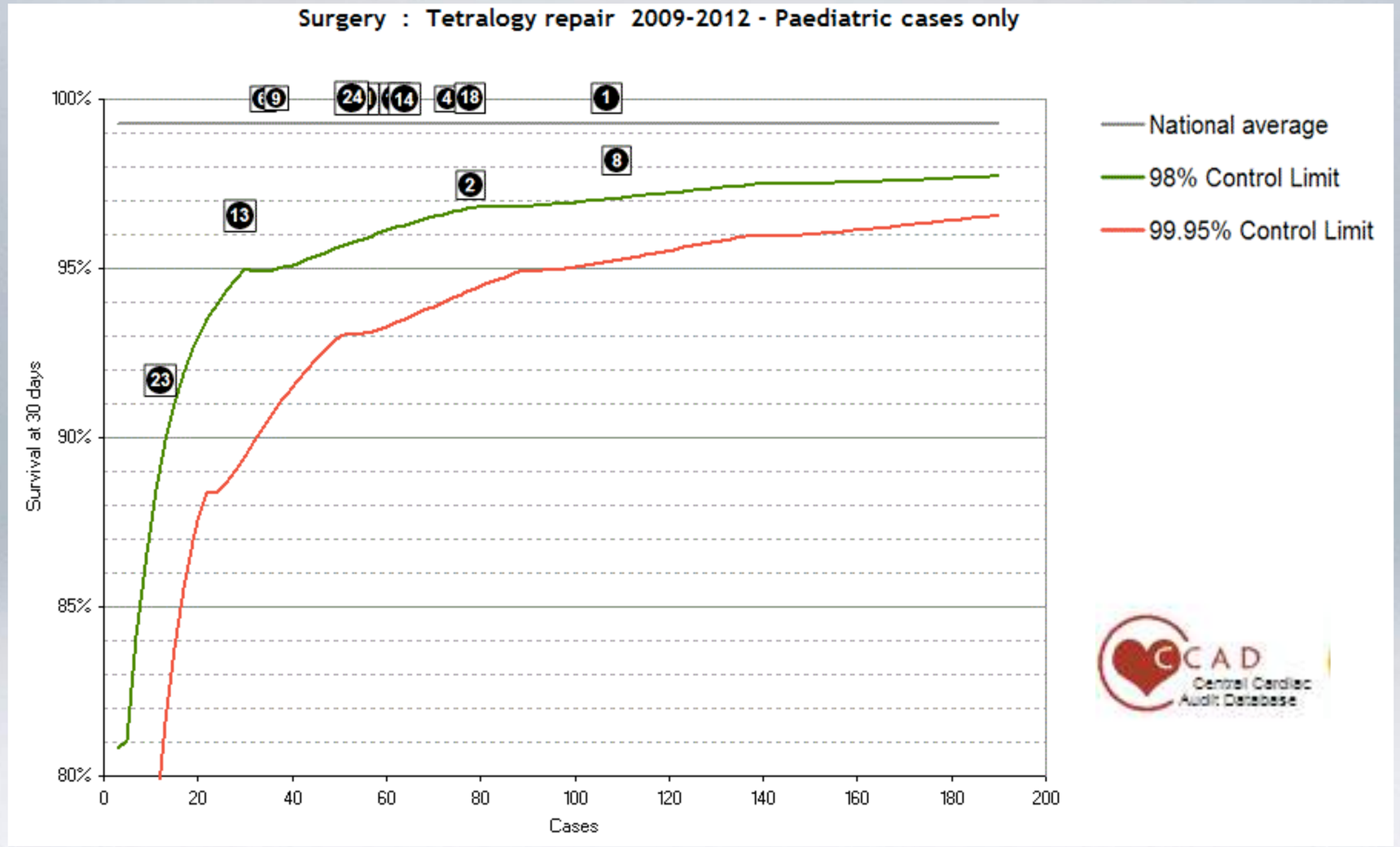

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the law of unintended consequences

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'I wouldn't let Leeds General Infirmary treat my daughter': Storm over Professor Sir Roger Boyle's comments

