# Nurse managers look for leaders

## By Anthony J. Carr, Area Nursing Officer, Newcastle AHA

**This article is an abridged version of a paper given by Mr Carr at the recent conference of the Rcn Association of Nursing Management which had as its overall theme 'The manager — worthy of his hire?'**

The question has been asked: are we worthy of our hire and are we worthy of our present hire fees? Make no mistake, the salaries of nurse managers are based on what we can offer in terms of management knowledge and expertise. Senior nurse managers may be worth a higher than their present hire fee. I mention 'hire fee' deliberately, not 'salary', first because that is the word given in my original brief, and second because I would like to negotiate my own fee on a contract basis.

I believe we have an expertise in managing the nursing services which has a very high price to it. What I mean by that is confidence in our own ability to plan a service, co-ordinate all those activities impinging upon the patient care area, to be able to organise those services very effectively, to make arrangements to train and develop staff to a very satisfactory level of competence, to fight for and obtain the necessary resources to enable adequate standards of care to be maintained, establish research programmes to enable staff to have a greater knowledge of what they are doing and why they are doing it.

Before I rouse you to a state of euphoria I want to ask a very serious question which would not have been asked ten years ago in nursing. It is: 'Whatever your age, have you ever thought of retiring early?'

The answer to that question goes to the root of the problem of morale facing senior nurse management today. I would guess many of you have in a joking way to your colleagues, but seriously to yourselves, asked the question 'Is it worth it all, is the pressure worth it all, is the arguing for resources worth it all?' And when you see deteriorating standards of care and feel helpless you say again, 'Is it worth it all?'.

The difficulties facing nurse management are large, and to many overwhelming. I will mention just a few of them.

### Manpower

There are encouraging statements from the Department of Health every year about the larger numbers of nurses in post than the year before. From my own rough calculations I have noted that since 1971 the erosions into the numbers of nurses we employ include the following changes in conditions of service: in 1972 a reduction in working hours from 42 to 40, thus a reduction of 4.76 per cent of the total working force; in 1974 two statutory holidays, which equated to one per cent of working time; in 1974 the Halsbury award, extra holidays for staff at staff nurse level and below equated to 1.5 per cent total loss of work force; in 1976 one extra statutory holiday which took away 0.5 per cent of the total work force, and, dare I mention them, the EEC Directives which in 1978/79 and 80, means a reduction of about 0.8 per cent of one per cent in the total work force available for service and finally the 37½ hour week. Add all those figures up and they come to about 8.56 per cent and, as nurse managers, we know two decimal places are significant when one is talking of large numbers of staff.

The figures show that in 1971 we had 246,000 staff working in the hospital service, and in 1976 we had 339,000 staff, an increase over seven years of 93,000. But when you take the loss of service this is reduced from 339,000 to 291,000 or 18.29 per cent. So the increase is not 93,000, if you are still with me, but 45,000, less 38,000 for a 37½ hour week. In 1981 when a reduction into the working week to 37½ hours occurs a further loss of 38,000 staff is calculated. A colleague has suggested that management should say clearly that there is no way of reducing the working week and offer instead to acknowledge that nurses have to work a longer week and add a special addition in percentage terms to their salaries at all levels.

This is just one side of the story, however, because what about the pace of work? Comparing the number of occupied beds in 1971 to 1976, we see there is a reduction of over 10.1 per cent. Very commendable. But if you look at the discharges and deaths over the same period of time they have increased by 1.6 per cent. Now fix those figures in your mind. With more than 10 per cent less beds, the work has increased by 1.6 per cent. But that assumes that in 1976 the work undertaken was the same as in 1971, and we know that it was not.

It is only when the figures on a national basis are reviewed that it is appreciated why nurses are saying that standards of care are deteriorating and as changes in conditions of service erode the hours available the number of nurses available in real time is reduced.

### Education

One of the difficulties of senior management, and I am sure this is true both in large industry, commerce, local authority, and the NHS, is that it takes a considerable number of years to get a controversial point of view known and accepted. I would like to speak here on the difficulties nurse managers have on first assessing and then implementing the 1977 Policy, which in turn interprets the changes envisaged by the EEC Directives, of the General Nursing Council for England and Wales.

