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**Enhancing Clinical Governance and Surgical Safety: A Service
Improvement Review of the Bristol Royal Infirmary Case**

Lecturer: Shepherd Ziko

Student Name - Aesha Patel

Student ID- 2432639

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1.0 Introduction

1.1 Background of the Case

One of the most notorious failures in the UK health system's history is the Bristol Royal Infirmary case. During the years 1984 and 1995, lots of children who had heart surgery in this hospital died (Dyer, 2001). Death rates were very high in comparison with the country's average. This proved that there was something gravely wrong in the hospital (Cleaveland, Lee and Gewa, 2023). It was not a mistake or a poor day. It was a lengthy and anxious issue that lasted for numerous years. Due to that, people started to lose confidence in the hospital, and the families were harmed in a manner that could never be restored (BBC, 2016).

1.2 Understanding the Problem

Expert examination of the situation revealed that it was not just a matter of the competence of the surgeons. The more fundamental issue was that the hospital lacked an appropriate clinical governance system. Clinical governance refers to the rules, checks and processes which ensure that patients are safe and receive care which is done properly (Macfarlane, 2020). These systems were also absent or very weak at Bristol. It implied that errors were not corrected, issues were not reported, and nobody was watching to determine whether the care was safe (Dyer, 2001). Leadership failed to see the warning signs early enough, and employees had a very low level of communication (Pasman, 2021). This enabled unsafe practice to proceed over a long period of time.

1.3 Why This Issue Matters?

The significance of this issue is that clinical governance is the foundation of safe health care. In case it is strong, health services learn from the errors, track performance, and safeguard patients (Aileen, 2025). However, once weak, it can be subjected to harm, and nobody can halt it. The Bristol case demonstrated how unsafe it can be in case a hospital lacks appropriate supervision. Children who had to undergo cardiothoracic surgery were not supplied with the full amount of care they needed, in terms of safety (Bevan, 2023). This was a clear indication that the system was failing, as the death rate was high, though there were no vigorous measures that had been taken over a long period. This also posed numerous questions concerning the management, control, and accountability of hospitals.

1.4 Indications of the Concern

It was evident that the situation at Bristol was a matter of concern. It was reported that the mortality rate in the hospital in the field of children's heart surgery was extremely high compared to the rest in the UK (Walker et al., 2022). Numerous families complained about the care that their children received. There was also a staff concern, though those concerns were not usually addressed in the right way. Problems could be overlooked as there were no adequate reporting systems. When the official investigation, which was conducted by Sir Ian Kennedy, confirmed the fact that the hospital was plagued with organisational and cultural issues (Kennedy, 2001). The investigation concluded that leadership, monitoring, and quality control were deficient.

1.5 Purpose of this Report

The aim of this report is to discuss the problem of inadequate clinical governance at Bristol Royal Infirmary. It will examine the original factors of the issue through plain and transparent structures. It will indicate how patient safety was compromised by weak governance systems and demonstrate why effective governance is fundamental to patient safety. The report will then suggest the real and practical solutions and improvements that can be made to curb such failures in future. The objective is to know what went amiss and what can be learnt by health services based on the case to ensure that patients are provided with safe and high-quality services.

2.0 Main Body

2.1 Comprehending the Primary Problem

Appropriate clinical governance was the primary problem in the case of Bristol Royal Infirmary. Clinical governance merely implies that there are clear rules with appropriate systems, and monitoring that ensure that patients are given good and safe care. These systems were feeble at Bristol and occasionally not in existence whatsoever. It is due to this that unsafe practices prevailed over the years. The hospital lacked proper monitoring of its results and was not learning from the problems (Gov.UK, 2002). Employees were not encouraged to raise their voices, and executives failed to act when warnings were there. This malfunction caused the care to be unsafe, particularly for children whose hearts had to be operated on.

2.2 Explaining Why Clinical Governance Matters

Clinical governance is significant in the sense that it enables the provision of a secure environment to the patient. It assists hospitals in self-checking their activities, correcting their mistakes, and providing better services. In a strong clinical government, risks are more easily detected at an early stage. It does a duty of holding people accountable. The Bristol shortage of these systems caused mistakes in work to be perpetuated with ease (Ng *et al.*, 2023). The families had their children in the hospital, believing that the hospital could keep them safe, while the systems were ineffective in ensuring the safety of their children. Due to this fact, a number of children were killed.

