A nursing view

Where have all the nurses gone?

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Medical staff must know of the shortage of nurses in many wards, particularly in the evenings and at weekends. But if they complain the doctors are told that the budget is overspent or that the number of nurses is up to establishment. Politicians and statisticians tell us that the numbers have increased over the years. So where are they? The shortage is due to inadequate establishments and to changes in training programmes. But an increased demand for nursing services and a general decline in quality of recruits are also in part responsible.

Nursing establishments

The numerical basis of most nursing establishments is lost in history but the building programmes—with their financial constraints—of the 1960s led to an attempt to standardise the numbers of nurses per bed, ward, department, and hospital. A formula was devised called the revenue consequences of capital spending (RCCS), which for a time provided workable guidelines. Studies relating nursing work load to staffing levels have been devised in several regions—for example, by Dr A Barr in Oxford and Dr Rhys Hearn in Birmingham. Since none received universal acceptance it has been impracticable to introduce a definitive standardised system. Unfortunately, a period of under-recruitment—the result of poor salaries and conditions for nurses—coincided with an attempt to improve staffing. But nursing had to compete with other increasingly attractive occupations for women. Finance and administrative officers used the underspending on the nursing budget to offset overspending elsewhere. Perhaps nurse managers were new to committee work; perhaps they had difficulty in stating their case clearly in statistical terms; or they may have failed to grasp the need to reserve funds from underspent budgets for future use. Whatever the cause, the nursing budget was reduced in subsequent financial years.

Meanwhile, the numbers of nurses have increased, partly by the employment of untrained hands and partly because of the Halsbury pay award.¹ In addition, a new breed of specialist nurses was created. This may have improved career prospects but it removed skilled care away from the patient. Personnel, allocation, planning, commissioning, infection control, and occupational health nurses were appointed. The cost of this increase in staff brought the nursing budget above the new lower level but still below that of the original establishment. This is now described as overspending but in reality underfunding has occurred.

Further confusion arises because the RCCS formula and regional norms (local guidelines for staffing levels) are estimated against nurses per bed. Area and district finance officers, however, may base the nursing budget on nurses per bed occupied so the nursing establishment becomes funded at a 75% to 85% level. Whether or not this represents underfunding

is a matter of opinion. Nurses could argue, rightly, that an empty bed for a day makes little difference to their work load. It is unrealistic to assume that staff can be moved around in response to the short notice of a hasty discharge and the reverse, an emergency admission.

The Whitley Council—over one-third of the members of which belong to affiliated unions—introduced the 40-hour week and Halsbury awarded extra holidays to all nurses in a misguided attempt to improve conditions. The RCCS formula was adjusted to include a percentage increase to cover this loss of working time but districts which failed to take advantage remain chronically underfunded. In most districts, however, the introduction of the straight eight-hour shift, which reflected the needs of the married and non-resident nurses rather than those of the patient, was not taken into account. The old split-shift system was designed for the patient: nurses were on duty in the mornings and evenings with time off in the afternoon. Patients need bathing, their dressings changed, and their bed made every morning. They need similar treatment in the evening to prepare for visitors and the long night ahead.

The early straight shift system extends from approximately 8 am to 4 pm, while the late duty usually covers the hours from 12.30 to 8.30 pm. There is, therefore, an uneconomical overlap of staff during the afternoons, when patients should be resting or receiving visitors. An ill patient cannot wait for comfort until 2 pm nor should he have to manage without it in the evenings. Attempts to reorganise the patient's day to coincide with the extra staff have failed. Care is less effective, which lowers the morale of patients and nurses. In addition, no allowance in establishment has been made for this largely ineffective overlap.

A further change in establishment has been the decline in skilled care, with false economy practised because of pressure to reduce budgets. Enrolled nurses, pupil nurses, and auxiliaries need less training and are less costly than staff nurses—who are State registered—and students. Whereas individuals can be excellent, the overall quality of nursing staff has declined as the proportion of undertrained staff has increased.

