

**The BRI Inquiry into Paediatric Cardiac Services in Bristol 1984-1995**

Name	Patricia Dorothy FIELDS
Address	Bristol Royal Infirmary Bristol BS2 8HW
Occupation	Professional Head of Nursing, Bristol Royal Infirmary

**Background**

1. I qualified in Wolverhampton in 1971 as an SRN, the modern equivalent of which is an RGN. I have undertaken courses on first line and middle management, as well as specialist nursing courses, but not specifically ITU or cardiac courses.
2. I worked in Wolverhampton from qualification until 1974 and moved to South Africa, where I worked until 1975, moving back to the UK to work at Northwick Park Hospital, undertaking general nursing, specialising in surgery.
3. From Northwick Park, I moved to the BRI in 1977 to work as Nursing Officer for Surgery, which was the most senior nurse role in the surgical wards.
4. I held this post until 1983 when I went on maternity leave. I returned to work after 6 months, to the same position.
5. I went on a further period of maternity leave in 1985, returning after 6 months, again to the same position, which I held for another 18 months to 2 years. I left in 1986 to have my third child, before general management was introduced, in about 1987/1988.

6. In November 1990, I applied for and secured a 3 months part-time contract with the BRI. I was employed as an Operational Nurse (Grade I) to organise the nursing services within the surgical unit as the unit was using high numbers of agency staff, and I had previously managed a nurse bank. This contract was extended. In 1993, I took over the management post for Trauma and Orthopaedics to cover long-term sickness absence, again working part-time. I held this post for around 9 months to 1 year, working with Maggie Peacock and then Kate Orchard as General Managers for surgery.
7. In 1992, I became Directorate Nurse Adviser for Surgery, taking over Mary Luhman's place when she transferred to Community as a General Manager. This meant that I was now the professional lead within the Directorate – I was the most senior nurse to bring professional nursing issues to, and it was my job to keep other nurses informed. The position was a Grade I and I subsequently transferred onto the senior manager's pay-scale.
8. In 1993 I became General Manager, Anaesthetics, whilst continuing as Directorate Nurse Adviser for Surgery. I was keen to retain the Directorate Nursing Adviser for Surgery role because the Anaesthetic Directorate was on call for surgery and that way I could keep in touch with both Directorates. Joe Devaney had been the General Manager prior to me and held the post for 3 years, working with anaesthetists Dr Brian Williams and then Dr Chris Monk as Clinical Director of Anaesthetics. Dr Monk had been Clinical Director for about 1 year when I became General Manager. We worked together for 3 years and had a good working relationship.
9. Around 1998, the Trust was re-structured and the Directorates were reviewed. The Directorate of Anaesthesia became the Critical Care Directorate. I applied for the Professional Head of Nursing position for BRI, BGH and Keynsham hospitals and was successful. I still hold this position today.

**Issue B1: The structure of paediatric cardiac surgical services at the respective sites at the BRI and BRHSC, including:**

(a) **the services offered**

10. I have no detailed knowledge of this, as my role was essentially an advisory one.

(b) **funding of services, and the incentives created thereby**

11. I am unable to comment on this as I had no involvement for paediatric cardiac surgery.

(c) **organisational set-up: lines of authority, chains of command, communication and accountability, both professionally and managerially**

12. In my role as Nursing Officer, I reported to the Senior Nursing Officer, who at that time was Miss Janet Gerrish. There were 6 other Nursing Officers in the BRI. I was responsible for all nursing staff in surgical wards, including those on night duty. The role involved mainly sorting out staffing issues. I was also clinically involved supporting the wards, for example, helping out on the drugs rounds. There were many students on the wards and I supervised their training. The students also had mentors and assessors during their training. Nursing Officers were regarded as nurse leaders, as there were no general managers then.

13. Although the cardiac unit was, at that time, still part of ITU, cardiology and X-ray as a whole, the Nursing Officer to the ITU and cardiac unit was, I believe, Lorna Wiltshire, who was succeeded by Lynn Green in around 1981. She and I covered each other's areas if one of us was away. Miss Gerrish, as the Senior Nursing Officer, and myself would meet with the sisters on a monthly basis to discuss nurse staffing issues.