2.3 Exploring the Problem with the Fishbone Diagram

A Fishbone Diagram also assists in dividing the issue into tiny segments. It presents the various causes of the key concern (Sakdiyah *et al.*, 2022). In the case of Bristol, the Fishbone Diagram helps to realise that a lot of things went wrong simultaneously. This demonstrates that it was not a simple error that caused the problem, despite the breakdown of the entire system.

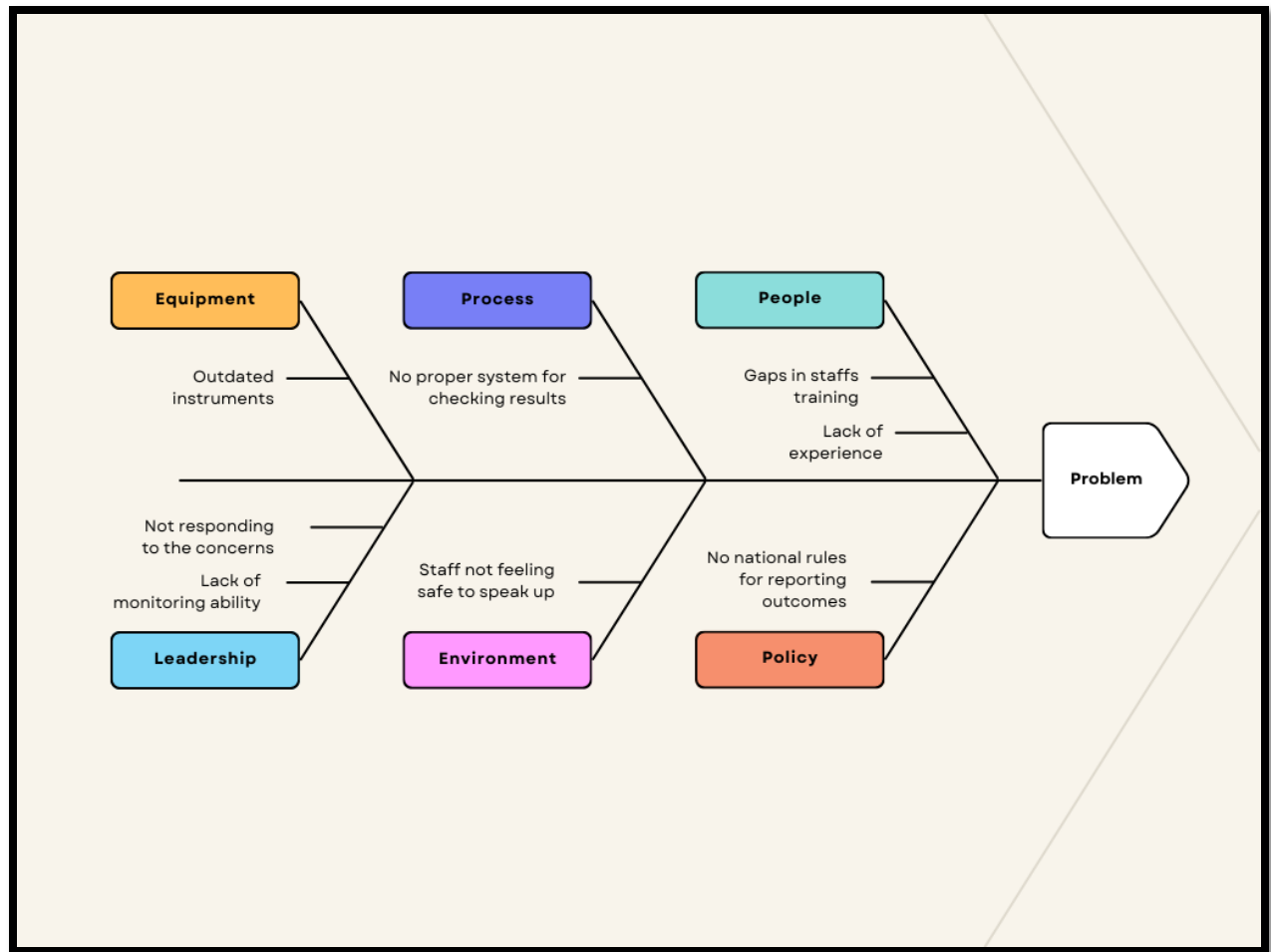


Figure 1: Fishbone diagram

(Source: Self-developed)

People

The hospital experienced issues in the areas of staff skills and communication. There are cases where surgeons lacked the experience in complicated heart surgeries. Employees were also not able to voice their concerns easily, as they knew they could get dismissed or even condemned (Ramsey et al., 2022). Problems remain undisclosed when individuals are not comfortable speaking out.

