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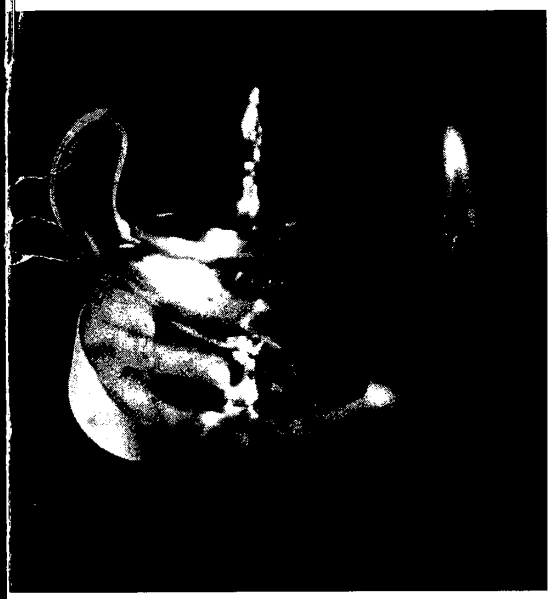

New for Old?
Prospects for nursing in the 1990s

Virginia Beardshaw
and
Ray Robinson

King's Fund Institute

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NEW FOR OLD

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New for Old?

Prospects for nursing in the 1990s

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The authors

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Contents

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Any errors of fact or interpretation are ours alone.

Virginia Beardshaw
Ray Robinson
September 1990

Introduction

... the shape of nursing cannot entirely be understood from within. Nursing is one interest in a division of labour whose boundaries are in a constant state of flux... Located as it is between a powerful profession jealous of its own freedom and prestige and the pervasive social concern of the economical management of deviance, the state of nursing is an early indicator of more profound social changes... There are a number of options for the future of nursing. Purely on demographic grounds the status quo is not one of them.

R. Dingwall, A.M. Rafferty and C. Webster (1988), *An Introduction to the Social History of Nursing*, Routledge, London.

Aim of the report

This research report attempts to clarify key issues in British nursing for health policy makers. It is specifically aimed at a non-nursing audience, in the hope that it will illuminate important aspects of workforce planning, management and health care delivery for National Health Service (NHS) managers and other people concerned with British health policy.

Nursing is an essential element of advanced health services. Nurses are responsible for the majority of professional health care given in Britain. More than half of all NHS staff are nurses, with nearly a quarter of all health service expenditure directed at nursing.

Traditionally, nursing practice and its organisation, management and future direction have been little discussed by policy makers outside nursing, despite the direct relevance of these subjects to the shape, quality and cost of health care as a whole. In an important sense, nursing issues have been marginal to the debates that have shaped British health policy since 1948.

One of the premises underlying this report is that this situation needs to change. The probable scale of the nursing recruitment and retention difficulties of the next decade mean that the cost of nursing care is set to rise sharply. This, coupled with increasing concern to manage inputs to health care effectively, will concentrate managerial and policy attention on nursing policy and practice.

Changing contexts of care

Nursing has already entered a period of change. Demographic shifts which affect both the size and the nature of the nursing workforce, and the age and dependency of the people they nurse, are one set of factors which are contributing to this. Major reforms to nurse training are another, as is the introduction of a clinical career structure within the NHS and associated attempts from within nursing to give a new direction to clinical care. All these factors interconnect, and are contributing to discussions about the nature of nursing work, and how its content should be changed and managed.

This debate cannot be divorced from the changes in the overall context of health care in Britain. Throughout the developed world demographic changes mean that there will be fewer young people to care for increasing numbers of needy older ones. New medical technologies contribute to new opportunities for curative interventions. This, and changing assumptions about the way in which care should be delivered, are increasing user expectations about the quality and effectiveness of health services. At the same time, an ageing population means that more and more people experience chronic disabling illnesses or conditions which require rehabilitation or palliative care at home. Throughout the last decade, these factors have combined both to increase health costs and to inspire efforts to contain them by governments of all political persuasions within advanced economies.

All of this means that nurses, and those who manage them, are having to face a new set of questions about the way that care is financed, organised, and delivered. For many, current concerns about nurse shortages will be a starting point for a wider discussion about how nursing relates to the changing context of health policy. A submerged tension between 'quality of care' considerations and pressures for cost containment underlies this debate.

This conflict – which is not unique to nursing – and the present focus on problems with recruitment and retention – has many parallels in past arguments about the size and skill-base of the nursing workforce. Throughout its modern history, the development of nursing has been shaped by competing pressures. Chief among them have been the labour requirements of health care institutions; the demands of doctors for skilled assistance; and the desire of some nurses to enhance the autonomy, satisfaction and status of their work. Historically, service needs have tended to prove decisive when nursing policy is made. One of the key questions for the future of nursing is whether –

in the light of demographic, social and educational changes – this will continue to be true.

This question is directly related to a set of issues concerning the future deployment of women in the national workforce. Nursing has always been largely women's work, and the development of nursing has paralleled the emancipation of women since the mid-nineteenth century. Today, as in the past, the majority of nurses are women. For many – particularly part-timers and unqualified staff – terms and conditions of service, career prospects and training are poor.

For these and other reasons, nurses have traditionally felt undervalued within health care institutions and hierarchies. Their pay has compared poorly with male-dominated occupational groupings, and their influence on health policy has been weak. Another intriguing question for nursing's future development is whether – as competition for labour sharpens during the 1990s, and women's expectations about what work should offer them increase – nursing will finally 'come of age' as an occupation, and be able to offer those who enter it improved pay, career prospects and conditions, along with a more influential voice in service management and health policy.

This is certainly one of the intentions of the reformist strategies for nursing discussed later in this report – perhaps most noticably the 'Project 2000' proposals for nurse education and the introduction of a clinical career structure. But the present current of nursing reform may run counter to the general tide of health cost control, and the newly critical perspectives on the efficient use of labour associated with it. Nursing skill levels, competencies and costs are coming under increasing scrutiny – and nurses, along with health professionals of all kinds, are having to face up to vigorous questioning of their special status. Coupled with acute nursing shortages this could lead to changes to nursing's skill base in the 1990s. In parts of the United States where nursing shortages are already acute, qualified nurses' wages have increased dramatically. At the same time, technicians and semi-skilled staff have taken over a number of tasks formerly undertaken by nurses (Boufard, 1990).

Currently, it is clear that the management of nursing as a scarce and costly resource will mean that discussion about nursing work, and its future direction, will be open to new influences and different constituencies. Wider understanding of nursing policy and practice, and the forces which shape it, will be needed if this debate is to be productive. If this report succeeds in clarifying some of the key issues in nursing policy for a wider audience, it will have achieved its main objective.

Guide to the report

The first section of this report looks at the numbers and types of nurses that presently make up the nursing workforce within the NHS. The second examines the nature of the recruitment and retention problems that are focussing policy attention on nursing, and attempts to put these into context. The third section examines the 'new nursing' – the ideological underpinning of the current reformist strategies for the occupation. The fourth discusses the Project 2000 reforms of nurse education and the introduction of a clinical career structure for NHS nurses. The fifth section looks at nursing management, and the sixth attempts to sketch out some of the implications of current proposals for the reform of health and social care in Britain for nursing. The final section speculates on directions for nursing in the 1990s.

Nursing in context

1

Nursing diversity

Nurses are the largest group of health workers in Britain. There are more than half a million qualified and unqualified nurses working within the National Health Service (UKCC, 1986). Their work, and the settings in which it is conducted, is extremely diverse. In practice, nursing is an occupation with a number of sub-groups, each with their own distinctive historical traditions, modes of training and approaches. This diversity makes it difficult to generalise about the nature of nursing and the unique role of the nurse. In this report, the term 'nurse' refers to hospital and community nurses of all types; midwives are not considered.

Nurses care for people in their own homes; in group homes and elsewhere in the community; in hospices; in schools; in general practice; in long stay hospitals and in general and specialist acute hospital settings. Nurse training is similarly various. The skills and approach that a community psychiatric nurse brings to her work with people with mental health problems living at home will be very different to those of a specialist nurse working in a neonatal intensive care unit. While the image of the nurse working with acutely ill people in a general hospital setting is still dominant in the public mind, today more than half of all trained nurses actually work outside of hospitals (UKCC, 1986).

In fact, the unity of all these different types of work under one occupational grouping is relatively recent: psychiatric and mental handicap nursing have different historical roots from general hospital nursing, and their practice remains substantially different from it. Grafting this branch of nursing work onto the stem of general hospital nursing has produced persistent tensions and difficulties. In practice, fusion was only achieved when hospital services were unified administratively under the National Health Service in 1948 (Dingwall *et al*, 1988). District nursing and health visiting also have distinctive origins and modes of working, and their integration into nursing has also been problematic.

Defining the nurse's role

One of the most popular textbook summaries of the nurse's role is the statement:

> *The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible (Henderson, 1966).*

This part of Henderson's definition stresses the nurse's role in restoring health and independence, and in caring for the 'whole person' – an emphasis that chimes in well with nursing's current concern to provide holistic care which maximises patient autonomy. Other definitions underline the importance of the nurse as a coordinator of care and treatments – an aspect of nursing work that is increasingly important as medical specialisms proliferate in acute hospital settings (Salvage, 1985). In practice, defining the nature of nursing work is difficult, and there is no universally accepted definition which covers all its facets.

Traditionally, medical and nursing roles have been differentiated by making a distinction between patient care – which is seen as the responsibility of nurses – and cure – which is the province of doctors. In practice, this distinction, while still widely accepted, has become difficult to sustain: care and cure are bound up with each other, and demand a concerted response from teams of doctors, nurses and other health workers in both hospital and community settings. Healing is a complex process, to which nursing care makes an important contribution. Indeed, in some clinical areas, medical interventions play a very limited part in recovery, with nursing having the major role. Perhaps partly in recognition of this, traditional demarcations between doctors and nurses are becoming blurred as nurses operate increasingly autonomously. This process is likely to continue, especially if, as seems likely, nurses in certain settings are permitted to prescribe a limited range of drugs, and make treatment decisions without medical supervision (DH, 1989d).

Nursing work

Direct patient care is the central pivot of nursing work in hospital: helping with feeding, bathing, dressing and movement; giving drugs and other treatments; and talking to, reassuring and informing patients and their families.

In the community, nursing work is similarly diverse with nurses providing specialist treatments for acutely ill patients; personal care for them and for people with disabilities; and health promotion, support and teaching for parents, carers, disabled and older people and people recovering from illness. Both in hospital and in the community, nurses also have an important educational and

rehabilitative function which arises directly out of the continuous contact they have with the people they care for.

One of the characteristics of nursing work is that it is difficult to specify with any precision. This is particularly true of general hospital nursing where, at different periods, nurses have done (and do) work which could be considered the province of cleaners, dieticians, porters, clerks, secretaries, ward housekeepers, receptionists and doctors. In fact, one of the persistent advantages of the nursing workforce to hospital managements has been the absence of a precise job description for nurses, who are in practice expected to be prepared to take on a variety of tasks outside 'patient care' in any strict sense (Davies, 1977).

This same fluidity exists outside hospital: for example, there are overlaps between community nursing work and the personal care given by some types of home care worker. In many community settings nurses also undertake treatments and health promotion work which, in other places, are undertaken by medical staff. 'Nursing' tasks of all types – including ones involving the use of sophisticated equipment – are also undertaken by family members, other unpaid carers, and, increasingly, patients themselves.

Traditionally, one of the most valued attributes of a nurse has been her ability to 'cope and get the work done'. Since nurses in hospital settings are the group in continuous direct contact with patients, they tend to be the ones to cope with the absence of other staff. This is particularly true outside of office hours and at weekends, where nurses may take on secretarial or clerical tasks, run errands, or act as extension therapists.

Organisation of nursing work

Within hospitals of all types, nursing work has traditionally been organised according to a task allocation system. This means that work within each ward is organised according to a fixed routine, with set tasks taking place at preordained points throughout the day. The care that individual patients receive is governed by this routine, rather than by their individual needs. Nurses move from one task to another, supervised by the ward sister or the senior qualified nurse. As a result, nurses have little sustained involvement with any patient as they move from one set of tasks to another (Pembrey, 1989). Although things are not so clearcut in the community, many district nurses still tend to adopt a task-centred approach focussed on treatments such as dressings, injections and personal care.

Task allocation systems have important advantages for managing care when that care is given by a semi-skilled, transient workforce where trained staff operate mainly in a supervisory capacity (Davies, 1977). This was traditionally – and remains – the case in most hospital nursing, where the nursing work force was and is composed of a high proportion of trainee and untrained staff. In this situation, nursing routines provide supervisor nurses with a method for maintaining control, stability and accountability for the care given by largely unqualified, continually changing workers (Proctor, 1989). They also create emotional distance between nurses and patients (Menzies, 1960).

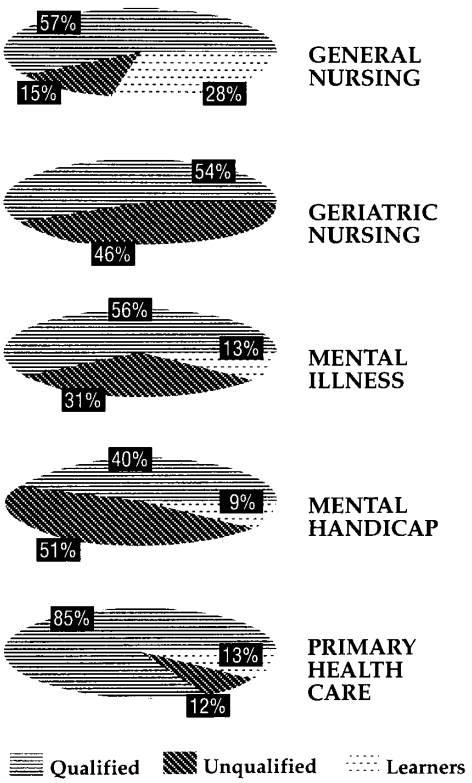
From the early 1970s, this traditional system for organising nursing work has begun to be challenged by proponents of what is coming to be called 'the new nursing', a development which is discussed in detail in section 3. In summary, this involves a new emphasis on patient-centred care, using the nursing process – a systematic, problem-solving approach – to devise personalised 'care plans' for patients. These establish overall goals for care, and identify appropriate treatment methods – wherever possible, in collaboration with patients themselves. Increasingly, moves towards personalised care planning have refered to particular theories of nursing practice, and models related to them (Roper, Logan and Tierney, 1985). Patient-centred nursing approaches are difficult if not impossible to reconcile with traditional ward routines and task allocation (Proctor, 1989).

The nursing workforce

In September 1987 there were 404,000 whole time equivalent (WTE) nursing and midwifery staff employed by the NHS in England (DH, 1989). This represented over half of the health service's total workforce. Expenditure on nursing services was estimated at some £4.6 billion in 1988/89 – nearly a quarter of total NHS expenditure. As such, nursing costs are an important component of public expenditure: some 3 pence in every pound of public spending is used to pay nurses.

Within the hospital services, the largest group of nurses – 173,000 – work in general hospitals. The second largest group – 58,000 – work in psychiatric hospitals. Another 42,000 nurses work in geriatric hospitals or units and 32,000 work with people with learning difficulties. Forty two thousand nurses work in the community nursing services. Proportions of trained staff vary greatly between these sectors, as Figure 1.1 demonstrates. For example, only 12 per cent of nurses working in the community are unqualified, compared to 46 per cent in the geriatric speciality and more than 50 per cent in the mental handicap sector. Many of these differences in skill-mix are long-standing: untrained nursing assistants and nursing auxiliaries have undertaken a substantial amount of the nursing work of geriatric and other long-stay hospitals since well before the beginning of the health service (Abel Smith, 1960).