14. I had very little direct involvement with cardiac surgery, except perhaps to cover the absence of Lorna Wiltshire who was the relevant Nursing Officer. If we were both on duty and finding it a particularly difficult shift, we would try to support one another, and possibly get in help. However, I do not recall being told of any particular or significant problems in cardiac surgery.

15. I also worked alongside the Trust's Nurse Adviser to the Board, who at that time was Margaret Maisey. She and I met with the Senior Nurse Directorate Advisers every other month to exchange information, for example on national issues, Trust initiatives in nursing and information on concerns that had been conveyed to Margaret Maisey by the Nursing Advisers, usually relating to staffing and workload. These were known as the Trust Nursing Advisory Committee (TNAC).
16. The surgical sisters had sisters meetings, some of which I chaired. These meetings were held monthly and were minuted. Around 15 people attended each month and if a sister could not attend, then she would often send a deputy. Information was disseminated from the Trust Nursing Advisory Committee (TNAC). Professional issues were discussed as well as training needs, workload pressures, and trends for development. The sisters would also share incidents which had happened in their workplaces.
- (d) **The extent to which medical and nursing staff were involved in management and managerial issues**
17. As a Nursing Adviser, I would get involved managerially by helping ward managers with the reconfiguration of skill mixes or the change of service provisions. Nurses had their slot on the agenda, and I would advise and support them to enable them to prepare and present their "case".
- (e) **facilities available at each site, including their use by other services, eg adult cardiac surgery**
18. I have no detailed knowledge of this, as I did not work at BRHSC and my role at the BRI was advisory, rather than clinical.

(f) **staffing: numbers, natures of posts held, criteria for appointment and employing body, training and experience, job plans or descriptions and their review, and patterns of deployment (such as the use of shared appointments and the rotation of skilled staff)**

19. I have already covered this (see paragraph 17). Ward managers were responsible for the day to day planning of staffing and managing nursing staff.

(g) **regulatory and disciplinary structures**

20. As a Nursing Officer and later as a Nursing Adviser I was involved in internal disciplinary procedures. These generally related to drug errors. I would look at the causal factors, and make decisions about training or development needs. Nowadays the process involves systems analysis, that is, regard will be had to the global issues, rather than just looking at human error.

21. When I first joined the BRI, there were set disciplinary procedures. It was left to the Nursing Officer and Senior Nursing Officer (Janet Gerrish) to decide on the action to be taken. If the error was so significant that it required immediate action, then that would be done.

22. On converting to a Trust, there were still set procedures. In this instance it would be the Nurse Adviser's role, together with the Trust Nurse Adviser (Margaret Maisey).

23. I have never had to refer a nurse to the UKCC for professional misconduct.

(h) **counselling and support for staff**

24. I believe that counselling has always been available at the BRI. My role as Nursing Advisor included supporting the whole nursing process and I felt that I was always available for nurses to raise any issues and concerns, or if they just needed someone to talk to.

25. Latterly, the Occupational Health Service has been available to staff, offering counselling and support. Initially, problems were dealt with “in-house” – I might be involved to assess the problem and suggest the sort of support that was needed. The Service is now used quite a lot.
26. To offer my support I would go to the Ward when there was a heavy workload and ask how that could best be managed – I would be proactive rather than waiting for someone to come to me to say that something was terrible.

(i) **relationship with the University of Bristol and other academic centres**

27. I have no knowledge of this, and so am unable to comment.

(j) **key managers and clinicians: identities, powers and functions, collaboration between disciplines**

28. As with the culture of all hospitals, I believe the BRI was, and still is, medically led. I think the General Managers sought the views of clinicians before other staff.