Process

The hospital lacked effective reporting mistake systems and result checking systems. Reviews of outcomes following surgeries did not follow a routine. This implied that there was poor death rates reporting and discussion (Peerally, 2021). There was no mechanism through which Bristol could compare their results to those of the other hospitals.

Equipment

Some of the areas were covered with outdated equipment. The failure to ensure the tools are well-maintained and replaced in time can impact the safety of the surgery (Peerally, 2021). Other hospitals had the availability of modern technology, while Bristol was not able to keep pace with the changes.

Environment

Silent culture at Bristol had led to a working environment at Bristol. This implies that the staffs were not supposed to ask senior doctors questions. This posed a challenge to unsafe practices. The support of an open dialogue and mutual learning should be provided within a safe environment (Provenzano *et al.*, 2024).

Leadership

The largest of the problems was leadership. Leaders were not helpful in listening to concerns or they were not skilled at reviewing performance, and they did not firm decisions to represent patients (Bevan, 2023). The leaders need to establish an atmosphere in which all people are comfortable talking and in which learning is promoted. It demonstrates how the inefficiency of leaders resulted in the continuation of the quality issue that remained unaddressed.

Policy

The national health policies had numerous gaps before the year 1999. The result of the performance did not have to be published in the hospitals (Aujla *et al.*, 2023). Decent quality monitoring and error, and mistake reporting systems were not powerful. Due to this reason, Bristol was in a position to carry on with unsafe care over many years, which could not intervened with at an early stage. It demonstrates that inadequate practice was not stopped as there were no strong policies in the country.

2.4 5 Whys Analysis

The 5 Whys technique can assist in digging deeper into the causes of why a problem did occur (ASQ, 2025). When we ask the question, why was the death rate of children higher? This is where we begin to dig out the causes of the problem.

Why were children dying at higher rates?

This was due to surgeries that were not done in a safe manner, and the results were not monitored.

Why did they not perform their surgeries safely?

Due to the absence of advanced methods of skills among surgeons and lack of appropriate examination of results.

Why did there not happen no proper review happen?

Due to the lack of good governance mechanisms to control the outcomes in the hospital.

Why was governance weak?

Due to the lack of priorities of the leaders on quality monitoring and gaps in national policies.

Why were leaders failing to focus on quality?

It was due to poor performance and discouragement of learning that was permitted in the culture of the organisation.

It is just a basic way of demonstrating that the underlying reason was the absence of governance and leadership. It was not all about a single surgeon or even a unit. It was a whole system problem.

2.5 The Implementation of the Donabedian Model

The Donabedian Model assist in comprehending the quality of healthcare by considering the following three aspects, including structure, process, and outcome (Tossaint-Schoenmakers et al., 2021).