Figure 1.1 **Qualified staff vary between specialities**

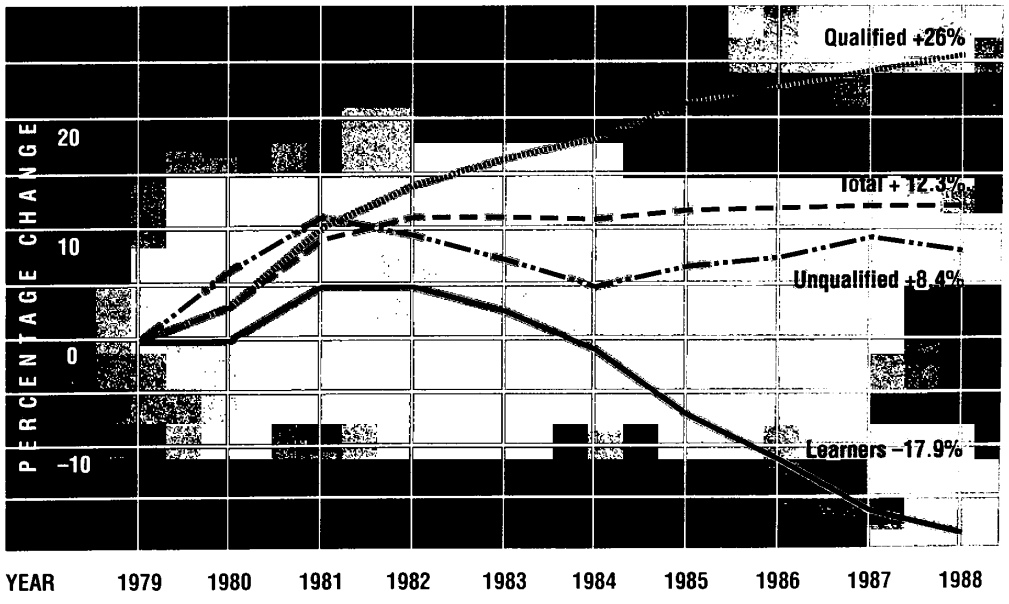


Source: Department of Health, 1990

Figure 1.2 shows how the nursing workforce has grown between 1979 and 1987. Over this period, growth was quite modest, apart from an increase of nearly ten per cent in 1980-81. Approximately half of the increase in that year is thought to be related to the need to employ more staff following the reduction in nurses' hours from 40 to 37 1/2 hours per week (HM Treasury, 1985, p. 163). Since then, workforce size has remained almost static, with growth averaging only 0.2 per cent per year between 1983 and 1987. Over the same period, total workload – as measured by the number of in-patient and day cases – has increased by more than 4 per cent per year (HM Treasury, 1989, p. 8, and see Figure 1.4). Moreover, reductions in length of in-patient stay over this period have also meant that the level of dependence of the average patient has probably increased, both in the community and in hospital.

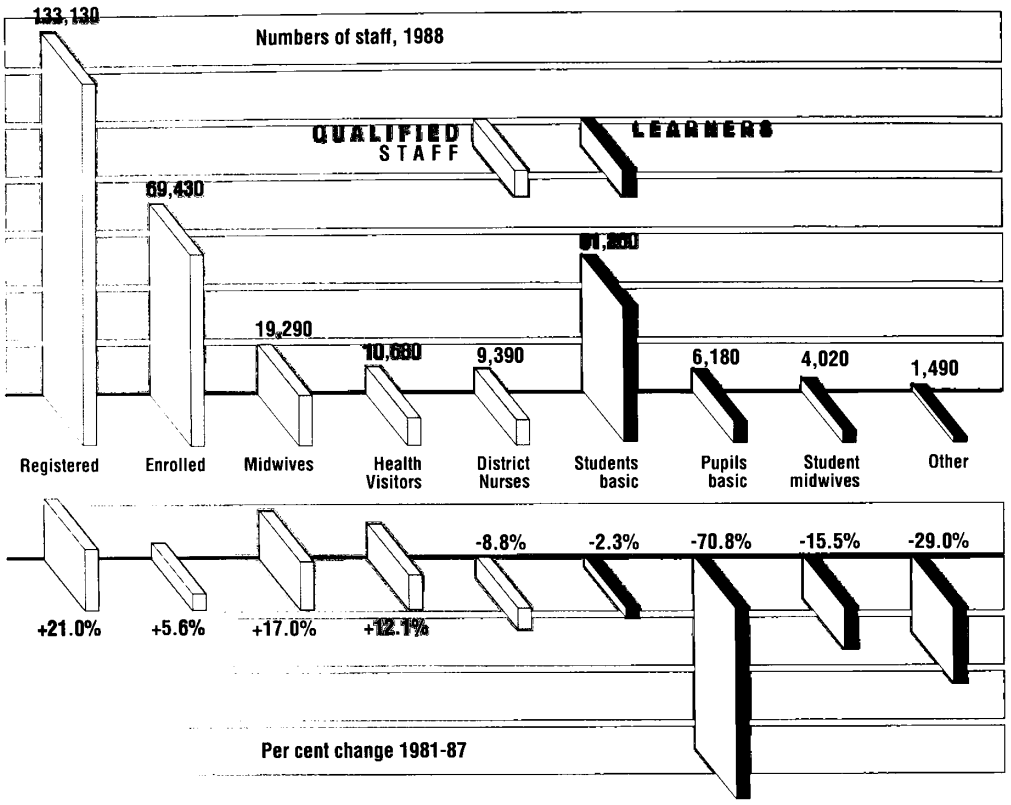
Figure 1.3 shows how the total nursing workforce is made up, and the changes in the size of each component group between 1981 and 1987. Among qualified staff, registered nurses are the largest group, with nearly 54 per cent of the workforce in 1987. Between 1981 and 1987 the number of registered nurses employed in the health service grew by 17 per cent. The numbers of enrolled nurses also grew by 8.1 per cent over the same six-year period, although total numbers peaked at 72,400 in 1985 and have fallen subsequently. Health visitor numbers grew as well, despite some fluctuations. In contrast, the numbers of district nurses fell steadily over the six-year period.

Figure 1.2 **The nursing workforce 1979–1988**



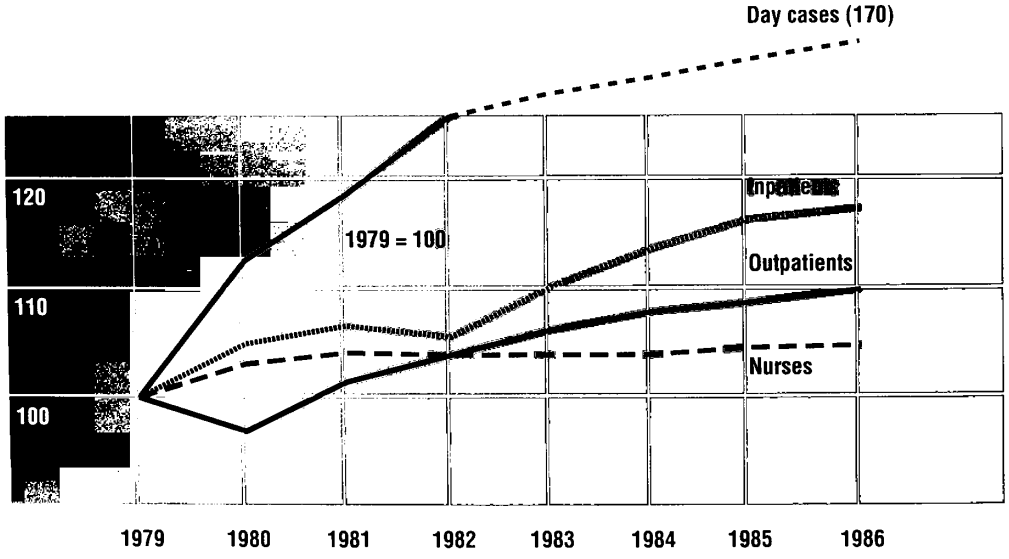
Source: Department of Health, 1990

Figure 1.3 **The nursing workforce: its make-up, growth and decline, 1981–88**



Source: Department of Health, 1990

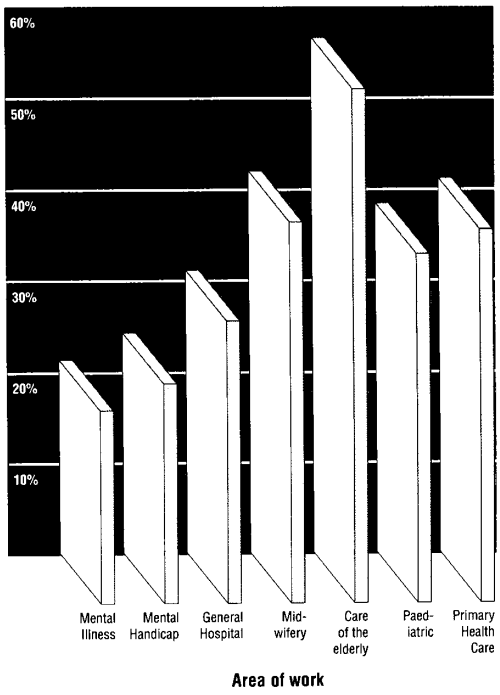
Figure 1.4 **Hospital activity and nurse numbers**



Note: Nurse numbers are given for whole time equivalents, and have been adjusted for the reduction in nurses' working hours in 1980.

Source: Delamothe, 1988

Figure 1.5 **Percentage of part-time nursing in each health sector**



Source: DH 1990

It was among nursing students that the most dramatic falls in numbers were recorded. Figure 1.3 demonstrates substantial falls for all categories of student and pupil nurses, with basic pupils recording a fall of over 60 per cent – a figure that reflects the Department of Health's decision to phase out enrolled nurse training as part of the 'Project 2000' reforms (see section 4). Shortfalls in the availability of qualified staff over a period when hospital activity rates grew steadily led to an increased reliance on agency staff: between 1983 and 1987 the number of agency staff employed by the NHS increased by over 150 per cent (DH, 1989).

Nursing and gender

Nursing is women's work. In 1988, 90 per cent of the total nursing workforce in England were women. At that time, more than a third of the English NHS nursing workforce worked part-time. The amount of part-time working varies markedly between health sectors, as Figure 1.5 illustrates. Along with teaching, nursing is one of the oldest established occupations for women. It developed in its modern form from the mid-nineteenth century, and present-day nursing still reflects its Victorian origins. As women's work, nursing has attracted low pay, and relatively poor terms and conditions of service – particularly when compared to traditionally male service occupations like medicine or the police force.

An historical perspective on gender

Nursing historians have argued persuasively that many of the enduring characteristics of nursing as an occupational grouping have their roots in the strategies used by nineteenth century reformers to establish organised nursing in the voluntary hospitals (Davies, 1976, 1977; Carpenter, 1977). These replicated within the hospital the existing gender relationships of Victorian society, and did not challenge prevailing male notions of womanly behaviour. Deference to doctors and acceptance of the 'handmaiden role' was a cornerstone of this strategy. Allied to this was the adoption of a vocational approach to nursing work, which was to be carried out as a humanitarian service, rather than for money. As a direct result, the nurse was expected to be

> *restrained, disciplined and obedient ... She should carry out the orders of doctors in a suitably humble and deferential way. She should obey to the letter the requirements of the matron and the sister to whom matron had delegated responsibility (Davies, 1977).*

Concern about nurses' discipline and vocational dedication was intense, and extended into their private lives in a way that ensured an almost cloistered existence for early recruits – a feature of nursing life that was undoubtedly effective in persuading Victorian families to permit their daughters to enter nurse training (Carpenter, 1977). Other elements of this nursing reform strategy included the acceptance of a very wide and ill-defined set of tasks as nursing work in order to maximise both usefulness of nurses as hospital workers and the authority of their supervising matron.

The successful pursuit of this approach allowed nineteenth and early twentieth century hospital matrons to assume responsibility for the domestic and administrative work of voluntary hospitals, and to control their female nursing and domestic staff. By doing so, they colonised an important vacant niche within the hospital's administrative structure, and one which doctors with their growing interst in diagnosis and scientific medicine found convenient to delegate.

Matrons and their ward sister deputies exerted hierarchical authority over nursing and domestic staff in a manner which replicated features of the relationship of power and control between the mistress of the bourgeois Victorian household and her servants. At the same time, the existence of strict hierarchies ensured the adequate supervision of a largely unskilled or trainee workforce (Carpenter, 1977). Skilled nurses, for their part, provided doctors with reliable assistance

and round-the-clock monitoring of hospital patients (Dingwall *et al*, 1988).

This nineteenth century strategy was transparently the product of its place and time, but many of its features – the subordination of nursing to medicine; the routine-based organistion of nursing work; the absence of a defined area of nursing competence; and the apprenticeship basis of nurse training feature largely on today's reformist nursing agendas. All of them owe something to nursing's status as women's work and to the fact that modern nursing has developed in parallel with the (partial) emancipation of women.

Men in nursing

Nursing is not solely a women's occuption, however. Today's psychiatric and mental handicap nurses can trace their origins back to county asylum attendants and poor law hospital workers, many of whom were men. Attempts to improve their pay and conditions through organised trades union action at the turn of the century were critical to their emergence as a distinct occupational grouping (Carpenter, 1980). This tradition – which also stressed the role of nurses as managers, in the absence of sustained medical supervision on the wards – is very different from the vocational, 'handmaiden' approach adopted by general hospital nurses within voluntary hospitals during the nineteenth and early twentieth century. The general hospital model of nursing proved dominant, however, and was 'exported' – with varying degrees of success – to poor law infirmaries and to asylums in the early part of this century (Carpenter, 1977).

Men have traditionally made a significant contribution to mental illness and handicap nursing, and the largest proportions of male nurses still cluster in these areas of work. However, the 1966 Salmon reorganistion of nursing management created new 'middle manager' posts in nursing, and men were recruited to these jobs in large numbers (Carpenter, 1977). Currently, half of senior nurse managers are men, while men constitute less than 10 per cent of the nursing workforce (Gaze, 1987).

Despite the traditional importance of men in the psychiatric and mental handicap sectors, and their recent prominence in nurse management, the great majority of nurses are still women. This is particularly true of junior and untrained ward staff in general hospitals – where the overwhelming majority of nursing auxiliaries, nursing students and enrolled nurses in hospital and community nursing are women. An increasing number of this group also work part-time because of domestic or family care commitments (Salvage, 1985). In common with other part-time workers, their pay and prospects for training and career advancement are poor.

Nursing's division of labour

Nursing has always depended on both trained and untrained staff in both hospital and community settings. Within hospital wards, qualified nurses – sisters or charge nurses and staff nurses – traditionally supervise the work of more junior qualified and unqualified staff and trainees. They may also undertake more complicated or technical nursing tasks, or 'special' very ill or difficult patients, although in practice there tends to be a considerable degree of overlap with unqualified staff even in these areas. Sisters are also responsible for most ward-based training, and for a good deal of administrative and clerical work (Runciman, 1983).

'Basic nursing care' in hospital – feeding, toileting, dressing, mobilising, bathing, bed making and the like – remains largely the province of junior staff: enrolled nurses; pupil and student nurses; and nursing auxiliaries, who are known as nursing assistants in mental illness and handicap hospitals. This distinction is less clear cut in the community, but even so routine personal care is often delegated to junior or untrained staff. For example, when bathing is undertaken by community nursing staff, it is almost entirely the responsibility of untrained community nurses.

Nursing auxiliaries/assistants make up a quarter of the present nursing workforce. They receive minimal 'on the job' training. Enrolled nurses – an intermediate grade, with two years' training but no direct possibilities for progress to more senior positions – make up a further 18 per cent.

Historically, nursing leaders have sought to make a clear distinction between trained and untrained nurses, and have campaigned for a fully trained nursing workforce (Abel Smith, 1960) . In practice, any sharp distinction between the two types of nurses is difficult to sustain since there are important overlaps between the work of trained and untrained staff and between nurses and informal carers. Nursing has always depended on significant numbers of untrained people, and this situation looks likely to continue into the next century as the pool of suitably qualified applicants for nursing education shrinks. The future contribution and role of untrained nursing staff in health care is one of the most important undecided issues for nursing in the next decade and beyond. A second is the question of who will control and manage nursing work.

Recruitment and retention

By the end of the 1980s, concerns about nursing recruitment and retention had begun to focus policy attention on nursing.

Concerns of this kind are not new, however: alarm about impending or actual nursing shortages is a recurrent feature of nursing history. The number of recruits to nurse training has related closely to the size of the cohort of women school leavers in the population during most of this century. Dips in the numbers of qualified women in this age group, and the growth of alternative skilled occupations for them, created persistent nursing shortages in the 1920s, 1930s and 1940s. This period was characterised by a spate of reports expressing concern about high wastage levels from nurse training courses and making recommendations about improvements to nurses' pay and conditions to staunch it. The situation was only gradually resolved by the introduction of the enrolled nurse grade to meet wartime demand in 1943, and increases in the employment of enrolled nurses and untrained nursing auxiliaries and assistants to staff the new National Health Service in the 1950s and 1960s. A significant proportion of these were recruited from outside the UK – notably from Ireland and the Commonwealth (Abel Smith, 1960; Dingwall *et al*, 1988).

Nursing turnover

Today, with a nursing workforce of over 400,000 people, a degree of staff turnover is to be expected. However, each year approximately one in ten nurses leave nursing. Two-thirds do not return. Moreover, one in five students either drop out or fail to register at the end of their courses. The traditional remedy for this wastage has been simply to train additional students to make good these losses.