12 Apr 2013 20:55

the law of unintended consequences

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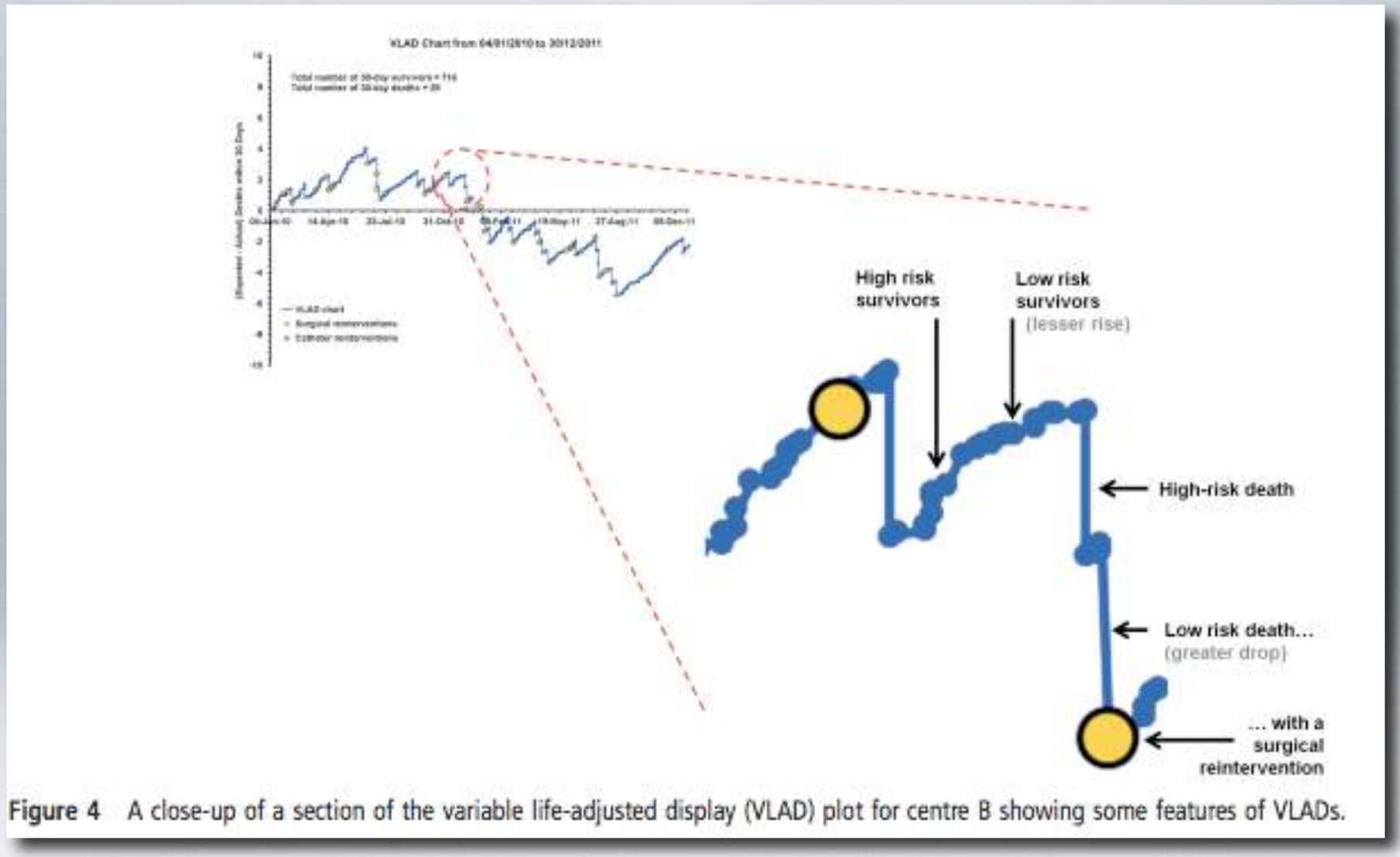

Figure 4 A close-up of a section of the variable life-adjusted display (VLAD) plot for centre B showing some features of VLADs.

Pagel C, et al. Heart 2013;0:1–6. doi:10.1136/heartjnl-2013-303671

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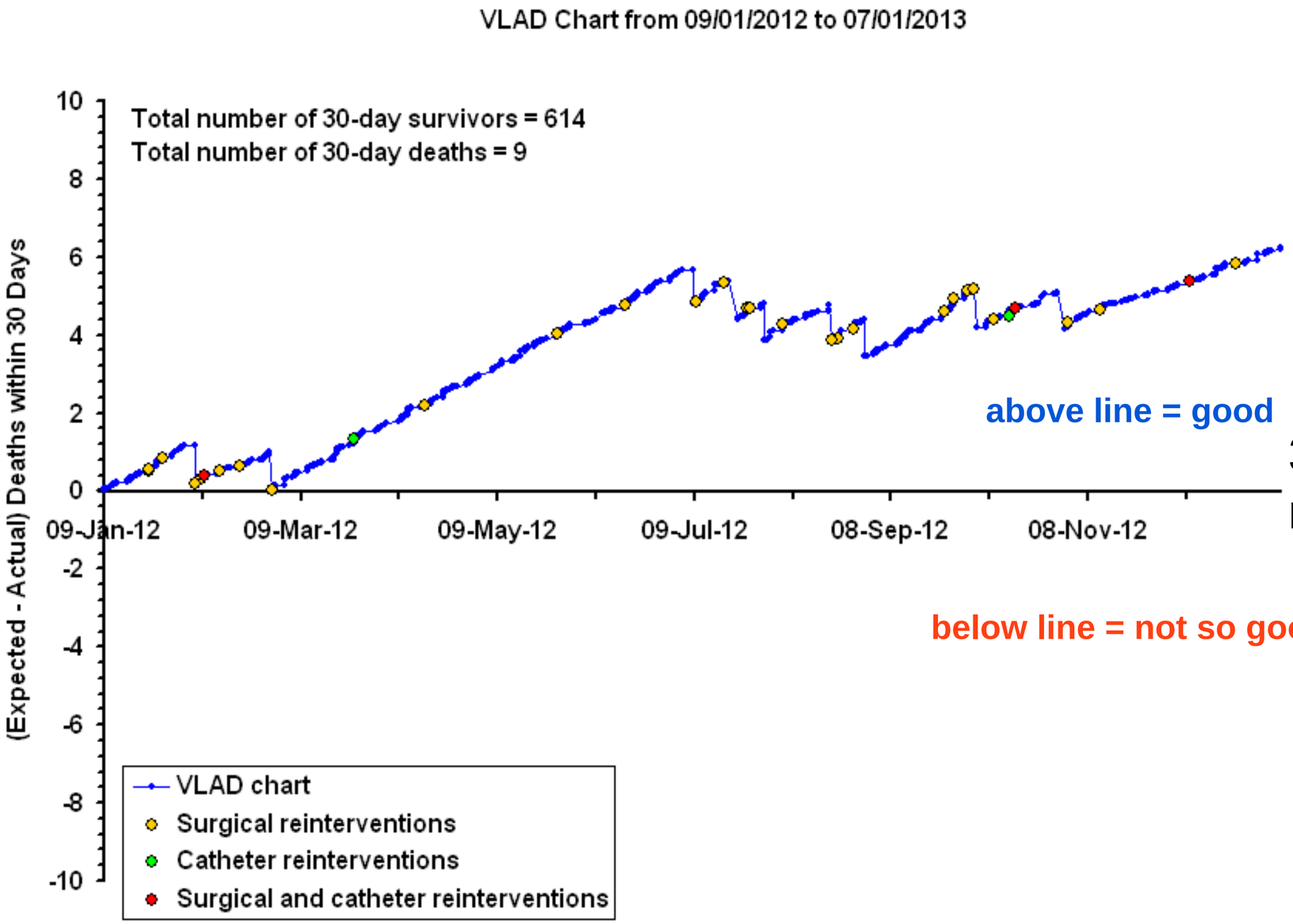
VLAD: Outcomes Corrected for Complexity

