What will history say?

There has been so much happening in the NHS recently that looking forward to developments in this year left TONY CARR somewhat confused. In spite of this, he predicts it will be an important year for nursing.

AN OUTSTANDING historical landmark in nursing during 1983 was the first election of the national boards for nursing, midwifery and health visiting. Large numbers of nurses who had opted-in to the elections exercised their right to vote. The transferable vote system, though confusing, produced the necessary numbers of successful candidates.

Now in power, the major task facing the national boards is to develop their own educational policy that will, in turn, lead to the establishment of a series of curricula and, from them, courses.

I would like to see firm proposals emerging during 1984 for discussion among nurses concerning their basic training. It is much more like crystal ball gazing than anything I know, both concerning the year and content, but it is important to have faith that some document will appear.

My view on this subject is, of course, subjective. The EEC directives for general nursing (first level) were interpreted by the General Nursing Council in its educational policy document of 1979, strictly in terms of time periods for the necessary specialties.

I believe many in the profession would welcome evidence in 1984 that second-level training was not only to be preserved but changed. What about a completely new 18-month basic course? It would have two main objectives.

First, the study of man as a social being. I think there must be a real move

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away from sickness-oriented care to the basic preparation of understanding people in sociological, behavioural, psychological and spiritual terms. Present training is a focus on illness, not well-being; injury, not wholeness; signs and symptoms of disease, rather than on real understanding of successful living.

How can nurses properly lead their patients into a measure of good health and recovery when they are taught that the basic recognition of recovery is essentially absence of pain, normal temperature, pulse and repiration rates?

It still amazes me that many patients on discharge still know little, if anything, about their illness and what they should do to achieve normality, albeit within whatever constraints that particular illness has imposed on them. Let the new nurse student first study the whole man and his environment, in all its dimensions, sufficient to understand that he is an extremely complex social being and, as such, reacts in many different ways to illness.

The other objective would be to teach basic nursing care and anatomy and physiology, the latter in terms of complete systems; that is, breathing, elimination, digestion and so on.

The educational policy committee of the English National Board may give this matter its attention in 1984. If so, I would suggest that this level be seen as registration. The clinical experience could be taken in many different clinical settings.

Will the profession be equally daring and abolish external national examinations? Continuous assessment and internal examinations based on previously designed detailed submissions would be an indication that we were thinking constructively. Will we be equally daring by beginning to think in terms of progression from registration to diploma and higher diploma courses?

Basic registration could approve a nurse to assist in the care plan of an individual patient, while successful completion of a higher diploma in general nursing, mental health, children's nursing (not sick children's nursing), could lead the nurse to be approved to plan and execute a patient's care plan. Again, I would hope that internal assessment and examination would be the model of operation.

What I have written is purely speculative, but it would be exciting if 1984 was the beginning of serious concentrated discussion on this essential subject.

Some health authorities, particularly those in London and the south, have for some time experienced a reduction of funds because of the application of the recommendations of the Resource Allocation Working Party. However, 1983 brought the first government overall reduction in revenue, and that in the middle of a financial year. Also imposed was what has become a yearly 0.5 per cent efficiency saving.

If that was bad news, then the secretary of state's imposition of manpower targets was received by some chief officers with disbelief – the approach was so crude. A reduction of manpower was required on March 31 1983, and in-post figures of an average of 1 per cent by March 1984.

Little did Mr Fowler realise the reaction from health authorities, the public, professional staff and even Conservative back-benchers. The crudity relates to the fact that the in-post figures of a health authority can vary by as much as 100 to 200 staff in one month.

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– Tony Carr

Health authorities may have achieved the reduction required overall by March 1984, but an intake of learners on the wrong date can make a year's effect useless in the eyes of the DHSS. Managers are being required to play the numbers game. At least the public outcry in 1983 made sure Mr Fowler backtracked on his demand for a 0.5 per cent reduction in doctors and nurses at the Conservative party conference.

But what of 1984? Will the figures required by the DHSS be achieved? If many health authorities fail to make the reductions, what action will be taken against either health authority members and/or their officers?

