SUPPLEMENT

Perspectives in NHS management

Issues in nursing management

YVONNE MOORES

What does nursing management mean to the average hospital doctor? The chances are that it means "Salmon," and my experiences of addressing doctors prompts me to say with confidence that the word tends to provoke a brisk reaction, especially among elder members of the medical profession, who remember with nostalgia the days of matrons and all powerful ward sisters. I propose to put the nursing management structure in perspective by providing some background to and facts about the Salmon reforms. In 1963 Brian Salmon was commissioned to lead a study into the organisation of the nursing services.[1] At that time these services were headed by a matron, who reported to the hospital management committee through the group secretary. Mr Salmon's team concluded that someone who shouldered the responsibility for such a large share of the group's expenditure—nurses cost about 40% of a hospital's budget—should report directly to the hospital management committee.

In retrospect it was, perhaps, a mistake to have assigned numbers to the new post holders, but the idea of appointing a nursing officer (No 7) to be responsible for the nursing service provided in, say, four wards of a hospital was cogently argued. There was logic in introducing a nurse manager at this level, as it facilitated the monitoring of ward nursing activities and standards. Two unforeseen consequences of this arrangement affected the medical staff. Firstly, many had become accustomed to thinking of "their" ward sisters, and the interjection of a nursing officer was inevitably seen as disrupting this feeling of ownership. Secondly, Salmon schemes were introduced in an era when early retirement was an option seldom taken by nurses and, consequently, some assistant matrons were suddenly returned to active service despite their lack of up to date clinical knowledge and skill. This prevented the service reaping the full benefits of the structural change immediately and, worse still, it sowed the seeds of scepticism among medical colleagues. Unfortunately, it also deluded people into believing that the number of chiefs had outpaced the number of Indians. Published statistics and the report of the Royal Commission on the National Health Service subsequently showed, however, that the proportion of nurses above ward sister level was lower than that before the implementation of the Salmon recommendations.[2]

The Salmon reorganisation produced some remarkably rapid promotions. Even so, I am convinced that the National Health Service now boasts an excellent body of clinically competent nursing officers. In many settings they have been instrumental in improving the quality of nursing care provided in the wards, and today's nursing officers possess a combination of management and clinical skill that encourages ward sisters to work with their colleagues in the manner originally intended by the Salmon report.

Welsh Office, Cathays Park, Cardiff CF1 3NQ
YVONNE MOORES, SRN, SCM, chief nursing officer

Can a nurse be a manager and what does a nurse manager do?

Behind the seemingly simple question, "Can a nurse be a manager?" lies a suspicion that the attributes that attract a person into nursing must inevitably conflict with those required to be an effective manager. The question may also imply a belief that a non-nurse with a talent for managing could and, perhaps, should direct the nursing service. What we should recognise, however, is that not all management has to be modelled on the pattern necessary to save the British car or steel industry.

The style of management needed to "control," for example, medical staff is clearly different from that needed to run an army or a supermarket. There would seem to be no a priori reason why some nurses should not be adept at managing the nursing service. It is, however, of vital importance that nurses see themselves as facilitators rather than "bosses." Nurse managers' single most important goal should be to ensure that the nurses who are caring for patients are able to provide the patients with the best quality of service. Monitoring performance is an integral part of achieving this goal. But in common with other professions, including medicine, nurses have made too little progress in doing this.

The management of any professional group requires appraisal of people's performance, and so members of that profession must be concerned in the management process. If the nursing management requires only such mechanical activities as producing off duty rotas a manager without a nursing qualification might be appropriate, but it does not so it should not. Senior nursing staff must, however, be able to identify those staff who possess the attributes needed to generate confidence among junior staff and colleagues in other disciplines. Too often in the past we have fallen into the trap of promoting people simply on the basis of their clinical competence, only to discover that they lack management skill or ability. Nurses assume basic management responsibilities from an early age—and I am not referring to those regrettable occasions when student nurses were left in sole charge of a ward at night. I am thinking instead of the multitude of activities that engage a typical ward sister intent on organising her ward effectively. She may no longer physically ladle out the soup or be responsible for the cleanliness of the ward but she still has to organise the provision of care and treatment for patients, to train and supervise the nursing staff, and to marshall the army of "visitors" to the ward—be

they consultants, physiotherapists, laboratory technicians, or relatives—who are quite oblivious to what goes on behind the scenes and sometimes impatient at not receiving instant attention to their requirements.

The 1974 reorganisation saw the team approach to managing the service formalised. Many senior nurse administrators felt threatened in this new environment, and this was nowhere better shown than in their desire to follow crash courses in such topics as understanding accounting concepts, etc. Many of them now recognise the futility of much of that desperate search for defensive knowledge and are content to let the finance officer do what he does best. If nurses or doctors are not able to comprehend what is being said to them by administrators or finance officers it is for those officers to make themselves better understood. The nurse's major contribution to the deliberations of the team should be to bring a perspective born of her experience, as, presumably, do the doctors. Ironically, just as the different parties have developed a clearer understanding of each other's roles the game seems about to change and be played under the Griffiths rules.[3]

The Crimean contribution of Florence Nightingale was as much to do with management as with nursing techniques. All ward sisters are managers in the true sense of the word, and some of the best of them can and do go on to manage larger units.