Victor Tsang, Kate Brown & Martin Utley



above line = good

3y national

below line = not so good

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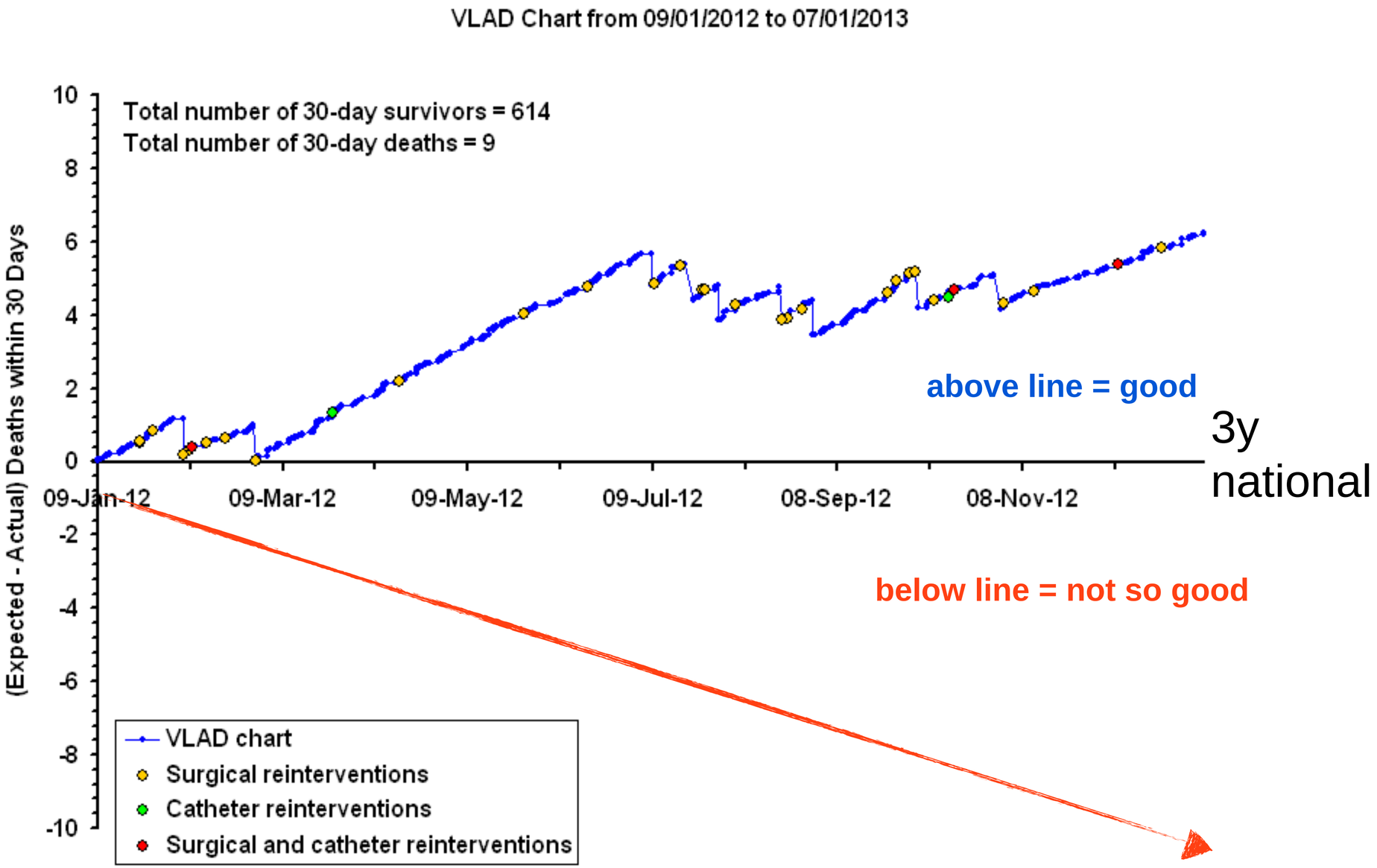
VLAD: Outcomes Corrected for Complexity

Victor Tsang, Kate Brown & Martin Utley



3y national

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Unit	Missing weight in 2011-12 data
BRC	0%
GOS	0%
GUY	0%
NHB	0%
RAD	0%
SGH	0%
ACH	0.3%
GRL	0.5%
BCH	1.2%
FRE	1.4%
LGI	34.7%

