The shape of things to come

Anthony Carr, ANO for Newcastle AHA(T), reviews the Royal Commission's report on the NHS — and finds it sometimes lacking in understanding of the nurse manager's role in relation to patient care

The report of the Royal Commission on the NHS in several places mentions the growing influence of nurses in the higher levels of management. Since the introduction of chief nursing officers in the late 60s early 70s, and area and district nursing officers in 1974, the nursing voice has been heard very much more clearly at management committee and area health authority levels, and I believe this has had a good effect on the management of patient care services. It is fully appreciated that the nurse has both the management structure and the duty rotas that are best able to show the weaknesses in the patient care services.

The Royal Commission has done its best to lay the myth once and for all that the Salmon Committee and Mayston recommendations have swollen the number of nurses in nursing administration. I don't know if 'myth' is quite the word to use because its definition reads 'purely fictitious narrative, involving supernatural persons, etc, and embodying popular ideas on natural phenomona'. Although I don't know . . .

To my understanding the medical staff in particular must be able to rationalise the changes in nursing administration in this way. I indicated in *Nursing Times* in February 1975 that in percentage terms the numbers of nurses in administration had fallen quite constantly from 1966 to 1973, and used an appendix of the Halsbury report to show this clearly. This did not persuade any single person that I knew that the figures meant anything and so I think we shall continue to hear the debate that good nurses are taken from the bedside and promoted into areas of administration.

It is very informative to talk to keen, eager nursing officers and ask the reasons why they left the wards to go into nursing administration. I did ask a nursing officer this question only last week. The reply was that she took the post because she saw she could use her previous experience as a ward sister both to support the younger sister and to assess the standards of nursing care being practised on the wards and take appropriate action if she identified unsatisfactory nursing practice.

Having this extra responsibility has enhanced her view of clinical nursing and increased her personal motivation considerably. She still felt fully involved in caring for patients. She taught learners and frequently assessed them for their practical examinations. When I asked about becoming a nursing officer for the extra pay she quickly enlightened me and stated that frequently ward sisters earned more than she did. She had not opted out of nursing but had become even more involved.

Perhaps what medical staff are really saying is that under the matron type of administration which they wish to return to, they managed the ward sister and there is perhaps some resentment of the nursing officer having taken over that role. This is why I believe the myth I spoke about earlier will remain.

The Commission stressed the need for developing the clinical role of the nursing officer in line with the recommendations of the Salmon Committee. In a survey published in *Nursing Times* about 18 months ago, I found that on average 25% of a nursing officer's time was spent in the patient care area in direct contact with the patient. Until, however, the senior nurse has patients to care for directly the difficulty of acceptance by the medical and other nursing staff remains.

I would, therefore, make what is for many senior nurses a most radical proposal. Every senior nurse from nursing officer up to and including area nursing officer should have a direct clinical involvement at sometime during the week.

As an illustration of how this could work let me put forward a few ideas. For a divisional nursing officer it could be a particular interest in a special group of patients such as those with multiple sclerosis. She could become knowledgeable in the latest treatments and development of new nursing techniques. Another could, as an example, have an interest in the care of the dying patient in hospital, have a working group of practising nurses advising her and go and work with them one or two half days or evenings a week.

Our medical colleagues have really shown us the way it could be done. Almost every medical teacher to medical students has a patient commitment. To do likewise so clearly 'keeps one's feet on the ground' and would allow the senior nurses to exploit years of previous clinical experience. This is equally true for tutors of all grades.

A combination of joint appointments as proposed between clinical and tutorial posts is welcomed, but why not extend this to management? Although I have been asked to talk about management, I believe clinical practice and management should be complementary in the same person.

Management of a hospital service

Although nursing is not specifically mentioned I have assumed it to be part of the services to be co-ordinated by the administrator in the hospital mentioned in Chapter 20, paragraph 27 of the report.

The one criticism I have of the report, and unfortunately it is a major one, is that the arguments put forward are sometimes superficial. The arguments for the chief administrator are not at all sound. It is no more than an assumption that an administrator co-ordinating all the services will improve the service to the patient. Can I ask — is this co-ordination to extend over 24 hours, seven days a week, including bank holidays? If it is not, I guess nursing again will be used as the unofficial backstop, unrecognised and, of course, unpaid.

I think the great fault in this

argument is that the Commission did not go low enough into the organisation before it made its proposal. It stopped at functional managers at hospital level. I go to the main purpose of the whole existence of a hospital — to care for people. What the Commission did not do was look at existing structures at the bedside.