This "easy come, easy go" model of recruitment meant that as late as 1986 one in every four young women leaving school with between 5 'O' levels and 2 'A' levels was entering nursing (Delamothe, 1988). The declining pool of young workers and a growth in competition for their services mean that this approach to nurse recruitment will not be sustainable during the 1990s. Between 1986/7 and the mid-1990s there will be a 25 per cent drop in the number of school leavers formally qualified to enter nurse training. The implications of this were first highlighted by the Judge report on nurse education (1985) and are summarised in the Department of Health's *Strategy for Nursing*:

> *Between 1964 and 1976 births in the United Kingdom fell by 35 per cent, and this fall will be reflected in the declining cohort of 18 year old school leavers from which student nurses are traditionally recruited, right up to the mid-1990s. There will be some increase in the numbers thereafter, but it will produce nothing like the pool of potential recruits on which the profession in earlier decades was able to rely. At the same time, other occupations and professions can be expected to compete more keenly for the smaller number of qualified school leavers coming forward so that nursing would be hard put to retain even its customary share (1989c, p.18).*

Clearly, with a drop in the size of the age cohort, maintaining the nursing workforce will require a dramatic rise in the already large proportion of school leavers entering nursing, unless nursing is able to pursue alternative recruitment strategies. Wessex Regional Health Authority, for example, estimate that by 1995 they would need to recruit 87 per cent of the appropriately qualified school leavers in their area to maintain establishment numbers, if existing wastage rates remain unchanged. This is clearly unrealistic.

Research on recruitment and retention

Faced with these difficulties, a number of recent reports and research studies have concentrated on why people enter nurse training, why they leave nursing and – in the light of this – what policies can be devised to assist staff recruitment and retention in the NHS. This research is based on large-scale national surveys of nurse attitudes as well as small-scale in-depth work on the factors that influence nurse retention in individual districts or units. Taken together, it gives a picture of the factors that contribute to nurse recruitment and retention.

A study commissioned by the chairmen of Regional Health Authorities in England, the Health Boards in Scotland and the Welsh Health Authorities was designed to study nurse recruitment and retention at national level (Price Waterhouse, 1988). This work was based upon a survey of 7,600 nurses carried out in the autumn of 1987. The sample included nurses working in the NHS, nurses working in the private sector and nurses who had left nursing. Reasons given for joining the health service were a desire to help others; the interest of the work; job security and a belief in the health service – all positive features of the job that need to be maintained and built upon

2.1

QUALIFIED NURSES' ATTITUDES TOWARDS NURSING

A survey of Royal College of Nursing members by the Institute of Manpower Studies, Sussex University, compared qualified nurses' attitudes towards nursing.

1. *Qualified nurses not currently employed as NHS nurses* tended to attach more importance to:

- **good accommodation;**
- **good creche facilities.**

When they had been working in the NHS, they had had less experience of:

- **doing a worthwhile job;**
- **being able to use their own initiative; and**
- **NHS hours had less often fitted in with their domestic circumstances.**

They tended to attach more importance to the following as influencing an eventual return to NHS nursing:

- **the creation of more part-time posts;**
- **the availability of refresher courses.**

2. *Those who were NHS nurses* attached importance to:

- **a good atmosphere at work;**
- **the availability of good staff facilities;**
- **a fair level of basic pay.**

They were more inclined to leave the NHS because of:

- **stress;**
- **poor promotion prospects;**
- **not being valued by 'government';**
- **reduced to advisory role;**
- **restrictions imposed by doctors;**
- **petty regulations;**
- **patients not improving 'whatever you do';**
- **effect on marriage;**
- **poor pay.**

3. *Those currently within NHS nursing who had not considered leaving* tended to attach more importance to:

- **using administrative abilities;**
- **receiving praise for doing well;**
- **good promotion prospects.**

They felt they had more experience within NHS nursing of:

- **control over workloads;**
- **doing a worthwhile job;**
- **a good atmosphere at work;**
- **good promotion prospects;**
- **special duty payments.**

They tended to attach more importance to the following as reasons why others left NHS nursing:

- **nurses' own ill health;**
- **hours not suiting their domestic lives;**
- **pregnancy.**

Source: R. Waite, et al, (1989)

to attract and retain adequate numbers of appropriate staff.

The Price Waterhouse study found that the most common reason given for leaving was pregnancy. However, other factors more closely related to the job itself were identified as important influences on retention. These revolved around levels of pay, workload and job satisfaction.

Attitudes towards pay

67 per cent of NHS nurse respondents to the Price Waterhouse study said that their pay was unsatisfactory and 85 per cent said it compared unfavourably with jobs outside the NHS. While these responses pre-date the introduction of the new career structure (see section 4), it remains to be seen whether the tightening competition for staff, and a consequent upward movement in general salary levels, will continue to place nursing at a comparative disadvantage in comparison to other sectors of the labour market.

Dissatisfaction with pay was also highlighted by another survey carried out in 1987, which was designed to compare the attitudes of people who stayed in or left nursing in one District Health Authority (Mackay, 1989). It was based on in-depth interviewing with student nurses, and a group of their trained colleagues. The study found that only a quarter of the sample were satisfied with their pay, and that more than half were dissatisfied. The nurses interviewed identified pay as the single most important aspect of the job which should be improved to encourage trained nurses to stay.

Nevertheless, the study makes it clear that nurses' attitudes to pay are complex. In particular, many nurses appeared to identify strongly with the concept of nursing as service, in which monetary considerations were perceived as secondary:

> *Yes I think we're overworked and underpaid but somebody once pointed out that if the wages were very good like the police force you get the wrong type of people coming into it. You get people coming into it for the money, not because they want to do it (p. 75-76).*

Despite this, the police did emerge as an important comparator group for nurses, with nursing pay frequently compared unfavourably with that of police officers:

> *I am fairly high up in the management tree and paid less than a police constable. Now that to me is pretty appalling. He's at the bottom of his tree and I am pretty near the top of my tree and I am paid less than he is (p. 76).*

This work and the Price Waterhouse survey found that pay is more important as a reason for not returning to nursing than it is for leaving.

Regional patterns

A study carried out by the Institute of Manpower Studies, Sussex University, confirmed that the NHS experiences an annual overall nursing wastage rate of approximately 10 per cent, but was able to go beyond other studies by pointing out the substantial variation between different regions. Figure 2.1 shows both the nursing turnover rate and the wastage rate from the NHS in different parts of the country. Turnover refers to nurses who leave one area but are reemployed by the NHS in another area, whereas wastage represents losses to the NHS overall. Two features stand out from the table. First it is noticeable that in some areas turnover is substantially higher than overall wastage from the NHS. In inner London, for example, around 30 per cent of the nursing workforce leave their jobs each year but about half of these leavers take NHS jobs in other areas. Second, there is a marked variation in both turnover and wastage rates between regions. Rates in inner London, East Anglia and Oxford were up to 4 times greater than those found in Northern Ireland, Yorkshire and Wales.

A breakdown of employment patterns and mobility shows quite clearly that inner London is markedly different from other areas of the country, including the rest of the Thames regions. Its workforce has proportionately more women who are younger and display the fastest rate of job turnover (although not wastage rates). They have low geographical mobility, usually moving elsewhere within inner London, and those who do leave the service usually take non-NHS jobs rather than retire or leave paid employment. Finally, London has relatively few part-time staff compared with other areas of the country.

In considering the likelihood of leavers returning to the NHS, it is relevant to note their destination on leaving the service. About 10 per cent of the IMS sample left because of retirement and would not, therefore, generally be available for future employment in the NHS. 50 per cent left for jobs outside the NHS, while the remaining 40 per cent left but did not take up another paid job. It is the last group who are most likely to return.

Mobility

The IMS study also examined nurse mobility. It concluded that while younger, single and male nurses can be considered geographically mobile for policy purposes, a high proportion of married nurses are comparatively immobile. In practice this is because domestic constraints limit their ability to move in order to change jobs or seek work.

In particular, the survey indicated that most female married nurses – the group that makes up more than half of the workforce – place priority on their spouse's career when deciding on future job and house moves. The IMS researchers comment that while this may reflect traditional cultural views of the male as head of the household and breadwinner, financial considerations are also likely to play a part. In 1989 the average wage of a full-time trained nurse equalled 98 per cent of male manual full-time average earnings, and 66 per cent of male non-manual full-time average earnings. Many married women nurses who return after a career break work part-time, and consequently earn less. In practice, therefore, there may be clear financial imperatives which underlie married women's deference to their spouses' careers (Buchan, 1990). In addition, Hart's in-depth work in Trent suggests that, on occasion, nurses take advantage of their husband's occupational mobility to move away from a less than satisfactory work situation (1989).

Workload and job satisfaction

Responses to the Price Waterhouse survey indicated that criticisms of workload related to the standard of service nurses are able to offer, pressure of work and its volume. For example, 72 per cent of nurses working in the NHS complained that there were not enough people to do the work and 68 per cent claimed that not having enough time was a source of real frustration. Taken overall, workload factors were a significant cause of dissatisfaction among nurses currently working in the NHS and are one of the major reasons why many leave and do not return.

Concerns about the management's approach included inflexibility (mentioned by 66 per cent of NHS nurses); lack of training opportunities for career development (60 per cent); failure to inform staff about decisions affecting them (55 per cent); and insufficient opportunities to discuss concerns with managers (52 per cent). For nurses who have left the NHS, lack of recognition from management was given as an important reason for their resignation and lack of desire to return.

While the concerns listed above were reflected in the responses of nurses across the entire sample, some groups showed especially high levels of dissatisfaction. Young nurses, recently

Figure 2.1 **Nurse Wastage from the NHS, per cent of workforce, 1986–87**

REGION	
1 SCOTLAND	10.3%
2 NORTHERN IRELAND	3.6%
3 NORTHERN	13.8%
4 YORKSHIRE	4.5%
5 NORTH WESTERN	8.9%
6 MERSEY	11.5%
7 WALES	5.6%
8 WEST MIDLANDS	6.8%
9 TRENT	11.0%
10 EAST ANGLIA	14.6%
11 OXFORD	14.6%
12 SOUTH WESTERN	12.7%
13 WESSEX	11.0%
14 THAMES – INNER LONDON	14.3%
14 THAMES – OUTER LONDON	13.7%
14 THAMES – LONDON FRINGE	10.2%
14 REST OF THAMES	12.7%

Source: IMS (1989) Table 5.3 p57

registered nurses, and nurses working in and around London all figured prominently in this category (Price Waterhouse, 1988).

Many of these findings were confirmed by the IMS study for the Royal College of Nursing (Waite, *et al*, 1989). This looked at the experiences of a sample of RCN members in each of three separate years: 1986, 1987 and 1988.

On the question of job satisfaction, around one third of the NHS nurses surveyed thought that the level of care they were able to provide was unsatisfactory. The most frequent criticism was of staffing levels below those necessary to meet increasing workloads. The study showed that the majority of nurses felt that workloads, frustration and stress levels had increased over time.

On pay, it was, once again, younger RCN members who expressed the greatest levels of dissatisfaction. Moreover, a regional breakdown revealed that satisfaction was lowest in the south east where over 50 per cent of the sample described themselves as 'very dissatisfied' (Waite *et al*, 1989).

Undervalued and unsupported?

In-depth interviews conducted as part of Mackay's survey of nurses in one district health authority suggests that the stress reported by nurses relates to feelings of being personally unsupported and undervalued by medical colleagues, managers and fellow nurses in doing what they perceive as highly responsible, high-pressure work (1989). Quotations from (respectively) a nursing sister and a student give a flavour of this:

> *... you've got to be practically moribund before they send you home and once you are there that's it. I don't feel anybody cares for us. Nobody. You are just there to do your job, get on with it, no matter what you feel like.*

> *Nobody sort of asks the nurse how she feels, or when did she have a break or whatever. You are just expected to sort of carry on. I think a lot of nurses feel you are just a number; you are just a pair of hands, a pair of feet – get on with it (p.100).*

These findings are echoed in another recent study of factors affecting nurse turnover and retention. This work – which was carried out in two large acute teaching hospitals in Trent Region – emphasised the importance that nurses attached to feeling that their ability to cope in stressful conditions was recognised by managers and medical colleagues (Hart, 1989). It also confirmed the key role of ward sisters in creating a working environment in which nurses felt valued and supported even when hard pressed – a finding that is bourne out by other research evidence from the last decade (Pembrey, 1980; Ogier,1982).

A transient culture

Hart's work in Trent also highlights features of nursing culture which contribute to high turnover. These include the fact that collecting experience from a variety of settings is highly valued within nursing, and is thus very important for nurses who wish to progress up the career ladder. Remaining in one post for longer than two or three years can be regarded with suspicion by colleagues and managers alike, who tend to treat it as a sign that the nurse concerned is becoming 'stale' or 'set in her ways'. In addition, this study suggests that nurses tend to respond to unsatisfactory or unduly stressful working conditions by leaving, rather than by attempting to confront or change them.

Hart concludes that this mobile, transient culture contributes to a kind of managerial 'doublespeak' on the issue of staff retention. Given prevailing values within nursing, nurse managers may have mixed feelings about implementing policies which attempt to retain staff. These may be perceived negatively as attempts to keep nurses who are bored, discontented or who should be encouraged to move on in order to broaden their professional experience (Hart, p.30).

Combining home and work

Many of the nurses interviewed in the Mackay and Hart studies considered that it was very difficult to combine nursing with family commitments:

> *... They don't make it very easy for women with very small children. Although I worked part time you've still got to be there for half past seven in the morning and my husband leaves at a quarter to seven so...it was just very difficult (Staff Nurse)* (Mackay, 1989, p. 87).

> *...you either work full time or on the bank virtually... You know, I think we have to become more flexible about the hours the nurses work and fit in better with one another's commitments (Sister)* (Mackay, 1989, p. 88).

Hart's work suggests that nursing culture generates subtle pressures which devalue the contribution of nurses who work part-time because of family commitments. Nurses who work full-time appeared to consider that part-timers are inevitably less committed to nursing, and there was also a general view that part-timers were discriminated against in terms of their promotion, training and career development prospects. In addition, full-time nurses strongly resented feeling that their hours and shifts had to be planned 'to fit round' the needs of part-timers (Hart, p. 62-68).

Poor communication

Poor communication at and between all levels of nursing staff and other members of the ward team

emerges as a major theme from Mackay's work. The repressive influence of nursing hierarchies is still, it seems, strongly felt by ward staff at all grades:

> *...the people in the hierarchy do not like troublemakers, they like people to toe the line (Staff Nurse).*

> *I'm not frightened of saying what I think...But I think if I said too much it wouldn't go down well and some people would close ranks and you get labelled as a trouble-maker (Sister).*

> *Anyone extrovert is branded as a troublemaker. Even though we are in 1987, if you speak out or have strong views you are asking for trouble... (Enrolled Nurse, p. 102).*

Mackay's study suggests that inter-personal tensions and poor communication between nurses themselves are a problem, and her findings are echoed in Hart's work. Both studies indicate that problems of this kind can be alleviated by the right kind of leadership from ward sisters. Difficulties of this kind are not new: evidence submitted to the Brigg's Committee suggested that 'the greatest cause of complaint was the attitude and behaviour of nurses themselves' (1972).

Action on recruitment and retention

Overall, the picture on recruitment and retention is clear and fairly bleak if present policies do not change. Nursing wastage rates are high and could get even higher. Return rates are too low to maintain staff numbers in many places as recruitment of new entrants becomes more difficult because of declining numbers of young people and stiffer competition from rival employers. Both these problems relate to critical underlying concerns with the content and management of nursing work, and their influence on overall job satisfaction.

Faced with these difficulties, and supporting evidence from the surveys examined above, it is clear that there are a number of priorities for future policy on nursing. These include:

- Increasing the job satisfaction of nurses at all levels;
- Improvements to pay and career structures;
- Improvements to training;
- Improving the management of career breaks;
- Introducing more flexible working conditions;
- Enlarging nursing's recruitment pool.

These priorities point to a need for greatly improved management of nursing and nurses within the NHS. If recruitment and retention are to improve, they must be reflected in national, regional, district and unit-level policy. Some of them feature in the Department of Health's *Strategy for Nursing*, which puts particular stress on the need to manage career breaks more effectively and to extend recruitment beyond women school leavers to include people in their late twenties and early thirties, members of ethnic minority groups and men (1989d). In addition, the research evidence makes it clear that attention to workload factors and efforts to improve job satisfaction will be essential to improving nurse retention (Weisman, 1982).

The following sections of this report assess in turn the extent to which these – and other – issues are being addressed by existing policy on nursing. Section 3 looks at improvements to training and career structures. Sections 4 and 5 examine current proposals to tackle the content and organisation of nursing work, and chapter 6 looks at nursing management.

The 'New Nursing'

3

Organising nursing work

Section 1 explained the traditional, routine-based approach to nursing, and also made it clear that the precise nature of nursing work was difficult to define. This section of the report examines the 'new nursing': an attempt to move away from a task-centred approach and to locate nurses' special expertise firmly in direct patient care.