Table B: data as submitted August 2012

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Unit	Missing weight in 2011-12 data
BRC	0%
GOS	0%
GUY	0%
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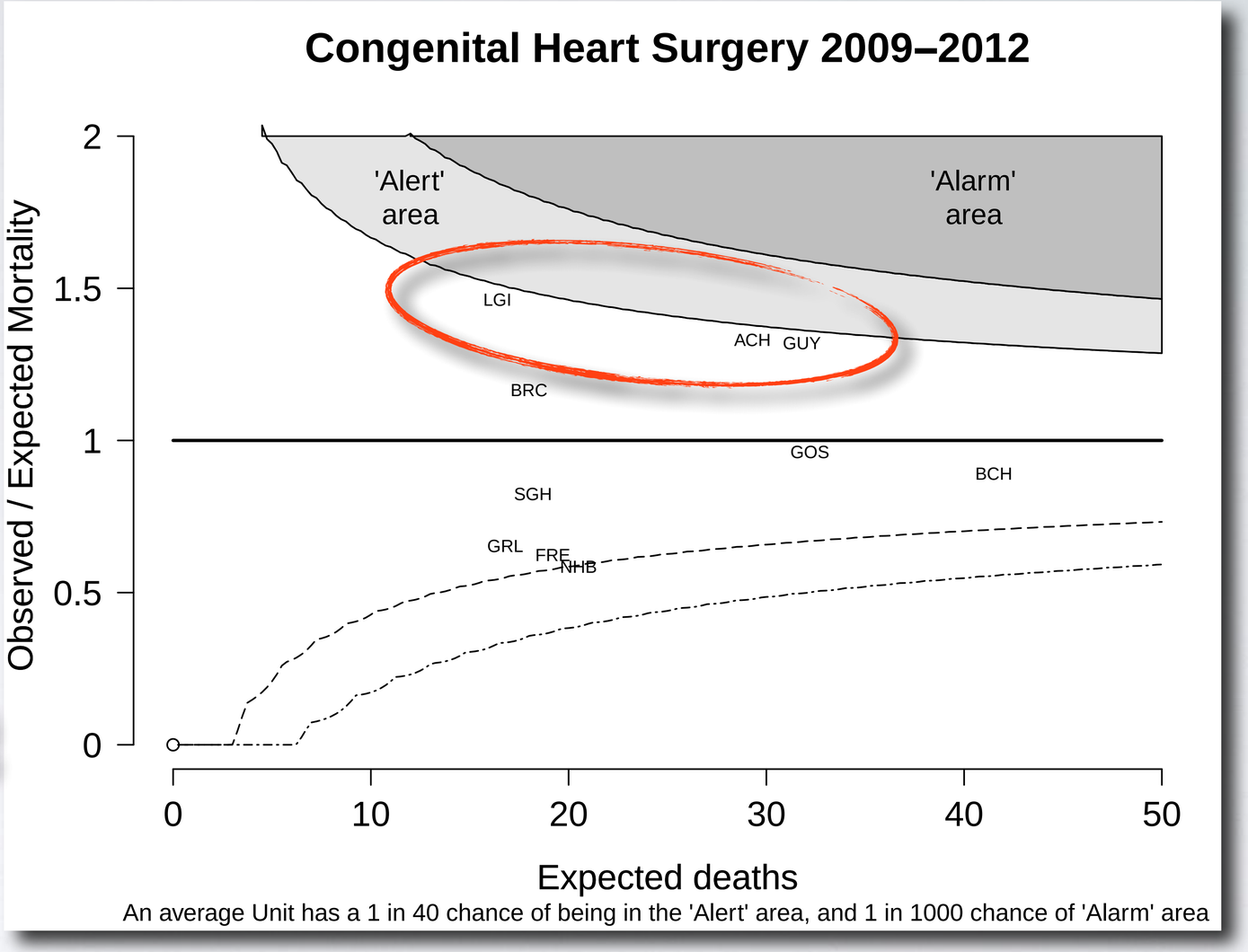
Table B: data as submitted August 2012



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EXCELLENCE

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nobody jumps higher by lowering the bar

