# Health service reforms in the United Kingdom after Bristol

*The health service reforms fuelled by whistleblowing continue*

In 1995, the tragedy in paediatric cardiac surgery at the Bristol Royal Infirmary, exposed by a whistleblower, ended the laissez-faire approach to patient safety, management of clinical quality and professional self-regulation in the National Health Service (NHS). Indeed, the impending impact of the Bristol case was poignantly captured by an editorial in the *British Medical Journal*, entitled "All changed, changed utterly".[1]

Britain may not be alone in whistleblowing. In this issue of the Journal, Faunce and Bolsin report on three such recent events in Australia[2] (*page 44*). These show an uncanny commonality with the Bristol case.

*What has happened in the NHS since 1995?*

In the immediate aftermath of Bristol, the then Health Secretary, Frank Dobson, took urgent action to place a duty of quality of care on chief executives of NHS Trusts, effectively ending any doubt about where responsibility would lie. In 1998, the new Labour government introduced two white papers, *The new NHS: modern, dependable*[3] and *A first class service: quality in the NHS*.[4] Although these described the regulatory framework for a quality-oriented healthcare service in England, the principles were to apply across the UK. Subsequent policy papers have added many refinements — including some 42 quasi-autonomous regulatory bodies in healthcare. These have just been pruned after criticisms of overly oppressive regulation.

The following are key elements of change in England:

- The National Institute for Clinical Excellence (NICE) is tasked to develop evidence-based clinical guidelines and to assess and evaluate new technologies and pharmaceuticals for the NHS.
- Complementing the clinical guidelines, National Service Frameworks were created to map out the essential ingredients of good clinical service provision. Originally, there were three — for coronary heart disease, cancer and mental health. Paediatric care was added after the report of the Bristol Inquiry.[5]

However, the focal process for the delivery of clinical care is clinical governance, which is defined as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding standardised care by creating an environment in which excellence in clinical care can flourish".[3] To monitor compliance, the government established the Commission for Health Improvement, which was superseded this year by the independent Commission for Health Audit and Inspection, to regulate institutional quality in both the public and private healthcare sectors.

Adding to all this bureaucracy and control are bodies with more specific functions. For example, the National Patient Safety Agency manages the reporting and analysis of "near misses". The National Clinical Assessment Authority advises NHS Trusts and complements the work of the General Medical Council (GMC) in assessing and retraining poorly performing doctors. In addition, there is a new, overarching body for coordinating the regulators of the individual health professions — the Council for the Regulation of Health Professionals. For the citizens, the Commission for Patient and Public Involvement in Health, together with local Patients' Forums, is to champion and promote public participation in the direction of local health services. This is a breathtaking array that even the distant observer in Australia might find daunting.

For doctors, the regulatory landscape has also changed dramatically. The recent consultant and general practitioner NHS contracts increase employers' control over the organisation of medical work, incorporate performance incentives and strengthen accountability. But it is the GMC's proposals for doctors' registration, training and discipline that are potentially most far reaching.

The GMC changes began in 1992 with a new approach to basic medical training — *Tomorrow's doctors*.[6] Even more radical was the publication, in 1995, of a patient-centred code of practice, *Good medical practice*.[7] If embedded successfully in the medical culture, the code will lead to positive changes in attitude on matters such as communication with patients and colleagues, teamwork, risk management, transparency, and whistleblowing. To strengthen compliance, the GMC tied the code directly to registration in 1998. The full effect will begin to be felt in 2005, when all UK

doctors in active practice will have to have a licence to practise that must be revalidated every 5 years. Revalidation will require doctors to submit evidence of their continuing competence and performance (assessed against the template of Good Medical Practice) regularly for review.

*So where do things stand now?*

Two recent reviews of the NHS show a picture of patchy performance through clinical governance, particularly in the workplace.[8,9] Data quality and some other systems issues are still a serious problem. But the central questions are about the medical and healthcare culture, and therefore medical leadership. Have the GMC and the Royal Colleges the will to see revalidation — and with it clinical governance — implemented as rigorously as required to give patients the assurances of the quality and consistency of medical care they are entitled to expect? Such questions are likely to be aired publicly again later this autumn when the Shipman Inquiry reports.

All these changes raise the question: will the need for whistle-blowing ever pass away? I believe this will only happen if the medical profession is prepared to put the task of embedding, demonstrating and communicating patient-centred professionalism at the heart of its vision for the future.[10] This task has to become central to our professional practice, our teaching and our research. It is the object on which our mutual leadership should be focused. The public expect no less.

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9 Leatherman S, Sutherland K. The quest for quality in the NHS. London: The Nuffield Trust, 2003.
10 Irvine DH. The doctors' tale: professionalism and public trust. Oxford: Radcliffe Medical Press, 2003. ❏