The 'new nursing' represents the ideological underpinning for current moves to reform nurse education and introduce a clinical career structure, which are discussed in detail in section 4. At one level, it represents an explicitly professionalising strategy, designed to give trained nurses a distinct sphere of influence within health care and greater autonomy in their work. As such, it has clear parallels with the approach adopted by doctors to define and control medical practice. In another, less well-articulated sense, however, the movement can be understood as an attempt to redress the increasing fragmentation and technical orientation of late twentieth century health services through the development of a distinctive, patient-centred model of care (Salvage, 1988).

The new nursing has achieved widespread support in elite nursing circles, and many of its tenets underly academic research and experiments with new ways of organising nursing work. Perhaps most importantly, it has had a central influence on Project 2000 – the programme of reform for nurse education that is set to reshape nurse training over the next decade – and will therefore have an key influence on nurse education well into the next century.

The long-term success of this approach is, however, open to doubt. Adoption of new nursing methods runs counter to well-established value systems within nursing itself, and poses threats to the supremacy of the medical profession within health care. Even more importantly, the cost of its implementation is unknown, and will be impossible to assess in any global sense.

Nevertheless, the new nursing has important implications for managers and policy makers within British health care. Will it improve quality? Will an application of new nursing principles improve nurse recruitment and retention by making the job more rewarding? What will it cost, and which areas of health care is it most suited to?

A new ideology

The new nursing is shorthand for a complex, multi-faceted movement to change the basis of current nursing practice. It centres on moves to replace the task-based method of organising nursing work with care more precisely tailored to individual patients' needs. In doing so, it seeks to substitute a professional model of organisation for nursing's long-established hierarchical, bureaucratic one. Its proponents base the new approach on a highly skilled nurse practitioner who will have the competence and self-confidence to plan, give, supervise and evaluate care tailored precisely to the needs of individual patients.

At the core of the 'new nursing' is a new emphasis on the clinical role of the nurse as care-giver, and a stress on the unique contribution of nursing care to healing. As such, professional nursing bodies' successful efforts to encourage the government to introduce a clinical career structure represent an achievement for the new approach (see section 4).

Nursing's statutory body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), has stated that the practitioner of the future must

> *... be competent to assess the need for care, to provide that care, to monitor and to evaluate care and to do all this in a range of institutional and non-institutional settings ... The practitioner of the future should be both a "doer" and a "knowledgeable doer"* (UKCC, 1986).

The independence, assertiveness and autonomy conveyed by this vision of the new style nurse is made in conscious contrast to the perceived failings of the insecure, ritual-bound, task-oriented one of the past and present. In addition, and critically, the new role implies a concentration on 'basic nursing care' – toileting, bathing, feeding and so on – which in conventional hospital nursing tends to be the province of untrained or junior staff: 'the practitioner of the future should be someone who [gives] care, not someone who only supervises it' (UKCC, 1986). One of the chief tenets of the new nursing is that, for the full therapeutic effect of nursing to be realised, care must be based on the whole range of needs of the patient as an individual human being. Basic nursing care must therefore become central to skilled nursing, since it is as important to patient well-being as the more technical tasks delegated by doctors to nurses.

3.1

TRADITIONAL AND PATIENT-CENTRED NURSING COMPARED

TASK ALLOCATION NURSING	PATIENT-CENTRED NURSING
Role of the Nurse	
Nurse takes on a variety of tasks, including ward housekeeping and clerical duties, in a serial fashion, according to ward routine and under senior staff's direction.	Qualified nurses have authority to plan, carry out and evaluate care plans based on individual patient need.
Nurse's competence based on ability to undertake a variety of tasks and 'get by and cope'.	Nurse's competence based on fulfilment of her therapeutic role as an independent practitioner in caring for individual patients
Division of labour	
Untrained and trainee staff give basic care; qualified nurses supervise.	Qualified nurse plans and implements care plans, assisted by other staff.
Role of ward sister/charge nurse	
The sister/charge nurse establishes and maintains ward routine, liaises with medical staff, supervises the ward team and undertakes a range of administrative, housekeeping and clerical duties.	The sister/charge nurse advises on clinical matters, manages the ward and undertakes staff development. She coordinates education and research.
Role of patient	
Passive recipient of care delivered by a number of nurses according to ward routine.	Active partner in planning for individual needs with the nurse.
Role of nursing management	
Manages nursing establishment and exercises authority over ward sisters.	Enables ward-level staff to function as independent practitioners by creating a climate in which nurses can learn, take risks, and innovate.

Tailoring care to meet individual need means that the new nurse must use a systematic, problem-solving approach based on sound, scientifically-based knowledge of best nursing practice. Throughout the new nursing literature the notion of the skilled, knowledgeable practitioner as the linchpin of the service is continually stressed. This 'new animal' will work in partnership with patients in designing care plans aimed at fostering independence and autonomy (UKCC, 1986). Box 3.1 summarises the difference between patient-centred nursing and the traditional task allocation model in a way that points up the scope of the changes involved.

Clinical autonomy

The new nursing has its roots in the early 1970s, when a number of newly established academic departments of nursing in Britain began to draw on American attempts to redefine the nurse's role as an independent clinical practitioner. On both sides of the Atlantic these moves grew out of a conscious

disaffection with nursing's traditional bureaucratic, authoritarian model of organisation. The women's movement, attempts to forge partnership between health care users and providers, humanistic psychology and moves to reassert 'holistic' patient care have all had a part in shaping it. Its explicit – though largely untested – justification is that patients will benefit from the new approach (Salvage, 1990).

Few of the new nursing's claims have been evaluated – not least because application of its principles, in whole or in part, is very much the exception in British nursing today (Robinson *et al*, 1989). However, the acceptance and promulgation of many of its key principles by the Royal College of Nursing and by the UKCC in its Project 2000 proposals for nursing education indicates that the new nursing has achieved broad acceptance within the nursing establishment (Salvage, 1990).

Implications of the new nursing

The new nursing is both a framework for a new kind of nursing practice and a practical strategy with – its advocates contend – potential for overcoming some of the occupation's most persistent difficulties: in particular, nursing's low status within health care; its long-standing retention problems; and its lack of a clearly defined area of expertise with a scientific basis for practice. They stress that the independent practitioner role is the only appropriate strategy to adopt in the face of demographic changes which mean diminishing numbers of nursing recruits, as well as changes in medical technology and user expectations that demand a more skilled, holistic approach to care. The approach has certainly attracted support from key nursing constituencies on this basis (Clay, 1987). As such it is an explicitly professionalising strategy, designed to enhance the status and (indirectly) the rewards received by trained nurses (Salvage, 1990).

For all the seeming simplicity of its emphasis on the 'new animal', the new approach to nursing has profound implications for nurses as an occupational group, and for the future organisation of health care. Box 3.2 summarises them. Many of them are inter-dependent, and achieving meaningful change will involve advances on a number of fronts at once. They include changes to well-established value systems within nursing; a reorientation of the ward sister's role and of nursing management more generally; and changes to the composition and work of the wider ward or community team.

Organising patient-centred care

Various methods for organising patient-centred care have been developed in the UK, although their application remains experimental. 'Primary nursing' – currently the most publicised method – involves allocating 24-hour responsibility for each patient's care to a trained primary nurse who plans, gives, supervises and evaluates care, wherever possible with the active collaboration of the patient. Although primary nurses will also supervise the work of 'associate nurses', who may be more junior or untrained staff, application of primary nursing methods implies the direct involvement of trained staff in basic patient care. 'Team' and 'patient allocation' methods are variations on this same, patient-centred theme: both involve establishing a detailed, holistic care plan with the patient, and then giving specific nurses or nursing teams responsibility for carrying it out.

In contrast, the task allocation method

3.2

PRECONDITIONS FOR THE NEW NURSING

- **Changes to the division of labour within nursing:**
  - **the trained nurse both delivers and supervises care;**
  - **the support worker 'aids' the trained nurse.**
- **Changes to nurses' value systems:**
  - **'hands on' patient care at the bedside or in the home becomes the highly valued province of trained staff;**
  - **acceptance of individual accountability for patient care.**
- **Changes to the ward sister/community nursing team leader's role:**
  - **clinical 'consultancy';**
  - **staff support;**
  - **ward/team management.**
- **Changes in nurse management:**
  - **facilitative and enabling instead of controlling;**
  - **devolves power over establishment and budgets to ward or community team level wherever possible.**
- **Continuing development of a clinical career structure for nurses**
- **Changes to nurse education:**
  - **students supernumerary to service requirements;**
  - **links with higher education;**
  - **fostering of a critical, questioning approach;**
  - **emphasis on continuing education and staff development.**

fragments care by assigning specific tasks to different staff: thus, a student nurse might take every patient's bed pan. The result, for patients, is being nursed by many different people, none with an overview of his or her condition.

Patient-centred approaches to care are increasingly being linked to the application of nursing models (McKenna, 1990). These attempt to provide a conceptual framework for nursing practice in order to guide the formation and application of individual care plans. Nursing models attempt to complement biomedical approaches to the treatment of disease by determining appropriate approaches to nursing care in the context of patients' family and living and working environment (Kershaw and Salvage, 1985).

Preconditions for change in acute care

Changing from a routine-based or task-allocation system to patient-centred nursing involves a transformation of the way that nursing work is organised on hospital wards, and the division of labour within them.

Box 3.3 gives a case study which illustrates the change in skill-mix required as a precondition for the introduction of primary nursing on an acute surgical unit at a major teaching hospital. Essentially, trained staff were substituted for untrained staff and there was a reduction in the use of enrolled nurses. A new post of 'ward auxiliary' was created to relieve trained nurses of housekeeping duties, and ward clerk time was increased slightly to provide administrative support for the senior sister.

3.3

PRECONDITIONS FOR PRIMARY NURSING: CHANGES IN SKILL MIX

The introduction of primary nursing requires changes in skill mix as staff move from a task allocation to a patient-centred style of nursing. At the acute surgical unit of the John Radcliffe Hospital in Oxford, a major change in staffing structure was needed before primary nursing could be introduced.

In 1984, the skill mix of the unit's nursing establishment was determined by historical precedent. It provided a reasonable number of 'pairs of hands', but staff were continually stressed. Analysis suggested that this was due to:

- **Inadequate registered nurse cover: wards were frequently left without a registered nurse to manage a shift.**
- **Abuse of enrolled nurses: enrolled nurses were frequently placed in a position of responsibility for ward management, clinical decision making and learner supervision for which they were not trained or paid.**
- **Inappropriate use of untrained staff, since nearly a third of the staff were nursing auxiliaries they undertook the bulk of the direct patient care.**
- **Inadequate supervision of student nurses.**
- **Limited supervision or peer support for staff nurses.**

With this staffing, moving beyond task allocation to a new patient-centred style of work was unrealistic. Accordingly a decision to upgrade skill levels of ward teams within existing budgets was taken. Figures A to C demonstrate how this was done - first by natural wastage of untrained staff (Figure B) and then by allocating untrained staff to other jobs within the hospital and bringing in others to assume ward clerk and sister's assistant duties (Figure C). These changes were traumatic for the untrained nurses who were moved: disruption to existing ward teams and patterns of working was considerable.

The effects of these changes were monitored using quality measurement tools, including patient satisfaction measures. Comparisons between test scores taken before and after implementation of the project indicated improvements in the overall quality of care, although improvements for any one measure were slight. These changes were supported by the subjective judgements of remaining staff, who were pleased with the shift from 'quantity' to 'quality' staffing. The new ward clerk and sister's assistant posts were valued by the nurses, who found themselves relieved of administrative and secretarial tasks.

Source: Binnie, 1989

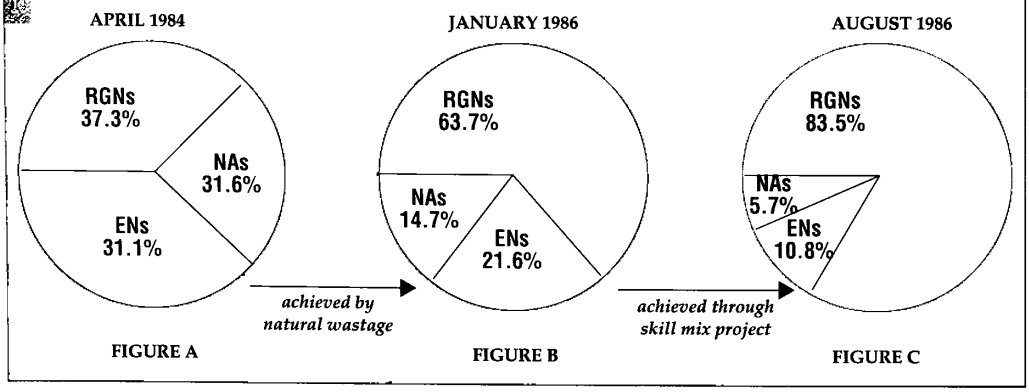


FIGURE A FIGURE B FIGURE C

These changes were achieved within existing budgets over a two year period (Binnie, 1987). They represent a fundamental transformation of conventional ward staffing, effectively doing away with untrained staff involvement in direct patient care. As such, they give an indication – though possibly an extreme one – of the magnitude of the changes required for the introduction of the new nursing in an acute hospital setting. The application of patient-centred approaches has not been limited to acute care, however: indeed, some of the most notable experiments with personalised care have taken place in rehabilitation, continuing care and community settings.

Challenging existing values

The introduction of personalised nursing also implies significant changes to nursing's traditional value systems. Currently, one of the rewards implied in becoming a qualified nurse is the power to delegate basic nursing care to untrained or trainee staff. Basic nursing is much less highly valued than the 'scientific', technical tasks delegated to nurses by doctors (Melia, 1987). Personalised nursing, with its emphasis on the need for trained nurses to give a good deal of basic care, involves a reversal of these time-honoured values.

As a result, the extent to which the majority of nurses will be willing to adjust to the changes to nursing's traditional division of labour within the wards is, as yet, unclear, especially since patient centred nursing is still largely the exception in British hospital settings (Salvage, 1990). Its development so far has depended largely on idealistic practitioner-advocates, sometimes working in unconventional contexts (Robinson *et al*, 1989).

The new nursing also makes substantial demands on ward sisters/charge nurses and community team leaders – whose conventional role of supervising and administering the ward or community nursing team must alter to one of clinical consultant, team manager and planner, and coordinator of research and education in the new nursing (see Box 3.1). This shift is one that has been consistently advocated by the Royal College of Nursing and others over a decade or more, but research into the way that ward sisters carry out their work makes it plain that few are currently trained and equipped to work in this way – nor are they generally enabled to do so by higher-level management (Pembrey, 1980; Ogier, 1982; Runciman, 1983).

Accordingly, a very significant reorientation of basic and post-basic nurse education is required to equip nurses at all levels for the changes implied by the new nursing, and the necessary reorientation of nursing work. These changes are, of course, exactly what is implied by Project 2000, and the 'new animal' it seeks to create (UKCC, 1986). The extent to which this reorientation will be achieved remains to be seen. However, the new nursing's emphasis on the clinical, therapeutic nurse also implies further development of the new clinical career structure for nursing – something that will require political support at the highest level.

Using untrained staff

In addition, there are important unresolved issues around the appropriate use of untrained nursing staff implied by the new nursing. The new focus on basic nursing involves, at its most extreme, an explicit devaluation of the contribution that nursing auxiliaries and other untrained staff make to patient care in conventional ward settings and their consequent relegation to work that has no direct patient contact (Binnie, 1987). This deskilling is potentially divisive to established ward teams, and has important industrial relations implications which, so far at least, advocates of the new nursing have failed to address (Salvage, 1990; Robinson *et al*, 1989).

A challenge to medicine?

Most problematic of all, perhaps, is the threat to traditional medical dominance that the new nursing implies. Claims to a unique therapeutic role for nursing involve a reassessment of the importance of patient care relative to cure, and the values assigned to these two inter-related aspects of health care. Dominant values in wider society support the notion that 'cure' – the province of doctors, until recently mainly men – is accorded much higher value than 'care' – which is perceived as women's work involving much less skill. Rightly or wrongly, this view is bolstered by a wider recognition of the considerable overlap between basic nursing and the work of unpaid, untrained family members who provide over 90 per cent of nursing care for people at home (Dingwall, *et al* 1988).

It is unclear how the new nursing would overcome these perceptions, which are shared by many nurses themselves. Moreover, the one-to-one relationship between a primary nurse and her patient parallels the traditional one ascribed to doctors only, and may be construed as a threat to it.

In particular, the development of the skilled, autonomous practitioner raises the possibility of substituting nurses for doctors in certain clinical areas. There is considerable potential for this in primary care, where nurses make a substantial contribution to the health promotion, screening, surveillance, counselling and routine treatment work of some GP practices. District nurses already undertake a considerable proportion of the care of elderly and disabled people at home, and the scope

of this work will increase if, as seems likely, they are given power to prescribe certain drugs and conduct a range of treatments without medical supervision. At the same time, possibilities for shifting certain types of acute and terminal care into the community through 'hospital at home' schemes brings with it potential for a blurring of the distinction between traditional medical and nursing practitioners (Taylor, 1990).