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nat. average

my hospital

best in class

100

95

90

85

80

75

70

Y1

Y2

Y3

Y4

Y5

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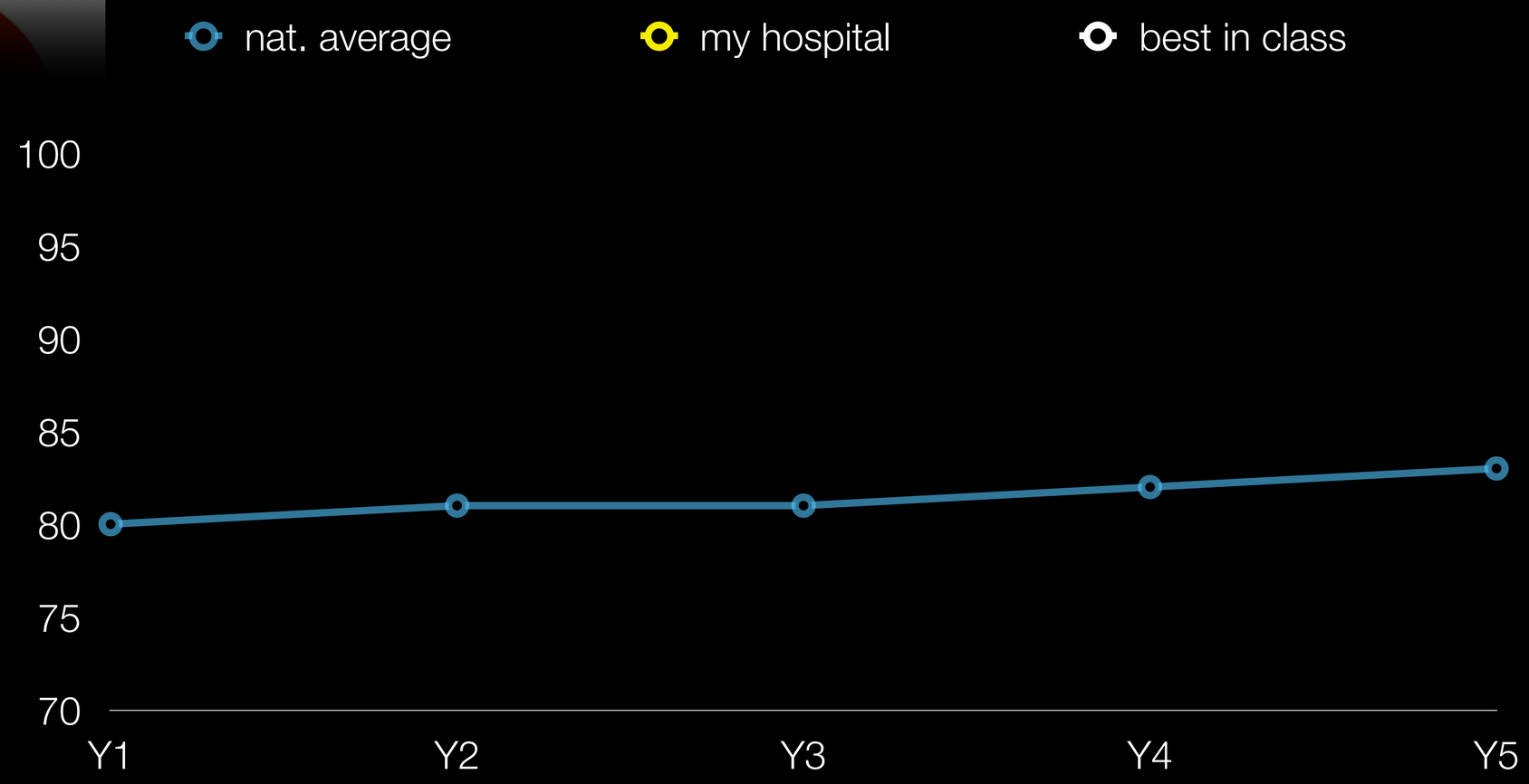

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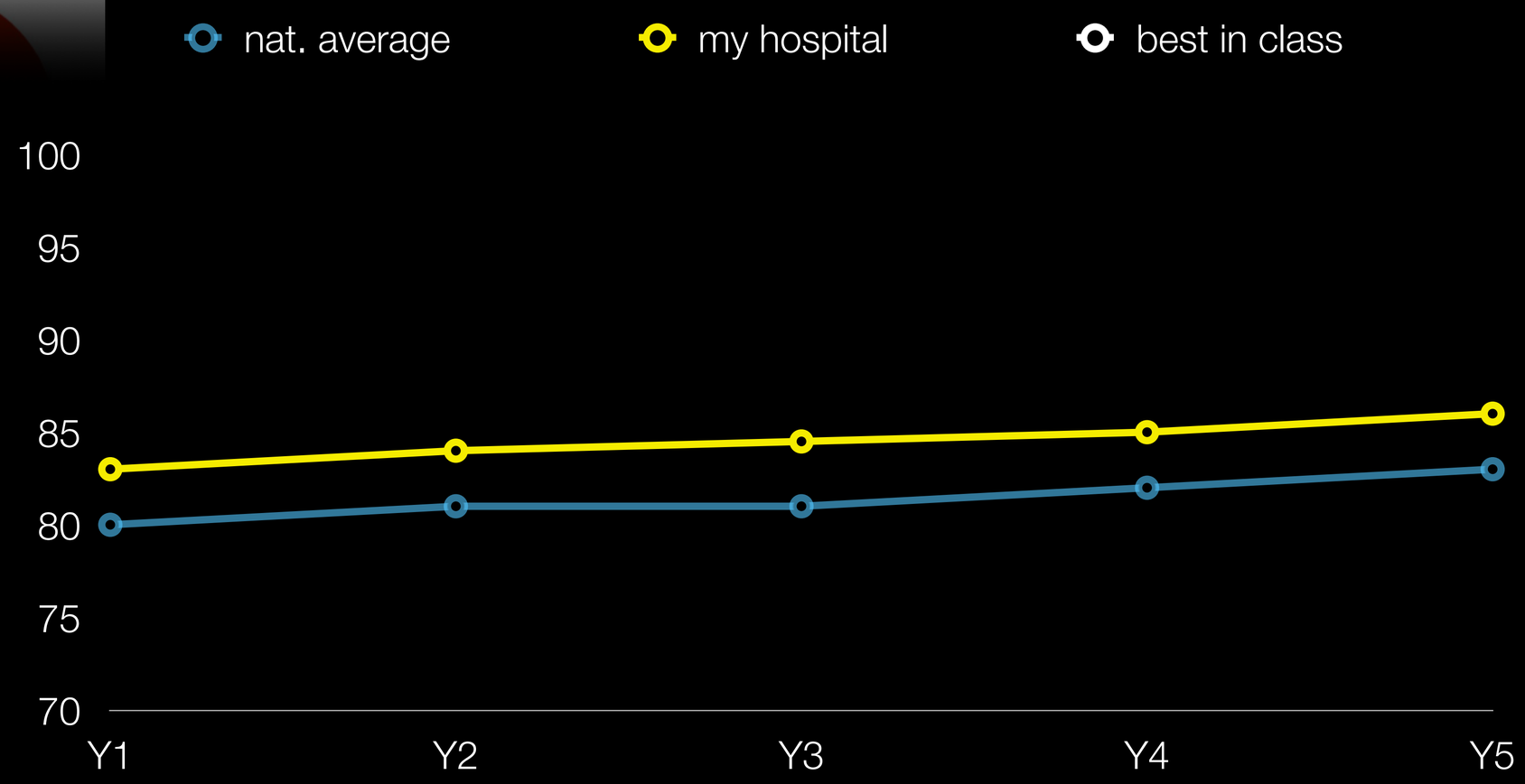