Changes in training

Of the total number of nurses 40% are in training. From 1975 student nurses were required to have experience of either geriatric or psychiatric care as well as obstetric or community care. No allowances in establishments were made for this extra training away from the general wards, and from 1979 students will be required to complete all four periods of secondment. Whereas these clinical specialties will benefit from student labour, it will be the general divisions which will suffer from a shortage of nurses, although this broadly-based training will improve the understanding and skills required by today's State-registered nurses. A new demand on nursing budgets arises from the requirements of the recently introduced EEC Directives² on nursing training; if these are not met nurses will be ineligible for registration.

The classroom-based State practical examination, which occupied students for one hour at the end of their training, has ceased. At present the SRN practical examination requires a

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pass in four specific assessments taken during ward experience. One such assessment covers a complete span of duty and each student is allowed three attempts for each of the four assessments; many of the examiners are ward sisters. So the cost in terms of less time spent on direct patient care is considerable.

The nursing work load has increased as a result of the earlier discharge of patients; medical advances have created extra demand for care, particularly in intensive care units; there are more elderly patients needing skilled care; and widespread use of potent drugs, monitoring equipment, and intravenous treatment has placed still further burdens on nurses. The vast increase in part-time staff—a consequence of more married nurses and the use of part-time posts as an inducement to recruitment—has resulted in a fragmentation of ward supervision, with too many nurses having an inadequate knowledge of their patients. With the greater numbers of married nurses, statutory maternity leave adds to staffing difficulties. Finally, unit meetings, time off for union stewards, study leave with no replacements, and the explosion of paper work add to the nursing duties—all at a cost to patient care.

Loss of morale starts at the top, and I hold the excessive administration engendered by the Salmon reforms³ and the 1974 reorganisation responsible. A senior nursing officer cannot be in full control of the hospital while responsible to a divisional nursing officer, who in turn reports to the district nursing officer: the hospital loses its identity in the process. Morale is further lowered by the lack of nurses, increased work load, and decreasing skills. Abysmal nurses' homes for those who are resident, together with the effects of union legislation imposed on professional people, are proving the last straws on the back of a once willing and well-motivated caring profession. Our best nurses are leaving for Europe, the Middle East, America, and private medicine. Sickness absence runs at a rate of 10% to 20%, and many good students discontinue training as their idealism turns to disillusion.

One bright spot

One bright spot is the teaching hospitals, most of which seem to have plenty of staff. They have wisely retained their uniforms, academic standards, and identity; they employ lower proportions of enrolled nurses and auxiliaries, and as a result students are held in high regard. Morale is high and recruitment and quality are being preserved, so that the teaching hospitals are assured of a regular supply of trained nurses at the bottom end of the salary scale (a new staff nurse is paid £3150 a year compared with £3813 for one of five years' standing).

Nurses are mainly women and, like good housewives, find virtue in making do. Reluctant to protest, they have unwittingly masked many deficiencies, which now loom large. In the struggle to establish their professional status and as a result of the Salmon structure many nurses became determined to work independently of the medical profession. Other nurses, caught up in the new nursing officer, senior nursing officer, divisional nursing officer grades, found their functions uncertain and their responsibilities overlapping. Their contact with the medical profession was reduced to dealing with the complaints of the ward sisters, some of whom were not slow in handing them over. In their turn medical staff had little patience with the confusing new structure. Furthermore, though male nurses account for only 10% of the profession, 70% of the top nursing posts are occupied by men, many of whom are even more determined to function independently. The working partnership which once existed with the medical profession has suffered considerably at a time when nurses need a powerful professional ally in their fight to maintain adequate establishments and standards.

How might this serious decline in the quality of nursing care be remedied?

Ward sisters' salaries must reflect experience and responsibility. If supervision of domestic staff could be restored to the sister, the domestic services empire could be reduced.

The present move to create clinical nurse consultants is, in my view, a misguided effort to establish a clinical career; they would confuse and erode the position of the ward sister still further, with little improvement in patient care. I think that the difficulties experienced by clinical teachers and nursing officers provide sufficient evidence against the appointment of the proposed new grade.