In secondary care, it is possible that new-style nurses could undertake many of the tasks currently done by junior doctors in acute settings, or that the 'doctor's work' currently done by nurses could be legitimated . In addition, there is obvious scope for nurses to undertake case or care management responsibilities for patients in both acute and continuing care. In some areas – for example, rehabilitation, continuing care of the elderly, nursing home and hospice care – nurses can (and do) assume overall clinical responsibility for the organisation and delivery of care, with doctors providing medical expertise as required. Such an approach is also potentially valuable in acute care, where it involves nurses taking the lead in what would normally be an acute ward in the district general hospital. Experiments with 'nursing beds' where this takes place are underway in some areas (see Box 3.4), and it is significant that one of of them attracted overt medical opposition (Pembrey and Punton, 1990). Unsurprisingly, then, the extent to which doctors will be willing to exchange their traditional 'handmaidens' for true clinical partners – or substitutes – is one of the most important questions posed by the new nursing.

Cost?

Another is cost. Since cost containment is certain to continue be one of the dominant themes of late twentieth century health care in advanced countries, it is clear that the widespread adoption of a new mode of organising nursing work will depend on its cost effectiveness. The extent to which these organisational changes permit – and are seen to permit – the more effective use of scarce and expensive staff will be a critical determinant of the fate of the new nursing. Since one of the most important sub-themes of cost containment in health concerns the cost-effective management of doctors' clinical work, the chances of nurses being allowed greater professional autonomy without careful attention to the effect of this on health costs is very unlikely. The new nursing will need to demonstrate that changes in nursing skill-mix and the organisation of nursing work use resources more effectively than traditional methods. Since cost is far easier to measure than quality, nurses will find this difficult to do (Buchan, 1990). Moreover, as mentioned above, improving cost effectiveness will raise a number of politically contentious issues including the appropriate

3.4

NURSING BEDS

Nursing beds are designed to meet the needs of people who need intensive nursing care to regain their health and full potential after an illness or accident – for example, a stroke. They can also be used to help people to die well, or to help maintain the highest possible quality of life for disabled or elderly people.

In Britain, nursing beds have been pioneered in continuing care for elderly people – notably in St Pancras Hospital, London. The approach also has potential in acute settings, where care traditionally tends to centre on medical interventions, and is generally not well geared to helping people with longer term problems reach their full potential for independent living. Indeed, many people recovering from strokes and other conditions with long-term effects are left to languish as "bed blockers" on acute wards, receiving attention as and when medical emergencies permit. In recognition of the difficulties this causes, an experimental project using nursing beds within an acute teaching hospital took place in Oxford Health Authority between 1985 and 1989 under the auspices of the HA's Nursing Development Unit (NDU).

THE OXFORD EXPERIMENT

The most striking thing about Oxford's NDU was that it admitted people who ordinarily would have remained on acute wards. The ward had the same budget as a standard geriatric ward in its teaching hospital. In most other respects, however, it marked a radical departure from conventional practice: nurses controlled admissions and discharges and they were free to develop new therapeutic techniques and approaches outside of medical control and standard hospital policies. The focus was on intensive, expert holistic care to help people make the fullest possible recovery. Nurses worked with patients to set personal goals and devise ways of achieving them through individually tailored care plans. Although the team was nursing-led, it was multidisciplinary: a geriatrican, physiotherapist and occupational therapist contributing their expertise and worked with patients within the agreed philosophy.

A system of primary nursing was adopted, with each practitioner caring for eight patients. Innovations in care included patient-held records, patient self-medication and the use of massage and essential oils, with nurses carrying out some procedures that are normally the responsibility of doctors.

An evaluation of the ward which compared its patients with a matched sample in conventional settings found that:

- **Quality of care was higher in the nursing unit.**
- **Patients achieved more independence there.**
- **The unit's patients were more satisfied with their care.**
- **Length of stay and cost-per-patient was no higher than in conventional settings.**
- **Fewer patients died in the nursing unit.**

Despite this success, the Oxford unit attracted considerable opposition from some medical staff, although others supported it. The NDU was closed in 1989 as part of a local cost-control programme. Currently, there are no other experiments with nursing beds in acute settings in the UK, although further development of the approach is now being planned in Oxford.

Sources: Pearson *et al*, 1988, Salvage, 1989; Pembrey and Punton, 1990.

deployment of untrained staff and the substitution of nursing for medical staff in key areas.

Patients as partners?

A third question is the extent to which patients will be willing or able to act as effective partners with the 'new nurse'. Salvage (1990) argues that primary nursing's 'partnership model' of interaction between patient and nurse has been adopted uncritically from psychotherapy, and ignores important differences between the psychotherapeutic context and the nursing one. In particular, it glosses over the fact that patients – in general hospitals at least – are there involuntarily, and their concerns centre on relief of physical disorders, and the pain and discomfort associated with them. They may therefore be unable or unwilling to contribute actively to their care.

Patient dependency also means that nurses have considerable power over the people they nurse. This power is reinforced by patterns carried over from traditional relationships between carers and cared for – most notably, that of mother to child (Salvage, 1988). While it is currently fashionable for health care professionals to advocate 'partnership' with patients – a theme that is in tune with wider efforts to permit service users a greater voice in health care – abdicating power, and/or changing the traditional basis of the relationship between professional and client often proves difficult in practice (Beardshaw, 1988).

Conclusions

This section of the report makes clear that the new nursing, and the changes implied by it, represent a potential reorientation of traditional nursing practice and organisation which would have profound effects throughout health care. At one level, it represents a professionalising strategy on the part of a key segment of the nursing community – notably academic nurses, professional nursing organisations, and influential nurse educators. At another, it offers genuinely positive approaches to some of the most perplexing issues confronting advanced health care systems. The promise of 'holistic' care in the face of ever-increasing medical specialisation and the possibility of the emergence of a new relationship between professional carer and cared-for are chief among these – along with the re-evaluation of the contribution of 'care' to health. At its simplest, the new nursing represents a sustained effort to rethink the functions and approach of health care's most important generalist workers.

However, the widespread application of new nursing principles, – and, in particular, the development of patient centred nursing in British hospitals – is a distinctly uncertain prospect, whatever the aspirations of its advocates (see Box 3.5). In particular, the demographic pressures affecting the supply of trained staff are likely to make the introduction of primary nursing more difficult, at the same time as – paradoxically – the implementation of 'Project 2000' both contributes to those nursing shortages and begins to transform nurse preparation in a manner intended to foster independent practitioners. The reaction of doctors to any transformation of the nursing role remains largely unknown – but it is unlikely to be wholly positive. Throughout nursing history, service needs and the stance of the medical profession have been critical determining factors for the direction of nursing (Dingwall *et al*, 1988). They may prove decisive for the implementation of new nursing practice as well.

3.5

THE NEW NURSING: ADVANTAGES AND OBSTACLES

POTENTIAL ADVANTAGES

- **Return to a 'holistic' approach in the face of ever-increasing medical specialisation and fragmentation of care delivery;**
- **potential for high quality, personalised patient care;**
- **increased job satisfaction for trained staff;**
- **emphasis on health and independence rather than illness and dependence;**
- **challenges to traditional routines and rituals could result in more cost-effective care.**

In theory, at least, this should mean that nursing becomes a more attractive career option for a broader range of recruits and that it adapts appropriately to the health needs of people in the next century.

OBSTACLES TO IMPLEMENTATION

- **Emphasis on cost containment may preclude experiments designed to improve quality;**
- **implicit challenge to medical dominance;**
- **nurses may find 'partnership' difficult;**
- **industrial relations/job satisfaction implications for support workers;**
- **nurses may prefer 'task centred' care;**
- **nurses may prefer delegating 'basic nursing care';**
- **management skills at all levels may be insufficient to bring about change.**

Pressures to contain health costs may come to dominate health agendas so completely that questions of quality may be eclipsed by them. At the same time, nurses' own value systems may act as an obstacle to change.

4 | Nursing reforms of the 1980s: *A clinical career structure and Project 2000*

Through its impact on NHS nursing career structures and on nurse education reforms, 'new nursing' ideology played an important part in shaping UK policy on nursing in the late 1980s. This section of the report examines these reforms in detail, and discusses their possible effect on nursing in the 1990s.

The introduction of a clinical career structure

Prior to 1988, the career structure for nurses and health visitors had remained basically unaltered since the creation of the NHS in 1948. Whatever its original merits, the system had failed to adapt to

4.1

NEW CLINICAL GRADES FOR NURSES AND MIDWIVES

SCALE A £5950-7355

Nursing auxiliaries and support workers without any statutory nursing qualifications who work under supervision of a registered nurse, midwife or health visitor.

SCALE B £7115-8115

Nursing auxiliaries and support workers, without any statutory nursing qualifications, who work regularly without supervision for all or most of the time, or who lead a team of Scale A staff.

SCALE C £8115-9650

Most newly qualified and junior enrolled nurses who are required to assess patient needs and provide care under the direction of a registered nurse, midwife or health visitor. These post holders may be involved in informal teaching of new or junior staff.

SCALE D £9335-10,700

This scale covers experienced enrolled nurses, ENs with a specialist post-basic qualification, newly qualified and junior staff nurses. These staff are responsible for the assessment of care needs, the development of programmes of care and/or the implementation and evaluation of these programmes.

SCALE E £10,700-12,390

This grade covers RGNs who plan, assess and develop care on the wards and who regularly supervise staff and practice areas. Staff nurses who have acquired specialist skills and experience and staff nurses with specialist post-basic qualifications come under this category.

Staff in this grade are expected to carry out all the relevant forms of care and are designated to take charge regularly of a ward in the absence of the person who has continuing responsibility. They are expected to supervise junior staff and be able to reach qualified and unqualified staff. They will normally have a first level qualification.

SCALE F £11,865-14,545

Qualified first level nurses who have continuing responsibility for the management of a ward, the setting of standards and the supervision and deployment of staff but where there are no basic or post-basic students on the ward.

This includes some ward sisters as well as school nurses, practice nurses, and some nurses with post basic qualifications and substantial post-qualifications clinical or teaching experience.

SCALE G £13,995-16,195

Staff on this grade have continuing responsibility for a ward or clinical area which includes managing and teaching staff, and planning and evaluating care; or who have overall responsibility for a community case load. This category covers many ward sisters and is the minimum level for qualified district nurses, health visitors, community psychiatric nurses and community mental handicap nurses.

SCALE H £15,645-17,860

Experienced nurses who carry continuing overall responsibility for the management of more than one ward or equivalent sphere of nursing, midwifery or health visiting in a hospital or community setting. Responsibilities include formulating policies at the clinical level, supervising staff, assessing training needs and teaching. The grade covers staff who are responsible for clinical expertise in a given area such as clinical teachers, clinical nurse specialists, supervisors of midwives and some experienced ward sisters with specialist skills.

SCALE I £17,305-19,600

Staff at this level may be managers of a unit, normally with overall responsibility for a clinical area, with responsibilities including budgetary control, staff deployment, planning and evaluation, research, teaching and policy formulation. The grade covers experienced clinical specialists and clinical teachers who are responsible for planning and evaluation of the teaching at basic and post-basic level.

Note: *Pay rates are given for staff aged 18+ years, and were current from 1st January 1990.*

the considerable changes within nursing that had taken place over this 40-year period. A particular concern was that it failed to offer a career structure that rewarded clinical skills and responsibilities. As a result, many nurses found that – unlike their medical colleagues – the only way for them to progress up the career ladder was to leave direct patient care completely. This problem attracted considerable concern in professional nursing circles, and led to a protracted campaign by the Royal College of Nursing and others for the introduction of a clinical career structure for NHS nurses.

Design

In response to this, the Department of Health's Nursing and Midwifery Staff Negotiating Council established a Joint Working Group on internal pay relativities and a clinical regrading structure in 1985. After extensive data collection on job specifications, the Working Group reached agreement on grading definitions for posts at nine levels of seniority. These were designed to replace all the current grades from nursing auxiliary up to and including senior nurse 7. This grade structure was submitted jointly by the Management and Staff Sides of the Negotiating Council to the Pay Review Body in 1988 with a request that rates of pay, in the form of a pay spine, should be recommended for the structure (Cleminson, 1988). The Review Body duly attached salaries to the grades. In recommending the proposals to the Governmnent it stated that the new system was designed to reward skill and responsibility, and expressed a hope that it would help overcome nursing's recruitment and retention problems (see Box 4.1).

Implementation

In the event, however, the implementation of the new grading system proved to be far from smooth. At both national and local level there was considerable acrimony between the staff and management sides, and by July 1988 the General Secretary of the Royal College of Nursing dismissed the exercise as: 'The biggest con that ever was' (Timmins, 1988).

A careful sifting of the flurry of words from both sides reveals two issues to have been particularly contentious. First, there was fear on the staff side that Treasury and DHSS pressures for cost containment were resulting in the application of a 'quota system' in which the number and types of the new clinical posts were being linked to the funds available instead of a genuine appraisal of the responsibilities of posts themselves (Cole, 1990). A second, and related, area of dispute concerned the management's interpretation of individual staff gradings. In this connection, the distinction between F and G grade sisters proved to be a source of particular discontent.

Funding the changes

On the issue of overall funding, it soon become clear that meeting the cost of the regrading exercise was going to exceed the Department's initial estimate of £803 million. However, concerns that this overshoot would not be funded proved to be unfounded. In October 1988 the Department of Health announced an extra £110 million of expenditure to meet in full the estimated final cost of the regrading exercise. This supplement was based upon Regions' own estimates of the costs they would incur. What was less clear, however, was the extent to which the known Departmental concern with the overall cost implications of the exercise had already transmitted itself to local management, and had thereby influenced their decisions on individual staff gradings. This consideration raises the second problem: namely, management's interpretation of grade definitions.

Local divisions

From the outset, it was clear that the regrading exercise – involving, as it did, grading half a million jobs over a period of 6 months – was going to be a mammoth task (see Table 4.1). It was bound to impose a significant additional administrative burden on management and staff representatives (Buchan, 1988). But the level of additional work arising from appeals by nurses dissatisfied with their grade allocations was almost certainly not foreseen.

Under the appeals procedure, nurses unhappy with the grade allocated to them could invoke an apeals process. In the first instance, an appeal could be lodged with the unit manager. If this was unsatisfactory, it could be considered by a panel at the district level. Subsequently, there was provision for referring a case to region, and ultimately to the national level. It was estimated that during 1989 100,000 appeals were lodged and by March 1990 up to 12,000 were still outstanding (Vousden, 1989; Cowie, 1990).

The way in which ward sister grades were allocated demonstrates the nature of the problem and the strength of feeling engendered by the appeals procedure. To achieve a G grade a nurse needs to have 'continuing responsibility' for a ward or clinical area. This was widely interpreted to mean that there could only be one G post per ward. Where responsibility was previously shared between two sisters, or between a night sister and a day sister, the new grading system was interpreted as allowing for only one G grade, the other sister being assigned an F grade.