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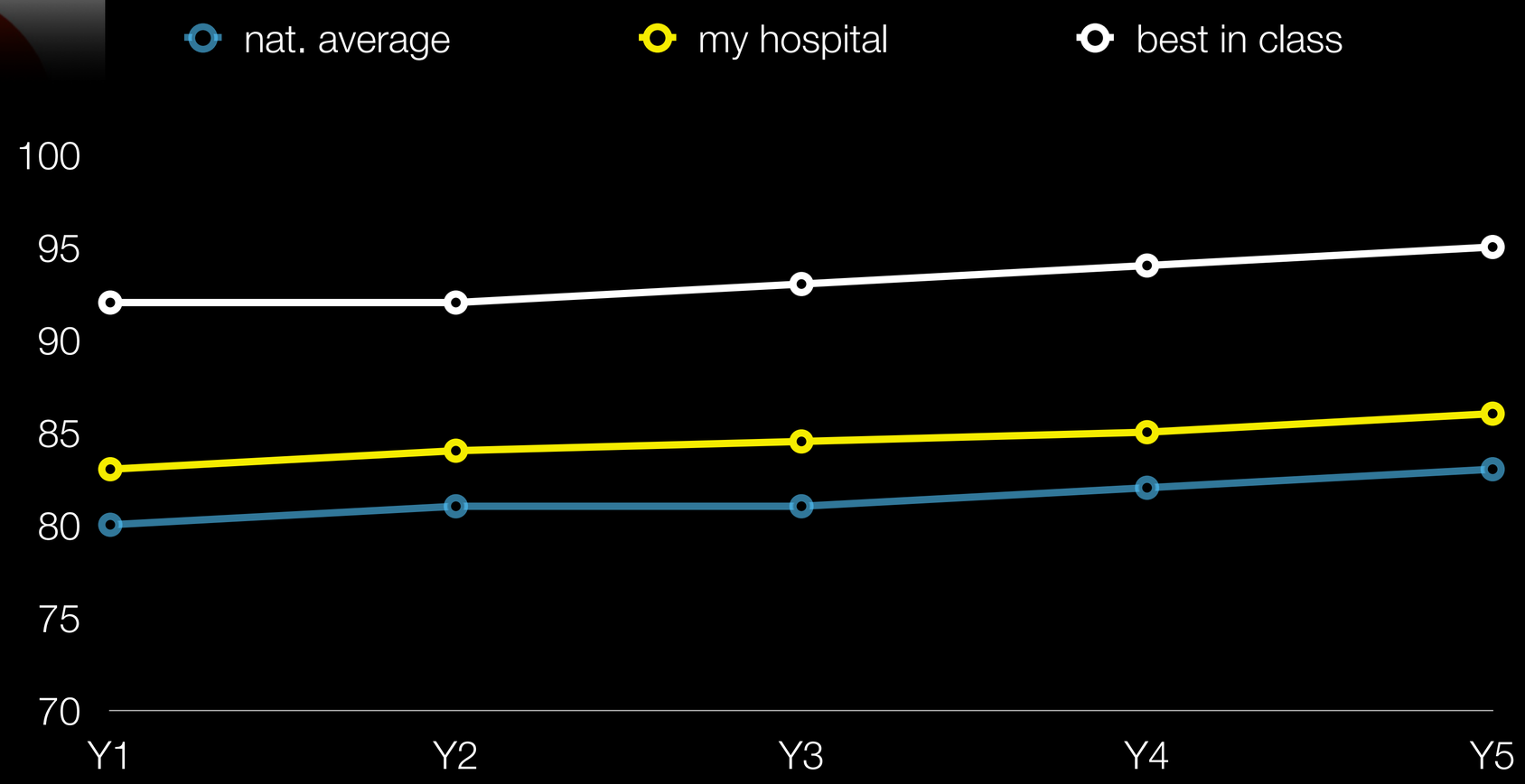