(k) **nature and scope of “outreach” clinics and other services offered by the paediatric cardiac team to local hospitals**

29. I have no knowledge of this and so I am unable to comment.

**Issue B2: The implications and effect of designation, and de-designation, as a supra-regional centre upon the financing, organisation, management and delivery of paediatric cardiac services at Bristol**

30. I have no knowledge of this and so I am unable to comment.

**Issue B3: The effect of the creation of the UBHT in April 1991 on the financing, organisation, management and delivery of paediatric cardiac services at the BRI**

31. When I returned to work at the BRI in 1990, on the initial 3 months contract, the Bristol hospitals were about to become a Trust. When the Trust was created, the structure became very fragmented. Everyone had their own budgets, all the way

through the structure. By way of an example, if there was a shortage of nurses on one ward, then agency nurses would be used, rather than asking for (or obtaining) help from another ward, because of the budget implications. This meant that units no longer worked together as closely and cooperatively as they had before, always being concerned about the implications for their own budgets, which were jealously guarded.

32. I was saddened upon my return to see such high levels of agency staff being used. It was difficult to get people to work together, even within the Directorate of Surgery. I noticed that there were power struggles within each of the Directorates because of the devolved budget structure.
33. I felt that the quality of care offered was bound to be reduced due to the large number of agency nurses. My first task was to advise Mr Roger Baird as Clinical Director for Surgery that, in order to sustain a good quality of service for all patients, we would have to close some beds on the ward, and reduce the numbers of agency nurses being used. The Directorate also needed to save money, without reducing the numbers of operations, by using its resources more efficiently across the Directorate.

**Issue B4: The implications of, and incentives created by, the means by which paediatric cardiac surgical services or staff members were financed or paid**

34. I am unable to comment on this.

**Issue B5: The nature, scope and use of the mechanisms and procedures (whether formal or informal) for establishing, monitoring and maintaining (a) safe treatment and care; (b) high-quality treatment and care; (c) professional competence and (d) managing costs; and/or for monitoring clinical outcomes and adverse events**

35. The sisters organised and chaired standards group meetings. I did not regularly attend these in my role as Directorate Nursing Adviser, but I would usually get copies of standards that were agreed at the meetings. I would sometimes be asked for advice.
36. The Ward sisters had their own ward management meetings during this time. I did not attend these meetings unless I was asked to do so.

37. At the time, the structure was not so rigid that any nurse could not come and see me, and bypass their reporting sister, if it was necessary to raise concerns then and there. They could have the choice of a senior nurse, who was present on the cardiac unit at all times, or they could come and see me or, indeed, Margaret Maisey, who was always contactable.
38. People readily raised issues with me, although I cannot recall any specific instances. The types of problems I would have to sort out would generally be nurses with budgetary concerns and senior nurses asking for help in completing skill mix reviews before taking them to their General Managers.
39. I do not recall there being any significant problems with cardiac surgery during this time.
40. I did not see any surgical results, as these were seen as a medical issue involving only the consultant medical staff.
41. I did get involved in investigating an incident where the wrong blood was given to a patient in theatre. I chaired the investigating committee, involving nurses and anaesthetists, which eventually led to drawing up protocols for the handling of blood in theatres generally.
42. I am not aware of any other incidents involving anaesthetics or surgery.

**Issue B6: Protocols and guidelines to assist clinical decision-making and practice**

43. Protocols and guidelines are devised at ward level and are reviewed regularly. There are protocols for almost every task and situation that can arise.

**Issue B7: Documentation and the maintenance of high-quality clinical records**

44. Again, this is an issue dealt with and supervised at ward level. It is every nurse's responsibility to maintain high-quality clinical records.

**Issue B8: The location of responsibility for (a) staffing levels and staff training; and (b) management and co-ordination of the staff team**

45. This is managed from ward level. I had an advisory role in skill mix reviews.

**Issue B9: The information made available to referring clinicians, and to members of the public, on the standards of treatment and care attained at the BRI**

46. I am unable to comment on this.

**Issue B10: Complaints procedures available to members of the public, their use and the responses to such complaints by the hospital, Trust or health authority**

47. Before achieving Trust status, it was my impression that there was not a robust complaints procedure in place. If the complaint required a nursing response, it would fall to the senior ward sister, and I would advise if I was asked.
48. Within the last year, there has been a more robust complaints system and if a complaint is received that requires a nursing response, then I would discuss the issues with the most senior nurse on the ward.