Where have all the nurses gone and how many should there be?

The number of nurses employed throughout the NHS has been steadily growing. In 1980 the NHS in England and Wales employed 125 881 state registered nurses equivalent to 105 416 whole time staff. The corresponding figures in 1950 were 50 701 and 48 577 respectively. An analysis of the figures shows that even allowing for the reducing hours of work there has also been a steady growth in the number of nursing hours. During this period there has been a quite dramatic reduction in the length of time that patients stay in hospital and a concomitant increase in the number of patients treated—patient throughput. This has had a substantial impact on the workload of nurses both in hospitals and in the community—in addition to the consequence of increasingly technical procedures. Nevertheless, doctors who ask where all the nurses have gone usually seem less concerned with the number of nurses and its relation to workload than with the loss of qualified staff. Their concern is to an extent justified, though I would take issue with the use of the word "all." Between 1940 and 1980 we produced over half a million state registered nurses, which puts the current staffing complement into perspective.

Training a state registered nurse costs several thousand pounds. For many years trainees were undoubtedly used to provide much of the care of patients in the mistaken belief that they represented a cheap form of labour. As a consequence the service felt under a little pressure to accommodate to the needs of an ever increasing proportion of qualified staff who wished to raise a family while continuing to work. A "shortage" of nurses in the 1960s and 1970s, however, forced hospitals to explore how married nurses could be encouraged back to work. We have now gone full circle and there is growing evidence that we are producing far too many state registered nurses and state enrolled nurses. Nationally, this imbalance will have to be put right and soon. We now know that those who were attracted back made a valuable contribution, and we surely have a responsibility to ensure that those we train are able to practise the professional skills that they have so expensively acquired. The opening question is, therefore, somewhat out of date and perhaps should be reworded to read, "What can be done for those wanting to work?"

This brings us to manpower planning and the pattern of training. Doctors are all too familiar with the medical manpower problem. The fact is that until recently nurses were not under pressure to produce sound methods for determining staffing levels. It has been left to outside observers to highlight the inefficiencies of the laissez faire policy. Without some sort of national manpower guidelines, matching output of trained nurses to nursing requirements and availabilities must be a hit or miss affair. Even so, the cold wind of cash limits has forced us, along with other health professions, to investigate seriously methods for determining what constitutes a reasonable nursing establishment. "Shroud waving" will no longer suffice. The work undertaken by the Griffiths inquiry has provided some useful insights in this area, though at least one North American system could readily and profitably be translocated across the Atlantic.

What is absolutely certain is that we must quickly harness the best of the methods be they American or British. Planning for staffing levels must go hand in glove with maintaining quality.

Can doctors go back to having their own ward sisters?

The answer to this question must be "no." Firstly, it would be putting the clock back in part of a well established management system. Secondly, tending to the needs of sick people whether it be hospital or domiciliary based, is increasingly seen as a team effort. In advocating the team approach I am not reflexly reciting the latest "accepted truth." Visit a typical burns unit and you will observe doctors, nurses, dietitians, and other paramedical staff all working together in a genuinely multidisciplinary manner to meet what are inevitably the multidisciplinary needs of patients. You will see the same constructive relations in most other environments, ranging from high technology units—such as those accommodating patients with end stage renal failure—to the home care of elderly patients.

The old cliché that doctors are in the curing business and nurses in the caring business is an out of date, simplistic dichotomy. Patients have medical needs but they also have nursing, dietary, and physiotherapy needs—to name but three. Almost by definition this range demands a team approach, and while some sympathetic and intelligent direction is called for this cannot be interpreted as "ownership." This is no new realisation stemming from experience of either the Salmon reforms or the 1974 reorganisation. As a one time sister on a men's medical ward I would like to believe that the consultants on the ward viewed the relationship between the nursing and medical staff as a mutually supportive one. I would not have stayed there for six years had this not been the prevailing ethos, and the ward would not have been the agreeable environment it was for patients and staff alike had this not been so.

What is the extended role of the nurse?

The demarcation line in medicine about just who does what have never been immutable. Responsibilities are constantly changing and indeed in one hospital tasks may be performed by nurses that elsewhere are more usually done by doctors. Americans used to look askance at how many British births were supervised by midwives, and who would deny that the so called barefoot doctors operating in several Third World countries are not a solution to medical care ideally suited to those environments. Lately, however, concern has emerged about what might be loosely termed "legal cover" for tasks performed. In part, this probably reflects a wider concern with the insidious increase in litigation by patients about which we seem intent on mimicking the American experience. We now find professional bodies demanding formal authorisation for a specified grade of staff to undertake a particular task. For better or worse it is a development that is here to stay, but, inevitably,

continued on page 332

Cost of pay settlement 1984

In a recent parliamentary written answer Mr Kenneth Clarke said that health authority cash limits for 1984-5 had been increased to reflect the government's contribution to the cost of the 1984 pay awards to staff covered by the doctors' and dentists' review body. The following table shows for each regional health authority the estimated costs for these staff which health authorities will be required to meet from their planned cost improvement programmes. Mr Clarke said that the programmes already submitted amounted to £100 million and so claims that no well managed authority should have difficulty in financing the award without reducing any patient services.