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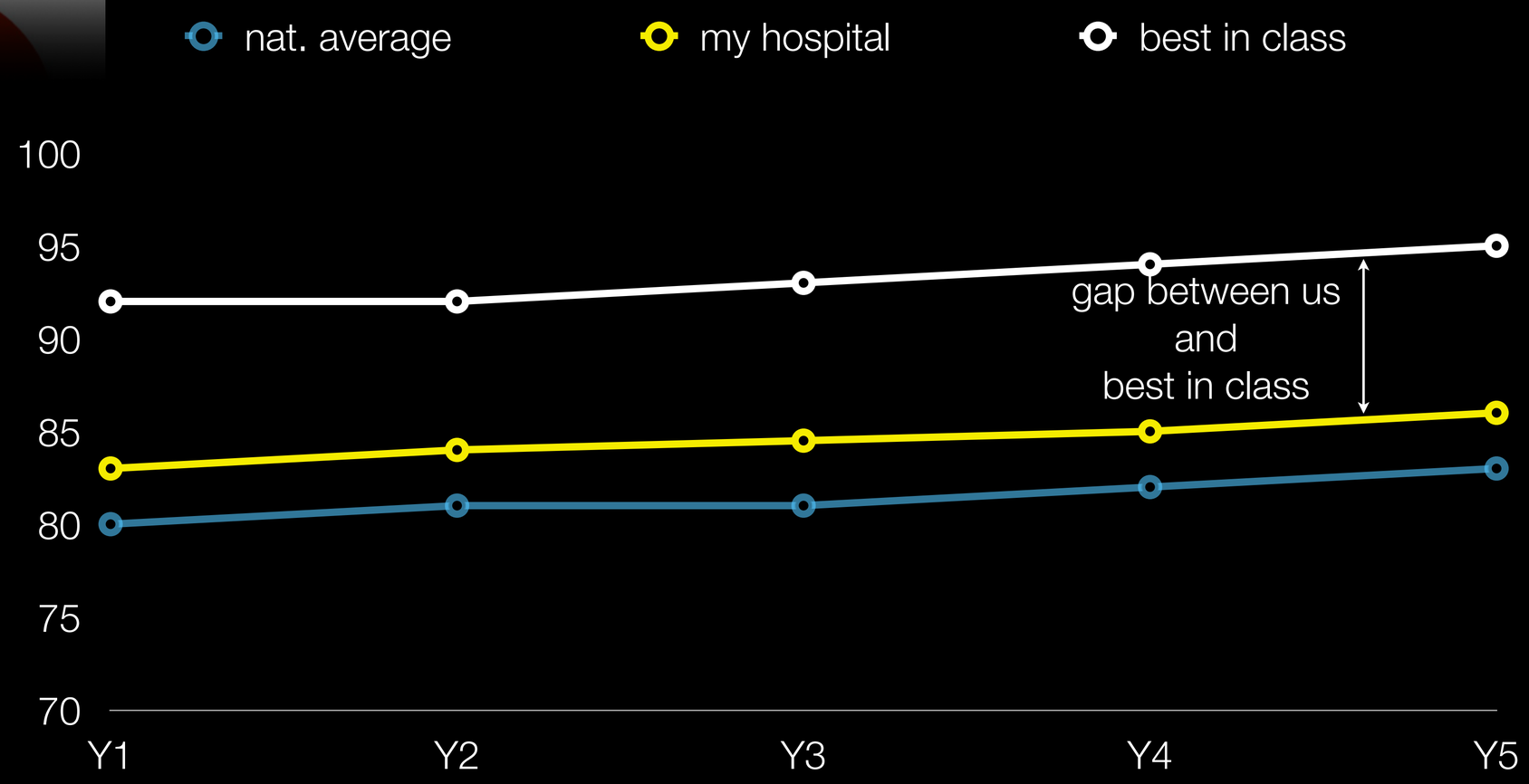

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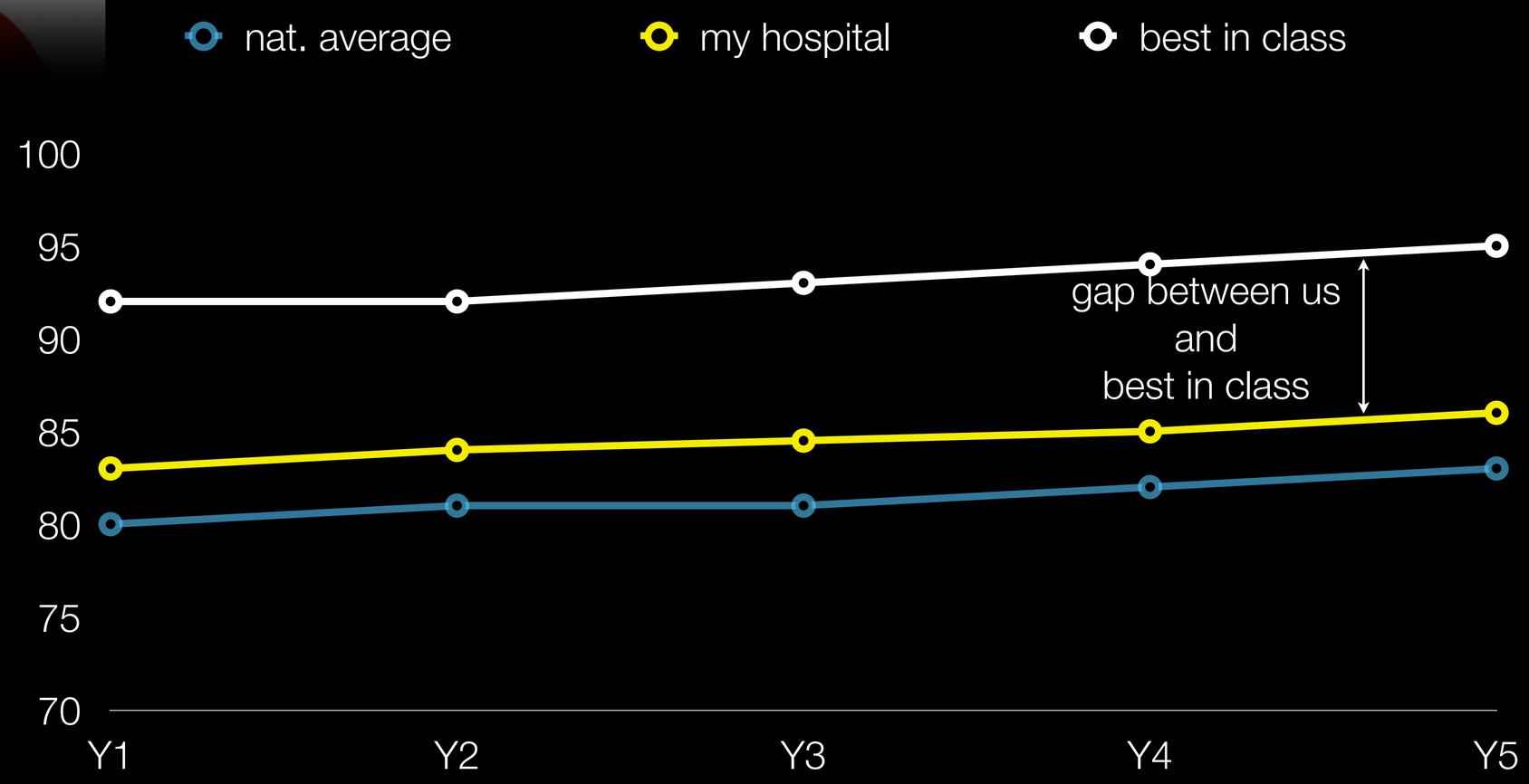
better than average shouldn't be good enough