Even though the Department of Health estimated that 45-50,000 sisters out of a total of 77,000 received G grades, this still left two out of three night sisters on an F grade (Nursing Standard, 1990). As a result, the regrading exercise has been particularly disruptive within ward

Table 4.1 **Old grades to new grades**

Percentage of old clinical grades assimilated in new grades, England, 1 April 1988

		Percentages transferred to each new clinical grade								
Previous grade	[1]Staff in post	A	B	C	D	E	F	[2]G	H	I
Nursing Auxiliary	90,819.73	86.3	13.5	0.3	-	-	-	-	-	-
Staff Nursery Nurse	2,357.19	2.3	89.5	7.9	0.3	-	-	-	-	-
Enrolled Nurse1	64,440.72	-	-	43.7	47.6	8.7	0.1	-	-	-
Enrolled District Nurse[1]	3,476.26	-	-	4.5	92.2	3.1	0.2	-	-	
Senior Enrolled Nurse[1]	3,774.55	-	-	2.1	49.8	46.6	1.3	0.2	-	-
Staff Nurse1	75,609.73	-	-	-	25.2	65.5	9.1	0.2	-	-
Staff Midwife1	9.012.88	-	-	-	10.4	77.1	12.4	0.1	-	-
Deputy Sister1	4,179.59	-	-	-	0.2	18.0	79.3	2.5	0.1	-
Nursing Sister II[1]	40,906.51	-	-	-	-	-	39.3	57.9	2.7	0.1
Midwifery sister II[1]	9,912.59	-	-	-	-	-	24.6	74.3	1.1	-
District Nurse (Sister II)[1]	9,881.94	-	-	-	-	-	1.2	94.8	3.9	0.1
Nursing Sister I	1,414.58	-	-	-	-	-	2.6	47.0	45.4	5.0
Midwifery Sister I	139.75	-	-	-	-	-	2.1	51.3	44.4	2.1
Health Visitor	9,275.43	-	-	-	-	-	0.2	96.8	2.8	0.2
Senior Nurse 8	3,352.81	-	-	-	-	-	0.3	13.6	56.2	29.9
Senior Nurse 8 (Midwife)	404.87	-	-	-	-	-	0.7	9.6	45.4	44.2
Senior Nurse 7	3,526.47	-	-	-	-	-	0.1	1.0	18.3	80.6
Senior Nurse 7 (Midwife)	360.93	-	-	-	-	-	-	-	18.8	81.2
Clinical Teacher	1,114.24	-	-	-	-	-	-	2.1	94.9	3.0
Fieldwork Teacher	1,369.85	-	-	-	-	-	0.1	1.7	97.3	0.9
Practical Work Teacher	1,498.11	-	-	-	-	-	-	1.3	97.6	1.1
Tutor	1,344.17	-	-	-	-	-	-	-	3.7	96.3
Tutor Midwife	428.11	-	-	-	-	-	-	-	2.1	97.9
Post basic students										
Enrolled	2,034.01	-	-	90.7	8.7	0.6	-	-	-	-
Staff Nurse	7,900.26	-	-	0.9	89.3	8.5	0.7	0.6	-	-
Deputy Sister	74.90	-	-	-	9.3	39.9	42.7	8.0	-	-
Sister II	368.67	-	-	-	3.3	1.4	72.6	21.3	1.2	0.3
Others	1,031.30	1.4	2.4	0.7	24.3	7.8	1.8	39.9	3.1	18.7
Totals	350,010.16	22.4	4.1	8.8	18.1	18.7	8.7	14.7	2.7	1.8

[1]Whole time equivalents [2]Excludes Post Basic Students

Notes:

1. Excludes some 3,500 additional '6' posts which health authorities have indicated they intend to create in future on existing two-sister wards.

2. The percentages may not always sum to 100 due to rounding.

Source: *Weekly Hansard* No. 1465, 28 November - 2 December; Written Answers, 28 November 1988, cols. 147-8.

teams, which rely upon collaborative teamwork (Rice, 1988). Disputes over job responsibilities involving midwives and district enrolled nurses also contributed to discontent in the community.

There is little doubt that the whole exercise proved to be extremely divisive at unit level, often setting nurse against nurse in competition for a limited number of posts. An additional bone of contention has been an apparent lack of consistency of interpretation of the new grades between health authorities, or even between different appeals panels in the same health authority (Cole, 1990). Moreover, in certain health authorities, it appears that the new grading structure is being interpreted as a strict nursing hierarchy of the old type, in which nurses progress 'up the ladder' according to seniority, rather than as a flexible structure that rewards nurses' clinical skills and responsibilities in a variety of settings.

In retrospect what judgement can be reached upon the new grading structure and its method of implementation? First, it is clear that the principle of providing an improved clinical career pathway for nurses is an important one. It would, however, probably have been better to try to divorce the grading exercise – with its specification of job descriptions – from the annual pay round. Nurses aggrieved at failing to be placed in a more senior grade clearly had their resentment compounded by receiving a less generous salary award than their colleagues. Admittedly this separation of grading and pay would only have delayed the process. Ultimately a higher grade would need to be reflected in a higher salary, as the Pay Review Body noted. Imposing a new career structure on nursing was bound to generate short run relative losers as well as winners. Only time will tell whether the long-term gains from a clear career structure will outweigh the

disruption that the implementation of the system has caused. This will partly depend on improved management of nursing work overall.

Project 2000: education and training for the future

While the clinical regrading exercise extends the possibility of a improved career structure for nurses, Project 2000 – the UKCC's strategy for the reform of nurse education – is designed to provide the education and training structure necessary to attract and equip new entrants for a career in nursing in the next century.

The context of reform

Ever since the introduction of formal nurse training in the mid-nineteenth century, basic nurse education has been conducted on apprenticeship lines. Before the beginning of the NHS, student nurses provided an essential source of cheap labour for voluntary and local authority hospitals, and this continued to be true after 1948. As a result, students' educational requirements have continued to be subordinated to service ones, and student nurses have remained isolated from their contemporaries in further and higher education (see Box 4.2).

A series of commentators within and outside nursing consider that this has had unfortunate effects on the quality of the educational opportunities open to nurses, and – as a direct result – on the calibre of nursing's skill base. Using students as 'pairs of hands' means that learning takes place in a haphazard way, as the exigences of the service permit. It has frequently proved difficult for students to relate their clinical experiences with classroom-based learning. Supervision of students in clinical settings is often inadequate, meaning that students are forced to rely on nursing routines and rituals instead of developing a reasoned and questioning approach to care.

Schools of nursing have been isolated from developments in other branches of further and higher education by their location on hospital campuses, and many are now too small to develop and deliver a varied, broadly-based curriculum. In any case, centring nurse education on hospitals is likely to prove increasingly inappropriate as health care acquires a stronger community base. As a result, throughout the 1970s and early 1980s a view that the educational opportunities open to nurses were inadequate grew in influential nursing circles, and were summarised in the report of the RCN's commission on nursing education in 1985 (Judge, 1985). This thinking fed directly into 'Project 2000' – the UKCC's proposals for a major reform of nurse education.

4.2

DISADVANTAGES OF TRADITIONAL NURSE EDUCATION

- **Service demands mean that practical experience and classroom education are frequently poorly coordinated;**
- **Unit-based learning can be poorly organised and must be fitted around the demands of the service;**
- **Training schools relate to hospitals and units and, as a result, can be dispersed, small and isolated, with insufficient resources to cope with a broadly based curriculum;**
- **Nursing students are isolated from their contemporaries in further and higher education;**
- **Training is centred on health care institutions, with insufficient emphasis on community-based work.**

Planning for reform

The Project 2000 report was published in May 1986 following a two-year consultation process initiated by the UKCC. Its aim was to identify the education and training needs of nurses, midwives and health visitors into the next century, in the light of the changing needs of society. Members of the project team were drawn from all four UK countries and from a spectrum of professional nursing practice. Following the publication of the report another extensive consultation process involving nurses, their union representatives, health authorities and other interested parties took place. Some revisions to the original proposals resulted from the second round of consultation and then, in May 1988, the Secretary of State for Health announced the government's acceptance of the project's key recommendations, with the important proviso that nurses accept a new training for health support workers – or unqualified staff – to be determined by the newly constituted National Council for Vocational Qualifications (NCVQ).

Moving closer to further and higher education

Project 2000 amounts to a full-scale reorientation of nurse training, which will now be based in institutions of further or higher education. Nursing students will become 'supernumerary' to service staffing requirements, and their time in clinical settings will be better supervised and more directly linked to course-based learning. Educational placements will take place in both institutional and community settings, and the curriculum itself will become more health (as opposed to disease) related, with an new emphasis on people as members of a wider society.

The new style training will consist of a eighteen month foundation course undertaken in

an institution of further or higher education, plus a further eighteen months spent in one of four specialist areas – general nursing, children's nursing, and the nursing of people with a mental illness or handicap. The Project 2000 team stressed that the UK is one of the last industrialised countries to train nurses on an apprenticeship model. The United States, Canada, Australia and New Zealand have all already developed genuinely education-based systems and the team considered that this suggested that a similar change of approach was long overdue in Britain.

Project 2000 will mean that student nurses spend, on average, 20 per cent of their time providing a service contribution over their three years of training. This compares with an estimated 80 per cent of students' time that is spent in service delivery at the moment. It is important to note, however, that this does not mean that only 20 per cent of a students' time will be spent in a practice setting – much of students' learning will continue to be practice-based.

The change to supernumerary status was seen as crucial by the Project 2000 teams:

> *We see [supernumerary status] ... as the single most important move in achieving the requisite level of educational control and transforming a situation where at present neither the learner is free to learn nor the teacher to teach (cited in Howie (1986)).*

By designating students as supernumeraries a major source of stress presently experienced by untrained learners should be removed. They should receive proper support during their clinical placements and no longer be treated as simply a 'pair of hands' (Howie, 1986). While in training, students will receive a non-means tested bursary, rather than a grant, in recognition of their service contribution. These will be controlled by the Department of Health.

Opposition to Project 2000

Project 2000 has not been without its critics, however. It has brought to the surface the longstanding differences between those who see nursing as a work requiring high calibre training for which critical judgement and a questioning approach are required and those who view it as an essentially practical occupation best learned from on-the-job experience. In effect, this is the latest act in a long-running dispute which surfaces whenever changes to nurse training or registration are suggested. It demonstrates the perennial tension between professional nurses' aspirations for a high-status qualification, some doctors' wishes for docile practical assistance, and service needs.

Today, critics of Project 2000 are to be found across the spectrum of health care interests. Devlin (1986), writing as a hospital consultant, disputes the claim that nurses need academic training and maintains that on-the-job experience offers a clear advantage, as much outdated clinical practice is taught in nursing schools because they are remote from actual practitioners. The Joint Consultant's Committee reiterated the view that practical skills are more important than academic ones and regretted the lack of consultation with doctors in framing the Project 2000 proposals (British Medical Journal, 1987). The National Union of Public Employees (NUPE) (1986) contributed to this general line of thinking with its claim that skill in nursing is not necessarily linked to academic qualifications. The union considers that many people will be excluded from nursing either because they cannot afford to undertake a three year course or because they are unable to meet the necessary academic requirements.

Service implications of Project 2000

While Project 2000 offers the possibility of improved nurse education, the proposals are not without their problems for the health service as a whole. In particular it is important to recognise that, at present, students contribute a major share of the staffing for direct patient care in hospital settings (Hancock, 1986). Reducing their service contribution in the future will obviously leave an important gap which will need to be filled.

Price Waterhouse (1987) estimated that making good the reduced student service contribution will necessitate an extra 5-6,000 new entrants in 1995. Over the following ten years, they estimated that the cumulative staffing needs resulting from student replacements and the cessation of enrolled nurse training (see below) could lead to a shortfall of up to 24 per cent in qualified staff by the year 2004. In reality, they felt that the situation is unlikely to be this bleak if strategies designed to reduce wastage rates and increase returns are successful – and Project 2000 and clinical regrading are expected to have a favourable impact upon both of them – and if additional entrants are attracted to nursing by widening entry gates and recruitment from presently underrepresented sections of the population, along the lines indicated in section 1.

An end to enrolled nursing?

Project 2000 recommends that there should be a single level of registered nurse involved in the delivery of care, trained to practice in community and hospital settings. To this end, it is proposed that the enrolled nurse grade should be phased out. EN training should be ended and existing ENs should be given the opportunity to undertake conversion courses leading to RN status. However, the qualification will continue to be valid and EN posts will remain widely available.

This proposal has encountered two main difficulties. First, it has proved unpopular with

4.3

THE PROJECT 2000 DEMONSTRATION SITES

From Autumn 1989 thirteen schools of nursing began to pilot Project 2000 training courses. These are:

- **Newcastle**
- **Sheffield**
- **East Suffolk and Great Yarmouth**
- **North East Essex**
- **North and South Bedfordshire**
- **Parkside**
- **Guildford**
- **Portsmouth and the Isle of Wight**
- **Winchester and Basingstoke**
- **Avon**
- **North Staffordshire**
- **Crewe and Macclesfield**
- **North Manchester**

It is obviously far too early to pronounce on the experience of these demonstration sites (Spender, 1989), but a careful monitoring of their successes (and failings) will be a crucial component of any strategy for the successful implementation of Project 2000 nationwide.

many enrolled nurses and their union representatives. The enrolled nurse grade was initially introduced in 1943, in response to a lack of qualified entrants to nursing in wartime. Subsequently, contributions from enrolled nurses have been very important in maintaining levels of nursing services in many hospitals. Indeed, since the introduction of the grade, many ENs have effectively undertaken the same work as registered nurses in many settings, although their status, pay and prospects have remained inferior.

NUPE has questioned whether abolition of the grade is the appropriate response to the problems of abuse and expolitation it has encountered (NUPE, 1986). It maintains that enrolled nursing offers an entry opportunity to nursing that would otherwise be denied to many people who have a great deal to contribute. Although it has been proposed that specific conversion arrangements and increased opportunities for continuing education should facilitate the transfer of ENs to the RN grade, a national shortage of health authority supported places on EN conversion courses is currently a major source of discontent amongst enrolled nurses.

The second difficulty with the proposal to phase-out EN status relates to its cost. It has been shown already that the Price Waterhouse's estimated "worst case scenario" predicts a 24 per cent shortfall of qualified staff that would need to be made good by the year 2004 if proposals for student supernumerary status and the ending of EN entry materialise. However, by reducing present wastage rates among both learners and qualified staff, and by increasing the numbers of returners, the additional numbers of staff required can be reduced. By assuming effective management action to improve recruitment and retention, Price Waterhouse estimate that the additional education and training costs arising from Project 2000 would amount to £400-450 million in the year 2004. Put another way the training costs per NHS entrant would increase by about 25 per cent. And significantly, their study shows that it is the cessation of EN training that exerts a major impact. The continuation of EN training would reduce the demand for students by nearly 30 per cent and reduce the cost level reached over 20 years by 36 per cent. Recognising the sensitivity of cost projections to policies towards ENs, the government's current proposals are to delay the phasing out of EN training for five years.

A Helper Grade

Helpers would assist qualified nurses and provide much the care presently provided by nursing auxiliaries. In fact many nursing auxiliaries could convert to the helper grade immediately.

The establishment of a helper grade is intended to fulfil a key function given the difficulties in recruiting nursing staff and the reduction in student service contribution. But important pieces of the training strategy for unqualified nursing staff are missing at present. These include the ratio of qualified to unqualified staff and the question of who will control helper training and manage their work. These issues, and their implications for nursing as a whole are discussed further in the next section of this report.

Conclusion

The introduction of a clinical career structure and the Project 2000 reforms to nurse education are elements of a reformist strategy for nursing which its advocates – notably the RCN and the UKCC – claim will improve nurse recruitment and retention at the same time as it equips nurses to meet the demands of health care in the next century. As this section makes clear, the changes are substantial ones, and will have a considerable effect on British health care over the next twenty years or more. However, their impact is certain to be tempered by the way nurses are managed over the same period – the subject of the report's next section.

5 The management of nursing

Nursing is one of the most costly inputs to health services, and nursing makes one of the most important contributions to the overall quality of patient care. Accordingly, managing nursing work is a key part of health services management.

It is also a very neglected subject. Nursing management, and the quality of nursing advice available to general managers within the NHS, are commonly agreed to leave a great deal to be desired in terms both of content and effectiveness (Strong and Robinson, 1988). Some of the reasons for this are historical, and flow from nursing's traditional bureaucratic approach to organisation; others relate to more general problems of managing health professionals (see Box 5.1). Still others are due to the poverty of past and present management development opportunities for senior nurses, and a failure to recognise the managerial importance of the ward sister/charge nurse post.

In short, the management of nursing work remains something of a 'black hole' within wider health services management. The subject and the issues involved in it are poorly understood, both by managers outside nursing and – often – by those within it. It is as yet unclear whether moves to manage clinical work more effectively will contribute helpfully to a new approach: interim reports on the government's resource management initiative, for example, concentrate on medical aspects of resource management to the neglect of nursing ones (Buxton *et al*, 1989).

This chapter attempts to disentangle some of the key questions which efforts to manage nursing more effectively must address. In doing so, it starts from the premise that nursing management must adapt to new circumstances. Traditionally, nurse managers have "minded" both nursing budgets and nursing establishments, rather than actively managing them. Staffing levels, ward or unit skill-mix and the money to fund both have been determined largely by historical precedent (Robinson *et al*, 1989). As a result, both the way that nursing work is organised and the division of labour within it has tended to continue unquestioned, with nursing sisters concentrating simply on ways of coping, and getting the work done (Ogier, 1982). In addition, until very recently, questions of skill-mix and ward or team management have been construed as matters for professional judgement, lying well outside the scope of general managers.

This is now set to change. The potential for recasting the traditional ward division of labour coupled with an increasing need to demonstrate effective use of resources within the health service must mean an erosion of this well-established *laissez-faire* style. As pressures for cost containment continue, and budgets are devolved to local level following the implementation of the NHS and Community Care Act 1990, it is likely that both skill-mix and support worker deployment will be perceived as an issue for general managers, rather than a matter for nurses alone (Buchan, 1990). In addition, these changes imply a much stronger focus on the question "what should be done?", in addition to nursing's traditional concerns with "who?" and "how many?" (*cf* Davies, 1977).

The management of nursing has two, interdependent aspects. One centres on the management of nursing work, and concerns issues like skill-mix and the role of the support worker. The other involves managing nurses, and centres on creating the conditions in which effective care can be delivered to patients. Central to both is the role of the ward sister/charge nurse, or community team leader, upon whom much of the responsibility for the management of nursing work and managing nurses rests.