Reduce afternoon overlap

The afternoon overlap must be reduced and a better shift system introduced that would run from, say, 7 am to 2 pm (six days) and from 1.30 to 9 pm (five days). Nurses could spend one week on the early shift followed by a week of the late duties, with the night shift starting at 8.30 pm. This pattern is effective in psychiatric hospitals, with a fair off-duty for all, but general administrative nurses, for reasons difficult to comprehend, think that such a system is unworkable. The ward sister could work from 8 am to 5 pm, thus partially covering each shift. An alternative arrangement would be to have a sister on each shift. Lack of transport before 7 am and after 9 pm is a constraint but a personal survey of non-resident nurses showed that hospital transport could provide a pick-up service at strategic places. I believe that nurses would be willing to contribute to this transport, which could be self-financing.

The effectiveness of the shift system is determined by the staff cover it provides throughout 24 hours. The example above would provide improved cover in the evenings and at weekends. Establishments should be planned around the shift system as this is more effective than trying to fit in off-duty for a prescribed number of nurses, but establishment numbers must also be sensitive to local needs.

I urge nursing and medical managers to challenge underfunding of the nursing services and insist on this being corrected, otherwise wards and units will close. A revenue reserve is necessary to cover sickness and holidays but this should not be used to subsidise permanent deficiencies. If that happens the spare capacity will disappear.

I am convinced that the higher the entry qualifications to nursing the better will be the recruitment. It is a false economy to lower standards so as to increase numbers because quality means efficiency. The nursing profession should capitalise on the present disenchantment with social work and teaching and recruit accordingly.

A stable level of permanent staff could be achieved by an exclusive "service" budget. Learners' salaries should be separated from the pay of permanent staff and funded through an education committee. This would identify the cost of training without removing the students from the wards and departments essential to their training. It should also protect junior students from being transferred too often between wards and from the unfair and hazardous responsibility of being left in charge. These practices are too common in the NHS and have increased sickness and absence rates, as well as causing early resignations.

I would advocate streamlining the Salmon structure: the senior nursing officer should be in full control of the hospital, reporting directly to the district nursing officer and working closely with the medical staff and the administrator. She needs administrative support from nursing officers, just as the matron needed deputies and assistants. The divisional nursing officer grade could be superfluous. Management would also be more effective if the Government corrected the harmful effects of the 1974 reorganisation: this change is urgent.

A routine assessment of practical skills during each clinical experience should become part of the examination process. This would remove the present costly artificial assessments for those in training and would also conserve the ward sisters' valuable time.

Employment of newly qualified nurses at a time when they are keen to practise their skills would reduce incremental costs

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Product liability: precautionary advice to dispensing doctors

The Rural Practices Subcommittee of the GMSC has been looking at the effects that possible legislation on product liability would have on dispensing doctors. The subcommittee was told that the Law Commission and the Pearson Committee on Data Protection saw no reason why medicines should be excluded from legislation and the final draft of EEC legislation would soon be going to the Council of Ministers (22-29 December 1979, p 1674).

If legislation was introduced in the UK—and Mr Patrick Jenkin has told the BMA that any legislation would not come into effect “for at least two years” (8 December, p 1525)—a dispensing doctor would have to keep detailed records to prove that he was not the producer. As well as recommending to the GMSC that medicines should be excluded from the proposed legislation, the subcommittee has issued the following advice for dispensing doctors should legislation come into force:

(1) The dispensing doctor will be liable for any defects in a medicine which is supplied by the doctor unless the producer's name is known and can be demonstrated.

(2) The dispensing doctor should prescribe and dispense proprietary products to avoid being regarded as the producer.

(3) Dispensed proprietary products should be supplied only in original packs to avoid the defence by the producer that the product has been “tampered with” by others.

(4) Patients should be presented with a manufacturer's leaflet or data sheet with the dispensed medicine to reduce the supplier's liability and provide the supplier with some defence that the patient had “assumed the risk.”