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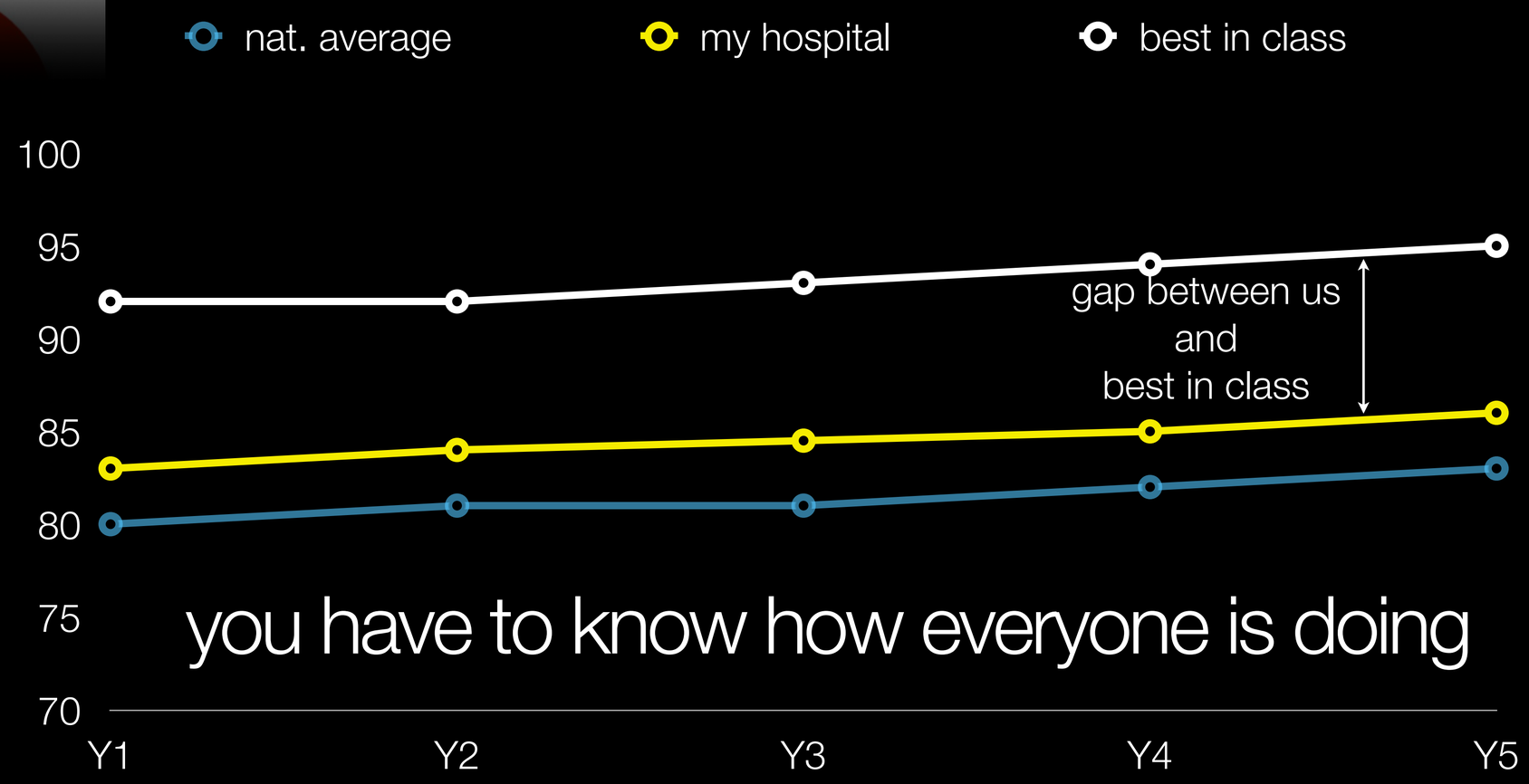
better than average shouldn't be good enough



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lies, damn lies, and statistics

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lies, damn lies, and statistics

“I have just learned that half
the paediatric cardiac surgeons
in this country
are below average.
This has got to be stopped!”

attributed to a very senior politician at the time of the Bristol Inquiry

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mediocrity must **NOT** be the benchmark for our future

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special thanks to

Dr Susie Thoms
Professor Sir Ian Kennedy
Sir Robert Francis QC
Roger Henderson QC
Professor Marc de Leval
Professor Jenny Simpson OBE
Professor Stephen Bolsin
Mr Richard Spicer
Dr Phil Hammond
&
everyone involved in Safe & Sustainable,
especially the parent & patient groups