The management of nursing work

Content and quality

Bureaucratic management styles, the absence of a clinical career structure, deficiencies in nurse education, and under-investment in nursing research have combined to encourage a ritual-centred, routine based approach to nursing care that has discouraged clinical innovation and individual initiative. As a result, surprisingly little is known about how nursing contributes to healing and recovery. In the same way, relatively little is known about the effectiveness of different kinds of nursing interventions, although a new emphasis on research and evaluation in nursing is beginning to change this.

If the content and quality of nursing is to improve, one of the key tasks for the management of nursing must be to create an environment in which the effectiveness, efficiency and acceptability of care can be evaluated, and high quality practice built on the results of successful experimentation and innovation. During the 1980s, a few innovative health authorities in the UK began to sponsor

5.1

NURSING MANAGEMENT: A CONDENSED HISTORY

NURSING REFORMS OF THE 1960s

The Salmon and Mayston reforms introduced a hierarchical nursing structure within hospitals and hospital groups. The function of nurse managers was seen as:

- **providing clinical support;**
- **managing nurse staffing;**
- **providing the nursing contribution to overall hospital management.**

Problems

- **Absence of a skilled cadre of nurse managers to undertake new posts and contribute to overall service management;**
- **Proposals implemented at speed with very limited management training for individual nurse managers;**
- **Limited administrative interpretation of management role by nurses;**
- **The structure meant that nursing career advancement involved a move into administration after ward sister level;**
- **Training used industrial and business models which nurses found of limited relevance to their work.**

1974 NHS 'GREYBOOK' REORGANISATION

A new administrative structure for the NHS was created, with District, Area and Regional tiers. Each level was managed by a consensus team, with nurse management input in teams at each level. Salmon-style nurse managers fitted into the new 3 tiered structure at Regional, Area and District levels, as well as within individual units.

Problems

- **Absence of a skilled cadre of nurse managers;**
- **Absence of essential information and other tools for effective nurse management;**
- **Hierarchical nursing tradition militated against effective innovation in nurse management.**

1982 ABOLITION OF THE AREA TIER OF NHS ADMINISTRATION

1984 IMPLEMENTATION OF THE 'GRIFFITHS' REFORMS TO THE MANAGEMENT OF THE HEALTH SERVICE

This involved the introduction of general management into the NHS to replace consensus teams.

Impact on nurse managers:

- **Nurse managers no longer ex-officio members of unit, District or Regional management teams/boards;**
- **Withering away of 'Salmon' hierarchies in many Districts with nurse management now organised in a more ad hoc manner to suit perceived needs of individual units/settings;**
- **Chief Nurse Advisor (CNA) post developed to give advice on clinical matters.**

Sources: Carpenter, 1977; Strong and Robinson, 1988; Robinson et al, 1989.

nursing development units (NDUs) in an attempt to develop centres of excellence in nursing (Salvage, 1989). Their work varies widely, and has included the introduction of nursing beds, work on skill-mix, and developments in clinical care. These, and other attempts to improve and evaluate nursing practice in clinical and academic settings may provide a base for developing more effective nursing approaches in the future.

Managing skill mix

One of the most important – and uncertain – questions about the future organisation of nursing concerns the role of support workers within ward teams and in the community. This uncertainty results directly from the UKCC's 'Project 2000' proposals for the reform of nurse education, which the government accepted with the proviso that work should be done on widening the entry gate into nursing and on the role and training of the new support worker. This was a reference to the UKCC's recommendation that there should be 'a new helper, directly supervised and monitored by a registered practitioner' (UKCC, 1986). This conditional adoption of the Project 2000 proposals is related to widespread fears within the NHS that the curtailment of student nurse participation in ward work will combine with the predicted fall in school leaver recruits to create very serious problems of staffing the health service unless new sources for nurse recruitment can be found (see section 4).

The skill-mix question is important because the proportion of support workers to trained staff effectively determines what qualified nurses can and cannot do (Dickson and Cole, 1987). It also influences overall nursing costs.

Currently, there are three main schools of thought on how support workers should be used in the future. Until very recently, the RCN and many academic nurses advocated an all-qualified work-force, with trained nurses giving all direct care, and support workers doing 'non-nursing work' like clerical and housekeeping duties. Project 2000 envisaged that 70 per cent of care will be provided by qualified practitioners, 28 per cent by unqualified helpers supervised and monitored by trained staff and 2 per cent by students (UKCC, 1986). Others, including the National Health Service Training Authority which is investigating the future role of support workers – appear to consider that the highly trained, Project 2000 nurse will need to be supported by a larger, rather than a smaller, proportion of helpers. Trained nurses would, as a result, become even more of an elite cadre than they are at present (Dickson and Cole, 1987). It is unclear where the required army of low-cost support workers would be recruited from, but it is possible that, as in the past, some at least might be migrant workers – possibly from southern or eastern Europe.

Experiments with the support worker role

Although the future role of support workers is important, the issue is clouded by confusion about the work they could – or should – actually do. In essence, there are three types of work which can be done by less skilled or untrained staff. In institutional settings these include basic nursing and personal care; housekeeping duties, such as maintaining stocks of ward equipment and linen; and clerical tasks including help with record-keeping, and receptionist duties. Different aspects of this work might be combined to create a coordinator post to manage the administrative and hotel side of the ward. In the community, there is scope for support workers to give some types of direct care and to undertake clerical tasks.

Experiments with various versions of the support worker role are taking place in innovative districts. These centre on attempts to develop 'ward housekeepers' or to develop the role of ward clerk to act as a kind of administrative assistant to sisters and charge nurses. The case study in Box 3.3 gives an indication of ways in which support worker roles are being developed.

Currently, however, attempts at innovation are being carried out in a piecemeal fashion, with little evaluation. There are few attempts to develop coherent personnel, industrial relations or training policies around the new roles. The limited evaluation work that has been done so far suggests that only modest efficiency savings can be made when support staff are 'traded' for nursing time under existing budgets, and that much more radical solutions will be needed to replace learner nurses' work on the wards (Robinson *et al*, 1989). Further, this and other research warns of potential industrial relations and staff retention problems if traditional roles are altered without careful attention to good personnel practices and the effects of the new status hierarchies and job content on support workers themselves (Salvage, 1990).

Cost containment vs quality of care?

In fact, the support worker debate is confused because – as Robinson *et al* (1989) have pointed out – it conceals three separate and at times conflicting agendas: labour cost reduction/containment; improvements in the quality of care; and attempts to improve trained nurses' job satisfaction in order to improve retention or make better use of the time and skills of trained staff. It is unlikely that all three objectives can be achieved by any one version of a new model support worker, and the debate is likely to continue, although impending central government decisions about support worker training will be important for shaping it.

Concentration on new types of support workers, whose sphere is in clerical or housekeeping work, in any case ignores the major contribution that existing support workers – the NHS' untrained nursing auxiliaries and assistants make to direct patient care. Already, nursing auxiliaries/assistants contribute the bulk of personal care and much other nursing-related work in long-stay geriatric, psychogeriatric, mental-illness and mental handicap settings (see Figure 1.2 and Box 5.2). Their contribution in these sectors is long-standing, although largely ignored in the debates about support for the trained nurse centred on Project 2000. Given demographic and cost containment considerations their work in these areas looks set to continue, and may well increase in other sectors of nursing as well.

It is also likely that – as today – the role of the support worker will be very different in different health care settings, and that these differences will actually increase. It is possible that as provider pluralism begins to influence the shape of British health care as a result of the National Health Service and Community Care Act 1990, nursing in the long-stay sector – and the training, pay, and conditions it attracts – will diverge very noticably from 'high technology' nursing in acute hospitals. If so, the approach and training offered for this type of caring work – and the way that it is managed – will be critical to ensuring service quality.

Problems with management information and control

Currently, nurse managers' ability to change skill-mix and alter the types of job that are done on particular wards depends on juggling historic nursing establishment figures – and their associated budgets – in order to fund innovative support worker posts (Robinson *et al*, 1989). Nurse managers do not have full budgetary control over staffing in NHS hospital and community settings: domestic and clerical staff are paid from central budgets.

Nurse managers also have very limited management information available to them. Routine workload measurement and cost information at ward or team level are unknown in most NHS settings. Patient dependency measurement tools, and associated nursing quality measures, have begun to be developed in the last decade, but their use can be cumbersome, time-consuming and expensive (Ball *et al*, 1989). Accordingly, there is a tendency to use them at wide intervals, so that the information they reveal is, in effect, an isolated snapshot which is difficult to interpret because of the lack of comparative data (Robinson *et al*, 1989). This lack of overall management information – and locating the power to make changes in staffing outside the control of nurse managers – hampers innovation and changes at ward or community team level, and makes reasoned responses to perceived changes in workload difficult to organise and justify.

5.2

SUPPORT WORKERS IN THE NHS

Support workers play a vital part in health care delivery in hospital and community settings within the NHS. They do not hold professional qualifications, and their work is various: support worker job titles include Nursing Auxiliaries, Nursing Assistants, Ward Orderlies, Ward Clerks, Bath Attendants and Aides. Within the NHS nationally, auxiliaries make up about a third of the nursing workforce, although there are wide variations between and within districts, for example:

- **in general hospitals between 4 per cent and 63 per cent of staff are auxiliaries;**
- **in community services, the proportion of auxiliaries can vary from none to more than a third of the workforce;**

Theoretically, auxiliaries and other forms of support worker work under the direct supervision of qualified staff. In practice, many undertake a very wide range of nursing work, often without any direct supervision. They tend to be barred from carrying out the more "technical" aspects of the nurse's job, such as taking blood pressures, giving injections or administering drugs although even here there are no hard and fast rules. In many NHS settings – most particularly geriatric and mental handicap hospitals - the majority of direct patient care is given by support staff.

As well as patient care, support staff can undertake clerical and other ward-based administrative duties. A 'sister's assistant' role is being developed in certain NHS general hospital settings to relieve the ward sister of routine clerical tasks, and jobs like answering the telephone.

Support staff generally receive little or no formal training for their work. For many, such training as there is amounts to working alongside another auxiliary for a few days on the job, although certain innovative NHS settings have introduced support worker training programmes. Many support workers work part-time, and some are therefore not entitled to the full range of employment benefits. Their conditions of service vary from health authority to health authority, and the clerical functions of support workers, in particular, are ill-defined.

Sources: Salvage, 1990; Robinson *et al*, 1989; Beardshaw and Morgan, 1990; DHSS, 1988 cited in Robinson *et al*, 1989.

However, concern about using nurses effectively has been growing and alternative or additional methods of determining nursing workload and estimating ward establishments from them are being developed (see, for example, DHSS, 1984). It may be that these techniques will develop into more usable tools which will permit the active management of nursing establishments and the skill mix within them. If this proves true, it may give managers from within and outside nursing the means to begin to scrutinise nursing work in a different way, and adjust the workforce and division of labour accordingly.

However this is done, it will be important for nursing skill mix and division of labour to be related to a wider examination of who does what in health care. As section 3 suggests, there is already an overlap between doctors' and nurses' work in some areas, and this may well increase as the effects of Project 2000 work through the system. Similarly, the new emphasis on fostering patients' autonomy and independence within nursing could mean that nurses' and therapists' relative roles need to be reconsidered in some settings. Finally, all discussions of skill mix, division of labour and labour substitution need to be framed within wider consideration of effectiveness and value-for-money: what combination of skills delivers the most effective and acceptable care to patients at the least cost?

Managing nurses

Much of the recent research into labour mobility in nursing suggests that the key to resolving nursing's recruitment and retention problems lies in providing nurses with satisfying and rewarding work that takes adequate account of their family and domestic responsibilities (Price Waterhouse, 1988; Waite, *et al*, 1989; Hart, 1989; Mackay, 1989). Although such an approach would appear obvious, it will be difficult to achieve if cost containment considerations dominate local health authority agendas. If, however, nursing skill shortages are a significant problem during the 1990s, moves to improve nurses' job satisfaction and conditions of service may achieve greater prominence.

Job satisafaction

Recent in-depth, qualitative research on nursing makes apparent the real satisfaction that many nurses take from their work. This derives from feelings that nursing is worthwhile in itself, and that it is in some sense valued within society (Mackay, 1989). Many nurses also derive considerable satisfaction from the cooperation and sense of teamwork that flows from being part of a close-knit work group (Hart, 1989).

However, this and other evidence suggests that increases in activity rates and other changes such as the contracting out of cleaning services may have resulted in an overall decline in job satisfaction for nurses over the last decade. The resource constraints of the 1980s, and the cost improvement programmes they have brought with them have also contributed to this. In addition, qualitative studies suggest that nurses frequently feel that their contribution is undervalued – or goes unrecognised – by their own or senior managers and medical colleagues. In addition, this work highlights the fact that nurses frequently feel

isolated and unsupported when coping with the stress of their work (Mackay, 1989; Hart, 1989). Hart's research in Trent also emphasises the importance of that allowing nurses greater control over the way that their work is organised and directed, in order to enhance job satisfaction.

Conditions of service

Over the next decade, one of the key issues for nurse management – and NHS manpower more generally – will be the extent to which nursing managers will be able to offer more flexible terms and conditions of work to meet the needs of qualified and unqualified staff who wish to work part-time – or take career breaks – to fulfil family commitments. The need to do both features largely in the Department of Health's *Strategy for Nursing* and policy documents from the Royal College of Nursing, but it appears that action at local level is fragmented and piecemental at best (Dean, 1987; DH, 1989d).

Management action to attract and retain women with family commitments will require skill and a well developed strategic sense. The key points for action to emerge from recent research are summarised in Box 5.3. Some are outside local management competence, but action on others is possible – though complex. To take one example, organising in-patient nursing rosters and clinic and other out-patient activity times to meet the needs of part-time nurses with school-age children could involve very considerable changes to traditional nursing shift patterns, and might also have an impact on medical and other staff groups within acute care.

Adroit, committed management will be needed to bring such changes about at unit or community team level, along with support from senior managers and good communication to ward-based staff. The skills needed to make changes of this kind are in short supply within nursing management as a whole (see Box 5.1), and there is currently little evidence that concerted efforts are being made to ensure more flexible work patterns within nursing in the NHS, although there is some experimentation taking place. Indeed, it is clear that many part-time nurses have markedly inferior career development and promotion possibilities when compared with their full-time equivalents, and that opportunities for flexible working remain to be developed.

The introduction of improved training and career development for both qualified and unqualified staff will involve obtaining commitments from higher level management to release the necessary resources. Skilled advocacy, linked to a well-developed training and recruitment and retention strategies will be needed to achieve change in an overall climate of resource constraint.

5.3

MANAGING RECRUITMENT AND RETENTION OF MATURE WOMEN

The Institute of Manpower Studies' survey of nurses for the Royal College of Nursing identified an interlocking action agenda for managers who wish to recruit and retain mature qualified women nurses on their workforce:

- **improve staffing levels in relation to workloads (eg by increasing establishments or, more likely given present funding and recruitment problems, by ensuring that daily fluctuations in the match of staff to workloads do not produce overload on some days, or by decreasing overall workload levels);**
- **provide support and occupational health counselling services for staff to help them cope with workload-related stress;**
- **improve pay and conditions;**
- **initiate "stay-in-touch" retainer schemes during career breaks;**
- **provide part-time and flexible hours;**
- **provide career opportunities for part-timers;**
- **provide child care facilities.**

Source: Waite, *et al*, 1989

The role of the ward sister/charge nurse

Research over the last fifteen years has emphasised the pivotal position of the ward sister/charge nurse in nurse management within hospital settings. Ward sisters act as teachers, leaders and disciplinarians within the ward. They play a critical part in organising and directing nursing work and in creating a harmonious and mutually supportive ward team. As such, they can exert a considerable influence on nursing turnover at the micro-level, and on the success or failure of innovation in patterns of care.

Given this, it is understandable that the 'new nursing' has identified the need for the role to be reinterpreted away from management by routine and control towards a more enabling, facilitative approach (see Box 3.1). That said, the potential for the post remains under-developed, with little in the way of systematic support or training and career development for ward sisters, charge nurses – or their equivalents in the community – in many places.

Nursing and the reform of health and social care

6

Three white papers on the reform of health and social care in Britian were published during the late 1980s (DHSS, 1988; DH, 1989a; 1989b). Their changes are embodied in the 1990 General Practitioners' Contract and the National Health Service and Community Care Act 1990. The full ramifications of both of these measures will take a number of years to work through the health care system, although their implications have been widely debated.

These reforms are certain to affect nursing at a number of levels, although the precise form that this will take is still difficult to predict. In the broadest sense, it can be argued that they represent a major shift in the way that health care is conceptualised by policy-makers at the highest level.

