

**The BRI Inquiry into Paediatric Cardiac Surgery in Bristol (1984-1995)**

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**Career and Qualifications**

1. Appendix 1 is a summary of the posts held at the Bristol Royal Hospital for Sick Children, usually known as the BCH.

**Background**

2. My role as Assistant General Manager is to work in conjunction with the Associate Clinical Directors of the services to which I am assigned, to support the clinical service and to plan for future developments. This is done in collaboration of other services, within and outside the Directorate of Children's Services, other agencies where appropriate, and in tune with the overall strategic plan of United Bristol Healthcare Trust.
3. Other responsibilities I currently hold are related to the commissioning process for the new Children's Hospital, professional lead for nursing and for the Education and Training Directorate within Children's Services.
4. Historically there was a Senior Nursing Officer post within the nursing establishment, that was the most senior post within the Children's hospital, directly responsible to the Trust Chief Nursing Adviser. When this post was vacated by Mr Neil Snee in (approximately 1990) there was no designated Senior Nursing Officer for a while, although as the senior person present I undertook the professional nursing adviser aspects. This remit was recognised and officially

assigned to me, from August 1998. By then, there was a Trust Director of Nursing, to whom I now report.

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

**B1 (a) the services offered;**

5. The general medical ward at BCH frequently accommodated children who were admitted for cardiological investigation, although the largest percentage of the patients admitted had oncological conditions. The ward configuration within the hospital provides an environment specific for babies and for adolescents, with the 1-10 age-group being allocated to a surgical or medical ward.
6. At BCH the closed cardiac surgery service was managed between the surgical ward and PICU and due to the areas of responsibility I did not have much involvement.
7. For pre-surgical investigations the child would be admitted, under the care of the cardiologists, to the medical ward. Following investigation the child would be discharged, with appropriate follow-up arrangements to attend out-patients or future admission date for surgery.
8. Cardiac catheterisations were performed at the Bristol Royal Infirmary until 1987. Any child undergoing such a procedure would be admitted to BCH, transferred by ambulance to the BRI for the procedure and then transferred back again by ambulance. In 1987 the paediatric catheter laboratory was opened at the BCH, which notably improved the service.
9. I am aware there was provision of a counselling service, available for families but cannot confirm exact details.

**B1 (b) funding of services and the incentives created thereby;**

10. There were ward based budgets for pay and non-pay, but clinical services were not separately identified or funded.
11. With the advent of Trusts, contracts for cardiology came into place and I became involved in the monitoring of these, in my role as Assistant General Manager. Any discussions with purchasers involved the General Manager and Finance department, I was not involved.

**B1 (c) organisational set-up: lines of authority, chains of command, communication and accountability, both professionally and managerially;**

12. Ward staff were professionally accountable to the Ward Manager, the Ward Manager was responsible to the Nursing Officer, the Nursing Officers were responsible to the Senior Nursing Officer (whilst this post existed), and then responsibility was to the Trust Chief Nursing Adviser, Margaret Maisey.
13. There was always a Hospital Manager at BCH. Nursing staff were accountable to the Hospital Manager though the Senior Nursing Officer. The Senior Nursing Officer might involve the Hospital Manager in professional disciplinary matters, but there was little direct contact in the 1980s.
14. Managers are now more directly involved with the delivery of health services. There is greater contact between ward staff and managers since the Trust was formed.

**B1 (d) the extent to which medical and nursing staff were involved in management and managerial issues;**

15. The focus for nurses was on the successful running of the ward. Strategic planning did not involve me, as a Nursing Officer, or those at ward level. Professional involvement was predominantly medical, with little involvement of nurses or professions allied to medicine.

**B1 (e) facilities available at each site, including their use by other services, e.g. adult cardiac surgery;**

16. Please refer to B1(a) above.

17. Parents were more often than not resident. BRHSC had accommodation on site and nearby in houses funded by the South West Heart Circle.

**B1 (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);**

18. There are recognised national guidelines for staffing for some services, for example, Intensive Care. Not all clinical services have such developed tools to ascertain required staffing levels.

19. In practice ward nursing establishments are heavily influenced by available resources, subject to satisfying requirements for patient safety.

20. There is an almost constant challenge to balance skill mix, funding and adequacy of staffing to meet the needs of the patients at the time.

21. Nurses are involved regarding re-deploying staff, booking agency staff and advising on further measures, for example stopping admissions to ensure that the ward environment is always safe.
22. All wards were and are training areas. Nurse training changed fundamentally with the introduction in 1990 (approximately) of Project 2000. This was a new 3 year diploma level course leading to one of four different qualifications, one of which is Registered Nurse (Child).
23. Every job had a description and this was reviewed prior to staff being appointed, by the relevant line manager.
24. Individuals were recruited to a named post, with a specific job description.
25. Redeployment was on a needs basis, day by day as the workload demanded. It was a fairly frequent occurrence to move nurses from ward to ward, to ensure enough nurses with the necessary skills/experience were covering every area of the hospital.