What services will be reduced or curtailed in 1984, occasioned either by the manpower cuts or the financial restrictions imposed? One can only guess. But it must seem to any logically thinking person that a government that just arbitrarily chooses a date – known to many nurse managers as a low month for recruitment – and reduces on that figure, is to cause a staffing crisis of significant proportions in some health authorities.

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It is to be hoped the intervention of the government will be as successful as the proposed cuts in NHS administrative staff. The idea of a staff commission proposed by the unions and professional associations did not find favour with the DHSS; instead, the new policy of decentralisation allowed regions to form their own policy based on a national policy.

The differences in interpretation were wide. At one extreme, it seems that some regions offered early retirement and/or redundancy to any officer aged 50 or above, while others would only offer retirement to officers after they had been on the interview circuit for many months at several levels in the organis-

ation. The consequence for those generous regions is that, in 1984 and subsequent years, they will be required to contribute to the millions of pounds of pension for those officers.

What may surprise some is that those regions which allowed officers to choose retirement had what can only be described as a large and overwhelming response. One is forced to ask why officers at the age of 50, holding – in many cases – important, interesting and challenging posts, are willing to take a net reduction of about 28 per cent in salary in real terms, and retire? Perhaps a reasonable explanation is that senior officers, in particular, are not prepared to be continuously chasing their own jobs at the whim of various government's aims at reorganisation.

This may prove an important matter in 1984. Nursing has, perhaps, had more formal change than any other profession or discipline. There are chief nurses who, being matrons in the late 1960s, were required to reapply under the Salmon proposals. In 1973, they had to apply for either an area or district position. Less than two years ago the "musical chairs" game of trying to retain one's own job, if it still existed, or a near alternative if not, brought extreme anxiety to many nurse colleagues. Now 1984 will bring the most fundamental change since the 1860s.

The advent of the chief executive/general manager is a major change. I even heard an MP say that Florence Nightingale would approve of these aspects of the Griffiths report. It just shows the ignorance of people in parliament, since the aggressive approach of Miss Nightingale was to wrench the service of nursing from its medical management domination – she always campaigned for all female staff to be managed directly by the matron. What we now have are proposals that will take away the general management responsibilities from nursing and give them, in many cases, to either an outsider or a person of another discipline.

More than 100 years of development in nursing are to be removed on the recommendations of a small group of businessmen who, having spent a while drifting round a few areas/districts, wrote a few reports of a subjective nature. Certainly, the quality of one report I saw would not have been accepted by a health authority if it had been written by one of its officers.

At the last general election the prime minister's slogan was: "The health service is safe in our hands." A pity that she did not disclose: "But we intend to reduce its resources and destroy organisational nursing as it is known today."

To say that general management can be separated from functional management – that is, professional function – is just not true when related to nursing. A general manager can determine the resources made available and then require the functional manager to work it to a predetermined level. There is no doubt in my mind that, very shortly, non-nurses will be telling nurses how to do their jobs.

So the fundamental change in 1984 is that nurses, in most cases, will lose the right to manage their own staff. These developments do show up the naivety of those nurse academics who have been proposing, for some time now, that the nurse practitioner is only responsible to her patients.

Nurse managers are there essentially, they say, to provide the manpower and other resources. Now other people will make those decisions and require a much closer monitoring of those resources than ever before.

Those nurse managers remaining will have the thankless task of trying to get back what Florence Nightingale gained in her battle with authorities. What can nurse managers in 1984 do? Challenge every decision made by a general manager if it affects the standards of patient care or reduces the decision-making capabilities of a ward sister, midwife, health visitor or district nurse.

The greatest ally the nurse manager has is the national board. Where training is at risk, use the education officers as an outside influence. Propose reductions in training if resources are reduced to the health authority, and spell out the consequences of decisions being made in the name of general management if it affects patient care. Finally, nurses may get a pay rise in 1984 – that is, if the pay review body ever meets!

When the 1980s are written as nursing history it could record with sadness that this was a period where nursing went into a decline, where its leadership was disillusioned, where morale was at its lowest, where patients suffered most from lack of resources. That is, of course, if its leaders want it that way.

Instead, it could read that the 1980s, starting from 1984, was when nurse leaders came to maturity. This was the year when they said enough is enough, and engaged in the battle to preserve, protect and enhance the profession and its standards of patient care. I wonder what history *will* say? □