(5) The producer's label should not be obscured by the dispensing doctor's label in any way, to avoid a defence by the producer that the product had been “tampered with” by others.

(6) Records should be kept for 13 years, particularly the name of the producer of a medicine, to avoid claims against the supplier (doctor) within the proposed 10-year limitation period.

The above applies to the normal supply of medicine by a dispensing doctor but all doctors supply medicines for immediate personal treatment and for administration (injections, etc). The problems become even more difficult in the case of injections, where it is unlikely that the giving of a manufacturer's leaflet to the patient can be regarded as an “assumption

of risk” and the use of multi-dose containers would enable the producer to claim that the product had been tampered with by others. Record keeping will become most important as it is unlikely that the patient will be aware of the name of the producer and the recent cases of alleged vaccine damage illustrate the

liability which could fall on the doctor supplying and administering the vaccine unless the manufacturer's name is known.

Finally, assurances should be sought from the defence societies that their cover will extend to actions taken under the proposed product liability legislation.

NHS in Scotland

Changes in structure and management

The Scottish Office has issued its own consultative paper in Scotland. (The consultative paper for England and Wales was published at the same time (15 December 1979, p 1605)). The document, *Structure and Management of the NHS in Scotland* (HMSO, 70p), contemplates no change in the existing 15 health boards but proposes the abolition of the district tier of management which exists in 10 of the boards. The Secretary of State hopes that as many decisions as possible about the day-to-day running of the Service will take place locally at unit or sector level. “This presupposes,” the paper says, “that there are

administrative staff of sufficient standing to act as effective managers at this level, and that they are given sufficient authority by the board to carry out their responsibilities in relation to hospital and community services.”

Views are sought on whether local health councils should continue and on how the professional advisory structure might be strengthened. The document refers to the staffing implications of the changes proposed, and the Government has given an undertaking that there will be consultation with staff interests at the appropriate time. Comments are requested by 30 April.

Clinical staff salaries: revised scales

In the light of the Government's decisions on the Review Body's recommendations in the Supplement to their Ninth Report (27 October, p 1084) the University Grants Committee has revised the salary scales of clinical academic staff. The new scales, effective from 1 April 1979, are set out below:

Staff holding honorary consultant contracts (lecturers, senior lecturers, readers)

The adjusted scale for NHS consultants applies, namely: £11 859 – £12 714 – £13 569 – £14 424 – £15 279.

The adjusted “fully up-to-date dates

appropriate to 1 April 1979,” for implementation by 1 April 1980, will also apply.

Professors

Salaries should be adjusted to up to £15 279. Where salary is currently less than £14 259 it should be revised in parallel with the adjustments in the consultant scale below the maximum. The arrangements for implementing “fully up-to-date rates appropriate to 1 April 1979,” as described above, will also apply.

Part-time staff

Salaries of part-time staff should be adjusted pro rata to the full-time salary figures.

and agency fees and improve the quality and morale of nurses.

Improving nurses' residences and providing distinctive uniform would be money wisely spent.

Meanwhile, thoughtful nurses seriously question the move towards a 37½-hour week. This objective is in part the consequences of rivalry between various TUC-affiliated trade unions which claim to represent nurses and by the competition between them and professional organisations for the membership of over half a million nurses. A further reduction of hours would exacerbate the present staffing difficulties: it would do little for morale, still less for patient care, and nothing to improve relations with clinical medical staff, many of whom work more than 40 hours a week.

Finally, patients depend on a successful combination of

medical and nursing care. Neither profession can work in isolation and each should try to understand the other's problems. Better understanding could lead to greater mutual support in helping to improve the NHS.

References

- ¹ Department of Health and Social Security. *Report of the Committee of Inquiry into the Pay and Related Conditions of Service of Nurses and Midwives*. London: HMSO, 1974.
- ² *Br Med J* 1979;iii:223.
- ³ Ministry of Health, *Report of the Committee on Senior Nursing Staff Structure*. London: HMSO, 1966.

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