**B1 (g) regulatory and disciplinary structures**

26. In respect of regulatory structures, nurses are registered with UKCC and regulated through a framework of professional nursing standards.
27. In respect of discipline there has always been a disciplinary structure/policy which has been reviewed over time. Every person receives a copy of this when appointed.
28. I have not often been involved in formal disciplinary proceedings. I can remember having been involved in three cases, which were eventually referred to the UKCC by the Director of Nursing. None of these involved cardiac patients.

29. My current role includes disciplinary matters at the appeal stage, after the ward manager has investigated, or if a more senior nurse is involved, I would be the investigating officer.

**B1 (h) counselling and support for staff;**

30. All staff are appraised annually to provide feedback, direction and support. Support is also provided through ward teams. Ward meetings include informal support with exchange of information and provide a network of professional colleagues and friends. More recently there has been greater awareness of the availability of the Trust's counselling services, which are linked to the Occupational Health Service.

**B1 (i) relationship with the University of Bristol and other academic centres;**

31. On the nursing side there are strong links with UWE, where nursing training is now based. Links with the University of Bristol are through the medical school, with medical students placed on the wards within the children's hospital for paediatric experience.

**B1 (j) key managers and clinicians: identities, powers and functions, collaboration between disciplines;**

32. In general there was good rapport between nursing and medical staff. Clinicians would do ward rounds with the nurse in charge, leaving instructions for the management of the patient, which would be carried out. Nurses now feel more able to raise and explore opinions with consultants than they did in the 1980's.

33. In respect of collaboration between disciplines, at ward level disciplines worked together for the patient; for example, nurses, physiotherapists and Records Department. There were not any multi-disciplinary forums to review case handling.

34. More recently, as nurse training has become more research and evidence based, nurses have become better equipped to challenge clinical case management. Nurses

are now trained to diploma level, which is a higher academic level than standard training used to be.

**B1 (k) nature and scope of “outreach” clinics and other services offered by the paediatric cardiac team to local hospitals;**

35. I was aware that the paediatric cardiologists travelled around the region to attend clinics. This didn't involve nursing or other staff.

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

36. I was aware that designation was a major issue for UBHT. I was aware that it was important, and that it centred around status and funding, but I did not know how these were linked. I was not involved with any issues surrounding this.

**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.**

37. The effect of the creation of UBHT was to place an emphasis on contract monitoring and budgets. There appeared to be an expectation that every employee ought to know about the contracts they were involved in, although this was rarely the case in practice. At ward level, the focus was on delivering the service.

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

38. I have no comment to make in respect of this.

**Issue B5: The nature, scope and use of 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.**

39. There were Trust policies in existence. Written nursing standards were introduced locally, following the launch of the RCN Dyssy System (1985), although I do not recollect any specific to cardiac services. In the main, standards were written generically i.e. Play, Escort. These standards are now streamlined and are written, implemented and monitored by nurses on the ward.
40. There were protocols which were medically led and sanctioned. Nurses would draft guidelines and seek consultants' input.
41. There were certain procedures for assessing any new staff in post. For example, nurses were required to attend IV administration training and needed to pass this before they could carry out that procedure. The responsibility now is on the nurse practitioner to gain and improve competence, and to be able to put this into practice.
42. Complaint letters and adverse events are monitored and any adverse event documented. Improvements were and are made, where indicated by what can be learnt from the experience.

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

43. There are now many more protocols. Staff are more knowledgeable about these. It is easier to gain access to information to facilitate the preparation of new protocols.

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

44. Every in-patient has a full set of nursing records. Part of the nurse's job description is to keep legible notes. The constant aim is to record notes contemporaneously but

this is sometimes constrained by practical demands on the nurse's time where patient safety is always the priority.

45. There is considerable duplication in the records, for example nurses used to have to write out administrative details repeatedly. This was reduced by the use of adhesive addressograph labels. Different departments have different documentation, for example PICU and the wards. My view is that there is scope for re-designing the notes to make them more patient focused, rather than by discipline.

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

46. I refer to my comments at B1(f) above.

**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.**

47. In respect of BRHSC, this was dealt with by the medical staff. In respect of nursing, the "philosophy of nursing" was introduced in around the early 1990s. As part of this, a more holistic approach has been adopted and patients are informed of their "named nurse" displayed on the head of the bed and on ward noticeboards.

**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 leadership.**

48. As Ward Sister or Nursing Officer, I was involved in complaints about issues at ward level. My involvement was to investigate and, maybe, draft a response. Complaints at that level tend to be about "housekeeping" issues, such as food, waiting time, staff attitude, etc.