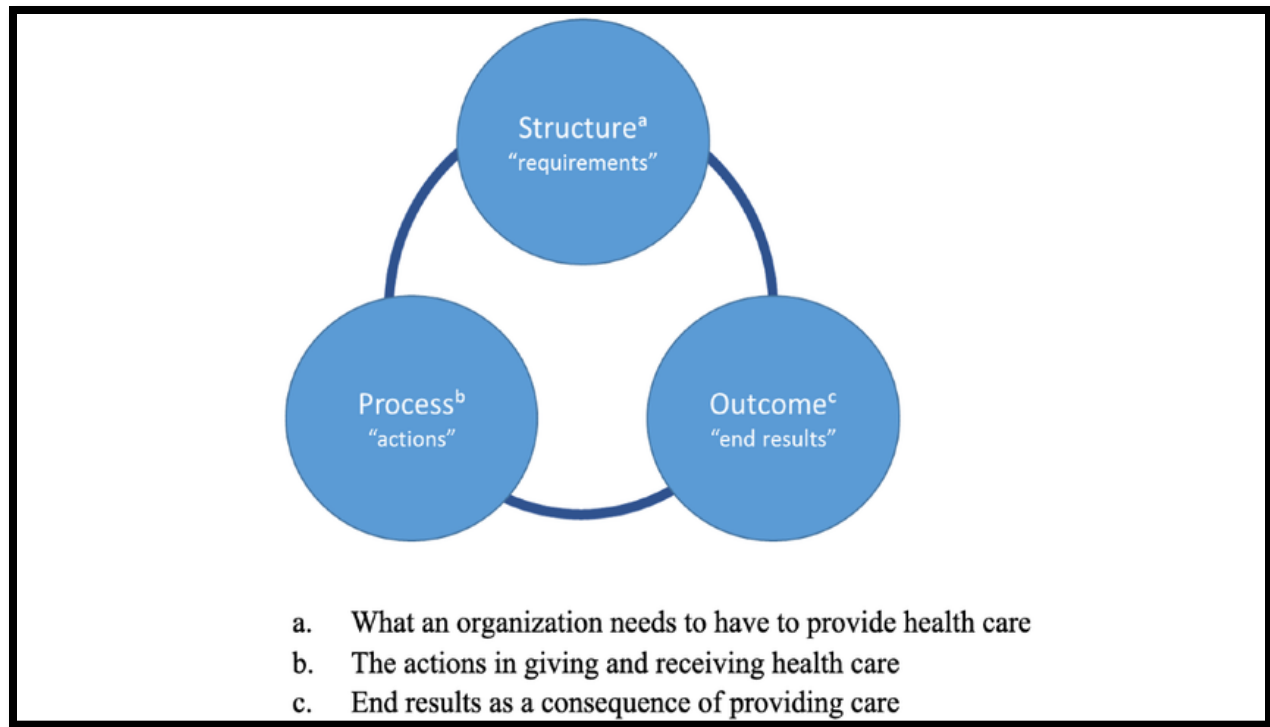


Figure 2: Donabedian Model

(Source: Tossaint-Schoenmakers et al., 2021)

Structure

Structure refers to resources, personnel, training, equipment and systems that assist with care. At Bristol, there were numerous structural factors that were inadequate. Employees were not effectively trained in intricate operations (Thompson *et al.*, 2025). Machinery was not continuously modernised. There were absent reporting systems. The strong structural aspects included leadership and culture.

Process

Process entails care delivery. There was a lack of process clarity and structure at Bristol. Pre-operative and post-operative checks were not done properly. Regular meetings were absent to talk about outcomes. Communication between teams was not very common, and the staff did not go through similar routes (Brooks et al., 2023).

Outcome

The last outcome of care is the final outcome of care achieved, typically in measurements of health and safety of a patient. The results at Bristol were bad due to the poor structure and process. The mortality rate was clearly indicative of the safety of care not being provided to patients.

The Donabedian Model establishes the fact that right processes and good structure are the foundation of reasonable results. Bristol did not succeed in either, and many children died due to this.

2.6 SWOT analysis

Strengths	Weaknesses
- Some staff were caring and wanted improvement - Bristol Royal Infirmary is the oldest hospital (Uhbristol, 2020) - Staff wanted better training - Some resources were available	- Governance was weak - Inadequate leadership along with inadequate communication (Brooks et al., 2023) - No proper reporting systems - Culture of silence
Opportunities	Threats
- New policies from the inquiry - Chance to rebuild governance - Better staff training (Rockall, 2024) - More openness and transparency	- Loss of public trust (BBC, 2016) - Risk of repeating mistakes - Staff leaving due to fear - Damage to reputation

Table: SWOT analysis

(Source: Self-developed)

The SWOT analysis demonstrates that Bristol possesses certain strengths like caring employees and a long history, though these were insufficient to promote safe care. The weaknesses were far more dominant. They incorporated bad governance, bad leadership, bad communication and no right reporting systems. Such faults posed significant risks, such as losing the trust of people and making the same mistakes. Nevertheless, such opportunities as new national policies,

improved training, and an opportunity to create a more open and transparent culture were also present. In sum, the SWOT analysis assists in observing that organisational and cultural failures were the key reasons for the issue.

2.7 Rationale of Strong Governance

The Bristol case suggests that good governance systems need to exist in all hospitals. Governance ensures that issues are revealed in time and solutions implemented promptly. It is also helpful in cultivating a culture of free-speaking staff and a culture of learning. Lack of firm leadership plays out as higher chances of injuries and repeated errors are repeatedly to occur (Hibbert *et al.*, 2023).

Evidence-based practice, effective reporting, and clear protocols are components that the hospitals in the modern healthcare setting need to employ (Melnik and Fineout-Overholt, 2022). They should also abide by the national recommendations and keep a close look on performance. Leaders should be transparent, candid and accommodating. They are expected to hear from the staff and patients, and they should be accountable to uphold safe care.