Nursing has a strong hierarchy from nursing auxiliary to district nursing officers or area nursing officers in a single district area. There is lots of criticism about it, but I suggest it is the most efficient, effective way of managing people. Domestics have a system of their own, leading to a senior supervisor. Normally, not including night cover, catering is the same, together with the laundry service. The latter service normally operating a five-day week excluding bank holidays.

What management organisation does the unit administrator have which would not need a major increase in the number of staff employed in his department if he was to genuinely co-ordinate all the services? I would hold to a very traditional, and to most, out of date view that all those services impinging directly upon the patient — that includes the domestic service, linen supply and catering — should not only be co-ordinated, but managed by the divisional nursing officer through the appropriate heads of departments.

What happens so often at present is that each of these disciplines have their own aims and objectives, and if these match up with the nursing objectives it is by sheer coincidence.

The report separates co-ordination from professional responsibility. In my understanding, that is the path that leads to a total abdication of responsibility on every side.

Manpower planning

How right the Commission is when it states that the major planning problem facing the nursing profession is to get the right number of nurses into the right places, particularly unpopular areas and specialties. No real solutions are offered at first sight and this is understandable.

So often it is forgotten that the nursing profession is made up of large numbers of women aged between 18 and 23 years — from a continuous labour point of view a very uncertain field on which to plan. The increasing higher marriage rate among learners is noted and many more nurses holding senior posts at ward sister level and above have family responsibilities. The movement of staff between hospitals is high, particularly among staff nurses.

Much of manpower planning in nursing is concerned with the intake of learners. For many years control of the establishment has been through the number of learners employed. That very basic control has now been challenged by new educational programmes. A learner, in service terms only, becomes as expensive as a ward sister. There is thinking that argues that the investment is just not worth the intangible results.

What else can be done? The Commission suggests more attention being paid to mature students and men in nursing. I believe this to be right although the results of the latter proposal have not been identified. To increase the number of men in general nurse training to say 15% in an area health authority would produce a greater stability in the workforce. Family responsibilities generally make a man more determined to succeed at work. Because of family commitments he is likely to stay in the locality. All this produces stability in the ward team.

If, however, the women continue to demonstrate high turnover rates, the number of men as a total of the establishment increases each year. It may be possible that within ten years of such a change in training patterns being implemented, a high proportion of all sister posts and above would be held by men. This would certainly change considerably the attitudes of medical staff and others towards nurses. It would have an adverse affect on the promotion opportunities of women.

Career development

There is little said about career development of staff. By this I mean managers taking part and achieving their two major aims, keeping staff and developing potential.

I am reviewing a proposal at present where, in addition to the normal advice given by tutors and others on careers, a properly organised central service will operate from the end of the second year of student training. The student will be seen at intervals until she qualifies. A tailor-made programme over the next year will be offered, based on the nurse's own interest and wishes. The programme will continue as long as the nurse requires it. It is hoped that this system will allow a nurse to exploit her own potential to the full with the help and encouragement of her senior colleagues.

Management development

It is a pity that so little is mentioned in the report about the development of management potential in staff. Much greater attention is focused on clinical practice and education, which perhaps reflects the lack of nurse management expertise on the Royal Commission. Contrary to popular opinion I believe that the future of nursing includes the proper development of nurses in management. It is a British disease to criticise management and eventually the organisations and institutions concerned get the leadership they deserve. There is no substitute for sound nursing management based upon exceptionally highly motivated, well qualified nurses.

How I wish that the report had mentioned the importance of adequate preparation for nurses holding management positions. There really must be a genuine move towards academic preparation for senior nurses of the future. In the areas of budgeting and financial control, planning of services, manpower forecasting and control, and the behaviour of organisations there is a need for research and teaching at higher degree level. Perhaps development of an academic approach among senior nurses to their own work may influence a research attitude at the clinical level of nursing.

Summary

Although I agree with many of the proposals contained in the Commission's report, I do not believe that many or any will affect to any large extent the way nurse managers view their work. This is sad, as a great opportunity has been lost.

I do hope, however, that the report will cause managers to review (a) their methods of work, (b) roles and responsibilities of staff, and (c) systems and methods of communications.

Finally, perhaps out of it will evolve a more careful study of nursing management from the bedside of the patient to the most senior nurse at authority level. It is still true that the small hospital run by a senior nurse controlling nursing, catering and the domestic service, is a very efficient, clean, happily co-ordinated establishment. I wonder, can we learn something from that model?

I will leave you with this statement by Ogden H. Hall: 'Structural relationships are not once and for all prescriptions but are "rules of the game" which are adaptable to changing situations and the changing desires of the participants.'

Anthony Carr delivered a longer version of this address to the conference on the Royal Commission held jointly by Nursing Times and Health and Social Service Journal.