49. Complaints at BRHSC were all signed off by the Hospital Manager. All complaints in respect of the Trust are now signed by the Chief Executive. This change has come about in response to a new national complaints procedure.

**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.**

50. Complaints are made through the line management structure as well as by informal discussions. As Nursing Officer/Assistant General Manager, I would raise concerns or complaints with medical staff if appropriate.
51. On the management side, I could go to the Hospital Manager about management issues, but I was less confident where I could go beyond that. Having reported to the Hospital Manager I expected the Hospital Manager to deal with it or to raise the matter with other relevant people.
52. I think that we are now better at explaining the problem and trying to find a solution, the management approach is now less formal and management is more approachable. This creates freedom to think about solutions and there can be more open discussion. In the early years, lines of authority were clear and quite rigidly adhered to for discussing and making decisions.

**Issue B12: The culture of the BRI.**

53. I can only comment in respect of BRHSC and would say that it was (and is) a friendly place. In the early years of the Trust there was greater competition between the specialities for funding and resources, whereas before there seemed to be greater collaboration, so that we were able to deploy staff fairly readily. Wards were not then competing to conserve their own resources, for example equipment and staff.

54. BRHSC focuses on family centred care, with facilities for parents, play areas, play leaders, etc. All services are patient and family focused. BRHSC has long been recognised as a regional speciality centre for certain services, e.g. oncology, bone marrow transplant, and cardiac services.
55. The Trust policy in respect of capability of staff is to approach it via education, support and teaching. BRHSC has always taken this approach.
56. In respect of staff, they tended to share problems within their ward/department teams. I am unaware of any victimisation, because it usually transpired that the problem was something that was a consensus view, and the complainant was not standing alone, but just the first to speak out.
- B13: The extent to which the structures and attitudes described under this Issue, B, differ from those commonly adopted by large organisations involved in risky activities; and the nature of any such differences.**
57. I am not able to comment on this.

**Issue H: The split site.**

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

58. I was not involved in the ICU at the BRI.

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

59. In respect of transfer between sites, I was only involved from a patient care perspective. The child for cardiac catheterisation before 1987 was sedated at BRHSC and an ambulance arranged to take the child and parents to the BRI. The child would be accompanied by a qualified nurse, and an anaesthetist would be available to receive the child at the BRI. Parents could go with the child if they wished. A nurse would then "recover" the child after the procedure and bring the child back to BRHSC when they were well enough to travel. This would again be by ambulance transfer.

60. The fact that there had to be a transfer took up significant nurse time. There were also some in-built delays especially in respect of ambulance timing. This did cause extra stress for the family and child, and could lead to the pre-med being extended if there were significant delays. Now there are not so many external factors to prevent the smooth running of the process, of transfer from the ward to the catheter laboratory within the hospital and back to the ward.

61. When children came in for pre-operative investigations they stayed for 2-3 days, and then went home with an outpatient appointment. We did not always hear what happened next. If a child was admitted for cardiac surgery, the child was normally admitted straight to the BRI. Even now, children can be nursed by different teams;

medical nurses for cardiology and surgical nurses for surgical procedures. There is, however, continuity with some members of the team remaining the same, for example dietician and physiotherapist.

62. Each ward has an admission list. Staff check the admission list and can see if a child with whom they have had contact has been admitted onto another ward.

63. I remember that there was an attempt to arrange an exchange of nurses at BRHSC with cardiac nurses at the BRI. However this was not very practical as all the posts were within the required establishment and the skills were different for both units. There was a general shortage of paediatric trained nurses for much of the period.

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

64. I was aware that medical staff did not like the arrangement of the split site. However, these were recognised specialist procedures and specialist equipment was needed. It was generally accepted that the procedures could not be done at BRHSC. We tried to ensure that a nurse who knew the child stayed with the child.

65. Over the years management reports referred to transferring the paediatric cardiac surgery service from the BRI to BRHSC. I became involved in liaising with Ward 5 BRI staff in the assessment of equipment, personnel and resources preparatory to eventual transfer in late 1995. I was mainly in discussion with Rachel Ferris, Directorate General Manager, and Fiona Thomas, Cardiac Nurse Manager.

66. There were several joint planning meetings for the transfer held at BRHSC, involving medical staff, anaesthetists, perfusionists, etc. The theme for the discussions was how the service could be accommodated and serviced within BRHSC. Initially I was the lead person at BRHSC on the transfer of paediatric cardiac services. William Booth, the Clinical Manager for PICU, then became involved in the detailed arrangements.

SIGNED : .....

  
BARBARA SHERRIFF

DATED : .....

24<sup>th</sup> June '99

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