3.0 Recommendation

In the Bristol case, the absence of effective clinical governance has been revealed to be the key issue. As an effort to enhance the quality of the provided care and maintain patient safety, the hospital requires straightforward, unambiguous, and effective measures aimed at the development of an effective system. These are recommendations to correct the sources of the problem, empower the personnel, and establish an open and learning culture. They are founded on the PDSA cycle, Lean thinking, and Six Sigma approaches as the given tools can assist hospitals in with their consistent and stable improvements.

3.1 Development of a Powerful Governance and Monitoring System

The initial move is to establish a proper governance system to be used to check on performance at regular intervals. The hospital needs to establish a quality monitoring team that will convene regularly and discuss the patient outcomes, staff issues and safety warnings (Alizadeh-Dizaj *et al.*, 2025). This team must consist of doctors, nurses, managers and patient representatives. Their task is to identify the issues in time and take immediate action. This will prevent the delays in making decisions and the escalation of problems.

3.2 Continuous Learning with the PDSA Cycle

The PDSA cycle or Plan-Do-Study-Act cycle, assists firms in creating and testing new ideas step by step before making major changes. (Wong and Headrick, 2020).



Figure 3: PDSA Cycle

(Source: Arije et al., 2023)

Plan - Find one minor change that is necessary, including better reporting of surgical outcomes.

Do - Implement the changes, with test them temporarily

Study - Inspections on what was effective.

Act - Permanently change it when it is useful, or modify it when necessary.

Implementing PDSA on a monthly basis will assist Bristol in learning and will help it improve over time. It also makes the staff feel engaged and reassured, as they are able to realise some improvements within a short period.

3.3 Using Lean principles for minimising delays

Lean thinking is geared towards the elimination of waste and simplifying work. Bristol had a lot of delays due to the fact that information was not shared in a proper manner, and staff meetings were too numerous. Through Lean, the hospital will be able to review all patients along all stages of their journey and eliminate unnecessary elements (Dewi et al., 2021). The easiest Lean measure is to have a transparent checklist for every heart surgery. This is to keep the staff organised and minimise errors. Teamwork is also promoted by lean since all people collaborate to ensure that the process is smoother.

3.4 Applying the Six Sigma model to minimise errors

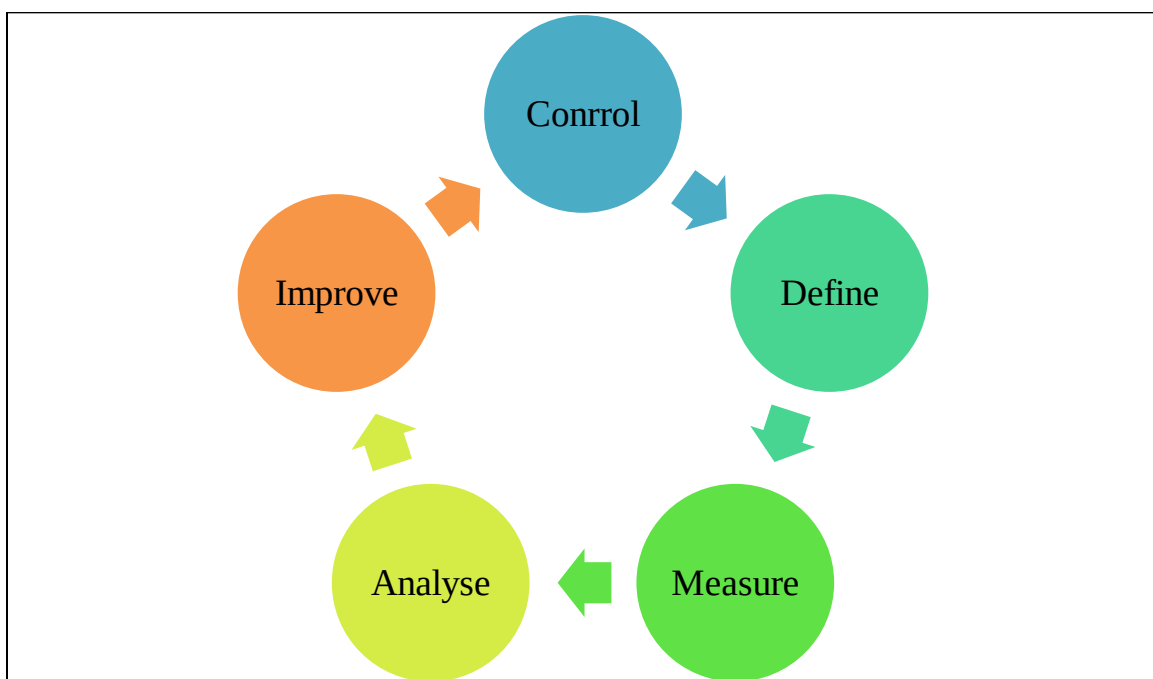


Figure 4: Six sigma

(Source: Self-developed)