**Issue B11: Mechanisms and structures available to staff members to raise, and to secure action upon, clinical or managerial issues of concern to them; and the limitations of such methods**

49. Before the Trust, there was no formal mechanism for staff to raise concerns, although it is much more formalised now. The present Director of Nursing has created mechanisms for senior nursing support within the Trust.
50. From a personal viewpoint, I would seek advice from a peer if I had a problem that I needed to discuss, ie another Nursing Officer or Mrs Maisey.

**Issue B12: The culture of the BRI, as expressed in such matters as:****(a) the relative power and status of key individuals, or groups such as managers, surgeons, cardiologists, anaesthetists, nurses, or professions allied to medicine**

51. The culture of the BRI was no different from that of other large teaching hospitals. It was very much medically dominated. When I joined, the Senior Nursing Officer worked closely with the senior doctor and managed the agenda. There has been a lot of change since, in that the BRI is not now as medically dominated. There is more regard to the multi professional agenda, staff recognise that they are not able to work alone.

**(b) The self-image and morale of such groups**

52. From my perspective, the nursing officers had a lot of work to do in order to overcome the medical dominance in existence at that time, to be allowed the opportunity to give a balanced, progressive view on nursing issues.

53. Morale was generally fine but any change that was introduced had to be implemented gradually, as some of the staff were rather more resistant to change.

**(c) identity and loyalties amongst staff members, whether towards other staff groupings, or to outside professional association or other societies**

54. To my recollection, the various staff groups worked together effectively. There were no large conflicts that I can recall. If any conflict did arise, which I believe may be the case in any large organisation, it was usually overcome, with every effort being made to resolve it.

**(d) leadership, team-working and communication between members of staff**

55. There were identified leaders for people to turn to. From the Nursing Officer perspective, I believe that both working relationships and communication within my team were good.

(e) **the responses towards poor performance by a member of staff**

56. In the early years, there was a very punitive approach to disciplining staff who had made mistakes, especially nurse drug errors. This has changed in time and is now viewed as an opportunity for re-training and identifying what can be learnt from those mistakes.

(f) **the attitudes towards patients who complained of poor service or care**

57. This was always handled sensitively, looked into and an appropriate response made. Nowadays, there is a more formal and robust approach – we are encouraged to look into it thoroughly and deal with the complaint promptly.

(g) **the attitudes towards staff who complained of poor standards of care and/or towards “whistleblowers”**

58. I was never exposed to anyone coming to me and saying that something was wrong and that they wanted to see something done. If they had, I would have advised them on the most appropriate route or taken it up myself or gone with them to see someone else about their concerns (for example if they were junior or not particularly confident). If anyone had approached me, I would certainly not have ignored the problem.

**Issue B13: The extent to which the structures and attitudes described under this Issue B, differ from those commonly adapted by large organisations in risky activities; and the nature of any such differences**

59. Having come from a clinical research hospital in London and not trained in Bristol, I felt that the BRI was very much a closed environment. Initially, I felt an “outsider” and that the other Nursing Officers were somewhat older and set in their ways. I did not get the impression it was a progressive environment, although this attitude changed during my appointment.

**Issue H: The effect of the split site upon the care of children**

**Issue H1: The extent to which (if at all) the quality of care offered was adversely affected by the fact that paediatric cardiac surgery and immediate post-operative care were carried out within a cardiac theatre and ICU catering for both adults and children**

**Issue H2: Communication and collaboration between the ICU of the BRI and the paediatric ICU of the Children's Hospital; and transfer of children between the two sites**

**Issue H3: The response of the clinicians and the management of the BRI to any problems created by the split site**

60. I have no knowledge of working at BRHSC and was acting in an advisory role, and so I cannot comment on this.

SIGNED : *Patricia Dorothy Fields*  
Patricia Dorothy Fields  
DATED : *24-5-99.*