Cost of pay settlement

Regional health authority	£000
Northern	207
Yorkshire	223
Trent	264
East Anglian	116
North West Thames	249
North East Thames	315
South East Thames	260
South West Thames	192
Wessex	164
Oxford	141
South Western	192
West Midlands	314
Mersey	166
North Western	287

Honorary contracts for junior clinical academic staff

Health authorities have been notified in circular PM(84)12 of the circumstances when junior clinical academic staff should be issued with honorary contracts and the form that these should take. The profession has been concerned for some time that honorary contracts were being issued with letters of appointment instead of honorary contracts.

Honorary contracts must be issued if there is a clear understanding that the doctor is to provide a service for the authority. The authority should be satisfied that there is clinical work to be done and agree the specific duties with the appointee. This should be formally recorded. It applies whether the doctor is providing a direct service to patients or an indirect one through a support specialty which forms part of the services provided by the authority. Letters of appointment, on the other hand, should be issued only if the doctor will neither undertake not supervise clinical procedures, nor provide any other service for the authority. The letter of appointment will simply ensure access to health authority facilities—for example, to enable the practitioner to be engaged solely on teaching or research.

The terms and conditions of service of hospital medical staff have been amended to clarify the terms of service which apply to honorary contract holders. The amendment came into effect on 3 July.

Remuneration of occupational physicians

The BMA's recommendations on the remuneration of occupational physicians have been revised in the light of the 1984 review body report. Copies have been sent to members of the association working in occupational health, but any member may obtain a copy by writing to the secretary to the occupational health committee at BMA House.

Perspectives in NHS Management—*continued from page 331*

it has focused attention on the whole question of who does what. Nurses have demonstrably never been averse to taking on board new responsibilities if these help to make more effective use of a team's combined talents. Of late, these changes might seem to have featured more bureaucratic overtones, but medical colleagues will readily appreciate the need for the attendant safeguards.

Does the nursing process help the patient or does it just add to the paperwork?

Earlier this year the *BMJ* published an article on the nursing process by Professor J R A Mitchell of the department of medicine, University of Nottingham Medical School.[4] Although his contribution was intended, presumably, as something of a "put down" of this development in nursing, I found myself agreeing with some, but not all, of his contentions.

The nursing process reinforces the concept of the team approach to the provision of patient care, but many would agree that there has on occasions been an unfortunate overemphasis on paperwork that has camouflaged the straightforward nature of a system intended to improve the nursing care of patients. The nursing process is intended to help identify the patients' nursing needs more effectively and to help in meeting them in the most appropriate manner. Some of these will be inseparable from medical needs, and the concept of working together is not only appropriate but essential. Enlightened medical practitioners will, however, acknowledge that many of a patient's requirements relate to his nursing care and these have always been left to nursing staff to organise. What is so wrong with nurses exploring how best they should respond to these needs?

Professor Mitchell was quite right in arguing that the approach demands the development of effective evaluation procedures, but let us give the nursing process some credit for having provoked a discussion that has helped to foster this recognition. Nursing interventions do exist. Medical staff are, for example, little concerned with scheduling or monitoring the hygiene and care of the skin. The more enlightened nurse would freely admit that she has limited information as to the consequences of alternative regimens on this front. Assessment procedures are needed, and fortunately more and more are slowly forthcoming as a consequence of a growing body of nursing research.

Nurses are not alone in not knowing the consequences of all our actions; indeed, White recently concluded that only 15% of all medical procedures have a proved effectiveness.[5] Professor Mitchell's statement, "as doctors know only too well from our attempts to evaluate the best way to manage heart attacks, cancer, stroke, and high blood pressure you get good answers only if you have well designed studies and suitable mathematical techniques," comes across as a trifle patronising. More important than the well designed study and the complex mathematics is an initial inquisitiveness. The nursing profession now has a gradually expanding academic base for those intent on studying nursing in that environment. This, in turn, fosters the spirit of inquiry that has helped to spawn the present interest in the nursing process. The more we, as nurses, know about the patient's nursing needs, how to assess them, and how to set about ascertaining the consequences of responding to them in alternative ways the sooner will we be able to make a greater impact on responding to the patient's total needs. That response is best made as the member of a team.

References

1 Ministry of Health/Scottish Home and Health Department. *Report of the committee on senior nursing staff structure*. London: HMSO, 1966.
2 Royal Commission on the National Health Service. *Report*. London: HMSO, 1975. (Cmnd 7615.)
3 NHS Management Inquiry. *Report*. London: DHSS, 1983. (Griffiths report.)
4 Mitchel JRA. Is nursing any business of doctors? A simple guide to the "nursing process." *Br Med J* 1984;**288**:216-9.
5 Tilquin C. *PFN 80—An information system for nursing care management*. Quebec: EROS, 1981.

This is the thirteenth in a series of articles on NHS administration and management, which started on 28 April.