According to Trakulsunti et al. (2020), Six Sigma assists in eliminating variation and errors. The medical results of Bristol were not stable due to the lack of proper reviews and standard

procedures. The Six Sigma initiative can be aimed at enhancing the precision of the surgical outcomes through establishing standard methods of operation. This implies that all surgeons take the same safety precautions and inspections. The hospital will be able to monitor these outcomes over the time in order to ensure a decrease in errors. Six Sigma is useful, as it does not rely on guesswork when making decisions.

3.5 Using PDCA cycle to control the quality

The PDCA cycle or Plan- Do-Check-Act concentrates on sustaining the quality (Malega *et al.*, 2021).

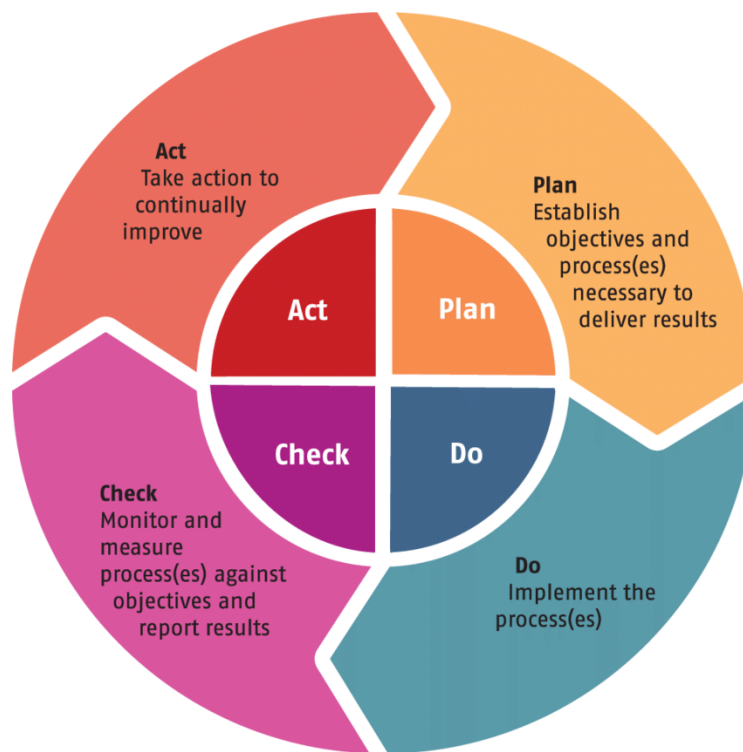


Figure 5: PDCA cycle

(Source: Heo, 2020)

Plan- Address all issues within the hospital including inadequate communication

Do – Develop a fresh checklist on communication

Check- Review results of the checklist

Act – Implement it as a effective procedure within the work culture

This cycle helps to make continuous development while assisting the hospitals to establish a sustainable system.

3.6 Enhance Training and Skills Development

Employees need to do continuous training, particularly for complicated surgeries or treatments. Junior employees need to be trained through mentoring approaches (Hookmani *et al.*, 2021). Additionally, leaders need to focus on individual team members, whether they feel confident or not. Employees can enhance patient results by doing training.

4.0 Conclusion

The Bristol Royal Infirmary case indicated how critical issues can escalate when a hospital lacks effective clinical governance. Several errors did not lead to the high number of deaths in the heart surgery of children. This occurred as all the systems, the leadership, the communication and culture represented by weaknesses simultaneously. The models applicable in this report included the Fishbone Diagram, 5 Whys, Donabedian Model and SWOT analysis which assisted in demonstrating that many areas caused failures to work together. They also demonstrated that the cause of the problem was lack of appropriate supervision, safety checks and learning.

The suggestions offered in this report will be oriented towards a safer and more powerful system. Such tools as PDSA, Lean, and Six Sigma can assist the hospital when it comes to systematic improvements as they promote teamwork, straightforward checks, and continuous education. The most significant transformation is the establishment of a culture in which employees feel comfortable to report and leaders immediately respond to concerns raised by the employees. The hospital can avert errors, and ensure the safety of patients in future by enhancing governance, training, communication and monitoring. The lessons of this case are that excellent systems save lives and high-quality and safe care are based on sound governance.

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