Now, of course, it depends very much on the type of nursing education that you offer to student nurses to the financial position that you find yourself in. But even when the financial situation is settled, senior nurse management is more than just obtaining resources and allocating them appropriately. Senior nurse managers must have a vital interest in the education process throughout, both at pre-basic and post-basic level, and so I raise the question that I have raised before, 'What will be the results of the varying training courses that will result from individual interpretation of the 1977 syllabus?'.

This is vitally important to the future of nursing in wards/departments and the community. Will you, for instance, in five years time have to start to prepare to offer registered nurses pre-basic preparation in those areas not covered in general training in sufficient depth? Will it be known, for instance, that from one famous hospital nurses with reasonable preparation can man appropriate departments in your local hospital but that you know from experience that from another training school ten miles away considerable preparation will have to be made?

Now I might be exaggerating the situation but it is a point to debate. What pre-basic education are we offering to nurses today and what effect will that preparation have upon the nursing services in the future? Make no mistake, some areas will reduce intake of learners if resources are not made available.

It must be the case that nurse managers *must have* the resources, not *may have* the resources if things are going well. There is also the problem facing us of re-training our loyal staff who do not move but stay year after year in the same position. Research shows that a person in post much over five years in the same ward or department tends to reduce her efficiency. It is the responsibility of senior managers to offer refreshment, reorientation, and reassessment of a person's capabilities at this point. Many of us fail miserably in undertaking this vital work.

This leads me on to another point about whether managers are worthy of their hire. 'If I were to come with you to your major hospital and walk round its wards and departments, would most people know who you are?'. The point of asking this question is to emphasise that we must re-learn the value of using our limited time more effectively. It has been said on management courses for years that work has a happy knack of expanding in useless directions to fill the time available — a corruption of Parkinson's law. We have to control time — it is about the only thing that is controllable.

Most of you must know this. Just try restraining yourself from reading the post for two weeks. Let somebody else do it and take the appropriate action. It is amazing how much time you have left to do the important things like the occasional visit to a hospital, to be seen, to talk about the problems at ward level, to look at the new treatments being

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offered to patients — much better than getting it second, third, fourth, fifth, sixth hand.

It really does not matter which management book you open today, there is widespread criticism of organisations that form themselves into hierarchies. Now, I want to defend that system of management. It is about time that as nurses we started to defend that which so many people criticise, including our medical staff, and that is management within an hierarchy. Most people, I am told given the opportunity, would prefer self development, rather than direction. I would challenge that statement.

In the service we offer to the public we are professionals who have a heavy responsibility to fulfil Florence Nightingale's first rule and that is that we do the patient no harm. This means reasonable discipline through an ascending order of authority and I have looked at this situation for many many years and I have come to the conclusion this is the only way to properly manage the nursing services. Now whether our critics call it a bureaucracy or what, I am saying that we should not be ashamed or embarrassed of the management structure we have.

There are many difficulties, there are many faults with it, but your staff today are looking for leadership, are looking for direction, are looking for that extra something that should be present in senior managers which can be conveyed through the descending levels of management to the staff offering direct patient care.

This leads me on to a subject which has received more than passing interest over the past few years, and may be actively being considered by the Royal Commission on the National Health Service, and that is the position of a chief executive.

I am told by many people that what is needed in the NHS today is dynamic decision making. I am told that this can only come about by appointing one senior person to act as the ultimate arbitrator and decision maker in an area or district. General administrators have a continuing interest in the subject. While I find all the arguments very interesting, when I look at the complexity of the NHS and see where power and authority for decision making lies, I find this concept totally unacceptable. The nursing profession and certainly nurse managers would, I believe, react very strongly, indeed, if there was a proposal put forward for serious consideration that a chief executive role should be created in the NHS.

I am at present reading a book about American hospital administration, which is very learned, but what is so fascinating is the defence of the chief executive in the American system because it is coming under attack from many quarters. The reaction of many administrators to the thought that doctors should join the boards of hospitals is that the doctor would undermine the authority of the chief executive. Another executive bemoaned the fact that 84 cents of every dollar spent in the hospital was under the control of either the doctor or nurse and that he had no say, or very little say, in how that money was spent.

To my mind, unless a chief executive can order his subordinates to control the primary resource within that organisation then he cannot be given the necessary authority to be a chief executive in the real sense of the word. Therefore, if a chief executive was appointed we find that the only thing he could do is to control the secondary resources, such as the provision of accommodation and support staff. He or she could not get involved very easily with the medical politics of treating patients and the way they were treated, which is the decision making area that spends most of the money. He could only advise on staffing structures within professional departments, and even if he restricted resources there are marvellous ways of getting research funds which bypass all the known management controls ever devised in teaching hospitals. He would find himself fooled many times by the sheer professionalism of articulate, highly qualified staff. But if you want a chief executive to control the secondary resources I could think of nobody better than the nurse manager.

It is very easy to look back to the good old days, and I still find myself talking of them and then, of course, have to check myself. Things were not so good as we believed. But even in those good old days when one assistant matron managed the domestic staff, and when a domestic was under the direct authority of a ward sister, I would guarantee that that ward or department would be cleaner than it is today with far less staff and far less supervisory control on a day to day basis. There is a very strong case to be made that all support services that actually impinge on the patient care area should be managed by the major profession, and that is nursing.

Perhaps one of the greatest indictments against us as managers, and I include the district or the area management team in this, is that during the recent industrial unrest ancillary staff did not really see themselves as part of the caring team. And when you analyse it, why should they?

Why has it never entered the minds of most senior managers that in an induction course for all new staff whether they be domestics, porters, laboratory workers, laundry workers, refuse collectors, cooks, whoever they are, no one ever thought of giving them two weeks or so in the patient care area, as an auxiliary maybe, under a very sympathetic and understanding sister, where they can really feel that their contribution counts.

I may be backward in my thinking but if there is any thought that a chief executive is required in area health authorities then I am quite prepared to look at those services and co-ordinate them through their managers. But in effect, this is not what a chief executive is all about, it is the person that has the ultimate authority for making the decisions and allocating resources, I believe, and I say it again, that the complexity of running the National Health Service in a local area or district is such that without total co-operation from the medical and nursing staff, and support services, there is no way in which one man or woman can effectively manage the service. We must challenge that proposal.

### Limited contracts

What the profession is looking for today, which I do not feel that it has is leaders. Perhaps this is not the time in our society where we are allowed the luxury to have people. I would like to see a scheme proposed where there would be minimum salaries for divisional nursing officers, area nurses, district nursing officers and area nursing officers. But I would also like authority to be given for any area health authority which felt it had severe troubles, and problems and difficulties, to be able to offer what salary it wished for a person to manage the nursing service. In specific situations authorities should be able to offer three to five year contracts at a salary personally negotiated and to allow the most senior nurse to make their own immediate surbordinate appointments on the same basis.

Can you imagine the reaction of the Rcn's Labour Relations Department? What are the hours of work? — unlimited; what are the holidays — what holidays? What is the position of the senior nurse who does not satisfy the authority? — contract terminated. What are the rewards? — £15-£25,000 p.a. with car covering the first two grades.

Just imagine the real excitement of being employed just for your own ability alone.

The senior nursing team would be the most dynamic group of people ever to run a nursing service. Only, authorities with well below average services would wish to avail themselves of the service and that is right. The work involved would be very difficult and hard and the rewards should be high.

### Manpower availability

With changes in the ratio of persons in the community of training age I believe that management has to review critically what it wants in terms of qualified staff five to 10 years from now.

Do you really want all the registered nurses we are presently attracting? What is the real plan for the SEN? What is her role? It has taken my working party on District Nursing over eight months to define her role in the community and I have not yet met anyone who can describe the SEN's role in hospital adequately.

Once we have checked to see what people can really do then perhaps we stand a chance to recruit effectively and retain staff. Isn't it strange more work is done on staff leaving rather than on staff staying? Find out what makes people stay and you may have just solved your recruitment problem. Finally, all managers must receive adequate training in priority setting and delegation of authority.

To sum up. Take heart dear manager, you were not appointed to be popular but to do a job. You were not appointed to make people happy but to allow them to have job enrichment and be fulfilled. You were appointed to lead your people to monitor standards of service. I can only hope Mr Chairman that we shall again bring forth a Moses in the profession to lead the people to the promised land of milk and honey.

**Bevan**