Caring for People, the government's proposals for the reform of support for the frail elderly and people with long-term mental health problems, physical disabilities and learning difficulties, places lead responsibility for its management with local authorities, although the white paper is careful to stress the importance of the health service contribution to community care (DH, 1989b). The way that health authorities respond to this is as yet unclear, but it may signal their piecemeal retreat from a number of different kinds of long-term care over the next decade. If this happens, health service community units – and the district nurses and health visitors who work in them – will face major changes, along with care of the elderly services and health service work with people with long-term mental health problems, learning difficulties and physical disabilities. The possible implications of these shifts in community care policy for the three groups of nurses most directly affected is discussed below.

At the same time, nursing in acute settings will be directly affected by the changes in health services managment outlined in *Working for Patients*, the government's white paper on the reform of the NHS (DH, 1989a). Self-governing units' ability to determine their own levels of pay, and to offer non-standard terms and conditions of service, may result in a general bidding-up of nursing wage rates and benefits packages in areas with nursing shortages. This process – through which qualified nurses' time becomes noticeably more expensive – may in turn encourage the fragmentation of nursing work, with many 'nursing' tasks delegated to technicians, ward clerks and the like, operating outside direct nursing control. There are already signs that this has occurred in parts of the United States where nursing shortages have been most acute – notably, the North East (Boufard, 1990).

There are also early indications that management changes made as a result of *Caring for Patients* are continuing the post-Griffiths trend of flattening nurse management hierarchies by abolishing senior nurse manager and advisory posts as new management structures are created, or as post-holders retire.

It is unclear what all of this will mean for innovation in nursing and, more particularly, the further development of patient-centred nursing, nursing beds and other new approaches to care. On the one hand, self-governance and local management of acute hospitals might serve to promote experimentation and new ways of working by making unit-level innovation easier. On the other, the cost control imperatives generated by the need to offer services at competitive prices within the health services' internal market may serve to damp down such initiatives, along with an absence of nurse leadership at senior levels. Whatever happens, it is clear that nurses will need to pay close attention to evaluating the cost and quality implications of any innovations: the only successful strategies are likely to be ones that can demonstrate quality of care improvements for the same, or less, cost.

The health reforms and community nursing

Community nursing looks particularly vulnerable in the face of the shift in social policy that the white papers seem to represent. This part of the report examines the nature of community nursing, its place in health care, and the reasons why its post white-paper future is uncertain.

Community nursing work

Nursing in the community takes a number of forms. It includes district nurses, who provide treatments, support and advice in people's homes and in community-based clinics; health visitors, who do health promotion work in people's own homes and in community-based clincs; practice nurses, who are attached to GP practices; and a variety of specialist nurses including some who are linked with particular forms of care or treatment – for example, stoma, diabetic and terminal care

nurses – or with separate client groups, such as schoolchildren, or people with mental health problems or learning difficulties.

Community nurses provide basic nursing, personal care, health promotion and teaching to people living at home, as well as specialist health care and support. They also help staff child health, family planning and other community-based clinics, and provide a variety of basic treatments and services – as well as advice and health promotion – from GP practices.

The policy context

Theoretically, at least, the potential for community nursing to expand and develop in the next decade is enormous. As lengths of stay in acute care settings diminish, and technology for home-based care continues to develop, the scope for expanding nursing at home is considerable (Taylor, 1989). At the same time, the need for home-based support for frail elderly people and other people with long-term conditions is certain to grow as the population ages.

Community nursing has always stood in the shadow of hospital nursing. Although many nurses have enjoyed the relative autonomy of working outside the regimentation of hospital settings, the location of community nursing services – first as part of local authority health services and then, after the 1974 reorganisation of the NHS, as poor relations to hospital-based services – has never been conducive to a high policy profile or consistent service development (Dingwall *et al*, 1988; Hughes, 1989). District nursing, in particular, has always existed outside the main thrust of nursing policy. Its marginal status has owed much to its voluntary, charitable origins and – after 1948 – its management by Local Authority Medical Officers of Health, and their failure to develop the service (McIntosh, 1985).

Rigidity and stagnation

Well before the major shifts in health services policy announced at the end of the 1980s, there was recognition of the need to address problems within community nursing. In 1985, two separate committees were established by the Secretary of State for Health and Social Security in England and the Secretary of State for Wales to review community nursing work and make recommendations.

The first to report, under the chairmanship of Julia Cumberledge, acknowledged frankly that the contribution of nursing to primary health care was failing to live up to its potential and that nursing services in the community were 'in a rut' (DHSS, 1986). Both this and the later report on community nursing in Wales, chaired by Noreen Edwards (Welsh Office, 1987), documented problems created by strict demarcations between community nurses themselves and other professional groups; difficulties of effective teamworking; poor liaison between hospital and community health services and poor coordination between community health and family practitioner services and social services.

In many instances, these deficiencies were linked to a managerial vacuum that meant that clear service aims and strategic planning were absent. The Cumberledge report underlined the problems engendered by 'the separate, traditional ways of working in which health visitors and district nurses appear to be trapped', which made teamwork and flexibility of approach 'difficult, if not sometimes impossible' (1986, p. 12). Some of these problems were clearly related to the structural difficulties and other perverse incentives affecting community care as a whole (Audit Commission, 1986). Others appear to relate to a blinkered, task-centred approach to nursing work adopted by some community nurses, as well as a failure to develop and manage their skills in a way which related to the needs of local populations and changing patterns of care. Evidence of this last point is clear from the hospital outreach teams or specialist nursing posts that have been established in a piecemeal fashion in some areas to care for diabetics, renal patients and other people with special health needs at home. It also features in many of the critiques of community care published towards the end of the 1980s, which point to rigid definitions of 'nursing work' and a failure to offer care that responds flexibly to the needs of people with continuing disabilities as a feature of the community health services (Challis and Davis, 1986).

Changing practice

The 'patch based' neighborhood nursing recommended by Cumberledge, and the primary health care teams advocated by Edwards have many similarities. Both are based on a new vision of the community nurse as a worker who can contribute to assessments of local health needs and provide individually tailored health care and social support to people and families in their own homes and other community settings. This approach is developed further in a recent paper from the District Nursing Association which – with clear reference to the current reformist nursing agenda – locates district nurses' special expertise in assessment, reassessment, quality monitoring, and team leadership based round patients' health and social care needs (Mackenzie, 1989). It suggests that district nurses should develop their role by extending their expertise in specialist areas; developing management expertise in areas like liaison with other agencies and acting as case managers for particular client groups (p. 22). These recommendations take their cue from the Project 2000 report, which states that:

... it is crucial that the task of allocating work in community settings falls to a specialist practitioner and that s/he carries direct responsibility for care, acts as a team leader and gives support to the registered practitioner (UKCC, 1986, p. 52).

Changing policy contexts

However, it is unclear whether the policy climate and the changing structures of health services will permit developments of this kind. In particular, the demarcations between health and social care provision suggested by Working for Patients and Caring for People, with local authorities assuming the lead role in community care, set the future of community nursing services in doubt (DH, 1989a; 1989b).

A 'worst case scenario' for community nursing suggests that community health services as a whole could wither and die as local authorities take responsibility for community care and acute units assume self-governing status. At the same time, self-governing hospitals might develop innovative outreach and 'hospital at home' schemes in specific areas and for certain types of conditions, but the risk is that these could be patchy, and ignore many chronic conditions and long-term needs. An added problem would be ensuring adequate coverage across the dispersed patient populations which self-governing trusts are likely to attract (Marks, 1990).

In this context, community nurses might well come to be seen as an expensive adjunct, which neither health or local authorities will be willing to finance. In the community care field, then, it is possible that District Nurses and Health Visitors might lose their place to a combination of social workers, home care assistants, specialist 'outreach' nurses and the new case managers. At the same time, 'hospital at home' and other specialist home nursing services managed from acute units could continue to erode community nursing's acute clinical base.

Alternatively, community nurses may find a centre for developing new approaches and capacities in the primary health care teams that will develop in general practice as a result of the new GP contract and the expanded remit of Family Health Services Authorities (FHSAs) (DH, 1989). Certainly, the potential for developing and enhancing community nurses' contribution to primary health care in this area is very real. Enterprising GP budget-holders and/or FHSAs may wish to employ nurses to conduct health screening, give treatments, run clinics, and make visits in order to provide improved primary health care services and/or to make the most cost-effective use of medical time. In addition, GPs who choose to work within practice budgets will have incentives to avoid unnecessary hospital admissions, and minimise in-patient stays. This could mean the development of community nursing and hospital-at-home teams from a GP practice base, although GPs' enthusiasm for such ventures remains to be tested (Marks, 1990). Whether these factors will create a fertile environment for the development of community nursing is as yet unclear. Currently, many community nurses consider GP practices to be poor employers of nurses, since they provide little scope for career development, clinical support, training, or innovative forms of working. If community nursing is to flourish as part of a new style of teamworking in primary care, it will be important for FHSAs, in particular, to develop coherent programmes for the development of comprehensive nursing services.

The future of mental nursing

The development of mental illness and handicap nursing have been intimately connected with the existence of the large asylums established in the nineteenth and early twentieth century. Dingwall *et al* (1986) comment:

As an occupation, mental nursing was a somewhat arbitrary creation of the Victorian lunacy legislation which swept up a miscellaneous collection of sick and deviant people and planted them in asylums rather than in prisons or workhouses. The medicalization of the asylums, and their ultimate reconceptualisation as hospitals, reconstituted custodial attendants as nurses for the mentally sick and the defective... General nursing and the nursing of the mentally disordered could be linked only to the extent that mental illness was defined as essentially organic and that pyschiatrists accepted the model of general medicine (p 143).

They go on to suggest that persistent underinvestment in mental health services and the questioning of institutional and medical models of care since the early 1960s has forced a 'crisis of occupational identity' on both mental illness and mental handicap nursing. Demoralisation and the persistence of custodial approaches in institutional settings has been a feature of mental nursing. At the same time, community-based alternatives have had only a limited development within either speciality. Mental handicap nursing, in particular, has been threatened by the emergence of 'social' and 'educational' models of care for people with learning difficulties, as well as policy recommendations advocating a new kind of carer.

Impact of *Caring for People*

Challenges to medical approaches to mental illness and handicap and the move to community-based services have meant that both branches of mental nursing have lost ground to social work,

psychology, psychotherapy and – increasingly – local authority-controlled social care assistants. The implementation of *Caring for People*, which gives lead responsibility for the management of community support for people with learning difficulties and mental health problems to local authorities, seems very likely to undermine both specialities further. It is unclear what advantages social services departments will find in the large-scale deployment of mental health professionals in the local-authority based support systems that emerge post-white paper. This is perhaps most particularly true of the mental handicap sector. This situation would seem to be designed to increase the demoralisation that has become a persistent feature of the remaining mental institutions (Beardshaw, 1981).

At the same time, it is also clear that the NHS will continue to make an important contribution to mental health services following the implementation of *Caring for People*, particularly in acute psychiatry. In the light of this, it may be that – as Dingwall *et al* (1988) suggest – the only viable strategy for psychiatric nurses will be to link their speciality more firmly to the development of general nursing, and to become a speciality branch within it.

Speculations on the future direction of nursing

7

This report was prompted by the widespread recognition that shifts in the demographic composition of British society posed a special challenge for the future of nursing in the 1990s.

Current and future recruitment and retention problems are happening during a time of great organisational change for health care. Over the same period, women's employment opportunities have widened – something that should mean that many women will come to expect more in terms of job satisfaction, career development, and material rewards for the work they do. These wider social changes are taking place at the same time as the educational reforms of Project 2000, which aim to change the capacities and orientation of the qualified nurse. All of these different factors coming together are certain to effect some kind of transformation on nursing.

It is also clear that the increasing technological sophistication of acute health care, and countervailing pressures to devise more humane and individually-centred approaches to health problems of all types, will demand a series of new responses and skills from health care workers. One of the most taxing issues for nursing is whether a new training and the renewed emphasis on clinical nursing will help meet these challenges.

The effective deployment of nurses will depend on the extent to which ward sisters, other nurse managers and health service management as a whole can develop greatly increased managerial and analytical skills. Reforms in training and the development of a clinical career structure must be linked to changes and improvements in management if recruitment and retention problems are to be addressed. Crucially, these developments must be directed at both the content and the organisation of nursing work.

A new approach to management

The development of a new approach to the management of nurses and of nursing work is the responsibility both of nurses themselves and of NHS management as a whole: nursing is too important – and costly – a component of health care to be seen solely as a professional matter. If this new approach is to be productive it will need to be grounded in a recognition of the importance of nursing's contribution to health care.

A new management approach will, in turn, be a critical determinant of the extent to which nursing's Victorian legacy of uncritical obedience, hierarchy and the undervaluing of nursing work can be finally laid to rest. If this proves possible, it will do much to make nursing into a rewarding occupation for women and men in the next century.

This report has identified a number of future challenges for nurses, and those who manage them. This final section discusses ways in which they might be approached.

Working for clinical effectiveness

Too little is known about the effect of nursing practice on health outcomes. Nursing is not, of course, alone in this: the same is true of all other clinical areas. However, if nursing practice is to evolve in a way that improves the effectiveness and acceptability of the care available to patients, nurse management – and health service management more generally – must be organised to support and learn from experimentation and innovation in nursing. This includes clinical practice itself; the organisation of nursing work; and experiments with nursing-led approaches to health care, such as nursing beds.

Reassessing skill-mix: the need for a wider view

A reassessment of skill-mix and traditional divisions of labour within health care is clearly a precondition for the cost effective use of nurses in the future. This is true both of work within the hospital and in the community: it is clear that considerable potential for substitution exists across traditional health service job demarcations (see Box 7.1).

Assessment of skill-mix and potential labour substitutions must be comprehensive, however: the traditional division of labour between trained and untrained nurses; trained nurses and clerical staff; nurses and therapists; and qualified nurses and medical staff all need to be examined closely for possible substitutions that are cost effective while maintaining or enhancing acceptability to patients and quality of care. Currently, skill-mix issues appear to be being considered rather narrowly within the health service. The tendency is to concentrate on the potential of support workers to relieve trained nurses of clerical and administrative duties. It may be that enhancing the ward clerk role will be useful, but this alone is unlikely to have an appreciable impact on recruitment and retention

7.1

SKILL SUBSTITUTION IN HEALTH

A comprehensive reappraisal of skill-mix in health must include an examination of all the following demarcations between different kinds of health worker:

MEDICAL/NURSING

Hospital settings

- **Procedures and tests;**
- **Information giving;**
- **Health promotion;**
- **Case management;**
- **Clinical management.**

Primary health care and community settings

- **Procedures and tests;**
- **Screening;**
- **Health checks;**
- **Health education and promotion;**
- **Information giving;**
- **Case management.**

NURSE/THERAPIST

- **Mobilisation;**
- **Independence training.**

NURSING/CLERICAL STAFF

- **Secretarial duties;**
- **Receptionist duties;**
- **Administrative and data collection/recording duties.**

NURSING/ "HOUSEKEEPING" STAFF

- **Ward stocking and supplies work;**
- **Linen;**
- **Catering administration.**

NURSING/TECHNICAL STAFF

- **Procedures.**

QUALIFIED/UNQUALIFIED NURSING STAFF

- **Basic nursing care.**

difficulties. It will also be important for new roles of this kind to be developed systematically, with attention to good employment and personnel policies (Robinson *et al*, 1989).

Improving the calibre of untrained staff

Many influential nurses would like to see change centre on the practice-based Project 2000 nurse – the 'knowledgable doer' who sets out to deliver high quality care to meet her patients' individual needs. But much of the new nursing agenda turns its back on the reality of who it is that delivers nursing care outside the family. That care is given by a combination of qualified and unqualified nursing staff.

Given the threatened skill shortages of the 1990s and continuing pressure for health cost containment, this seems all but certain to continue, the likelihood being that the NHS will become more, rather than less, reliant on untrained staff. Indeed, it is possible that if movement of labour within the European Community increases following the creation of a single market, untrained workers from southern (and perhaps eastern) Europe will fill health service vacancies in the same way as immigrants from the Commonwealth and Ireland did in the 1950s and 1960s. One of the major challenges for the health service as a whole will be to use these workers in a different way. In the past they have been treated simply as 'pairs of hands' – and given minimal training and poor pay and conditions. Little value is attached to their experience and skills.

One of the principle contentions of the Project 2000 strategy is that health care cannot continue to rely on an inadequate skill base. If so, this implies a reassessment of the considerable contribution of support workers to British health care, with associated moves to train them appropriately. These efforts should take place in tandem with efforts to equip qualified nurses to become autonomous practitioners.

Making nursing work more rewarding and attractive

In the 1990s and beyond, health authorities' capacity to staff hospitals and community units may well hinge on their ability to offer nurses attractive terms and conditions of service, including more rewarding and flexible part-time work and enhanced career development and training. Doing this on a scale sufficient to have an impact on overall nursing recruitment and retention may involve a very significant investment in the development of innovative shift and other work patterns, as well as changes designed to increase nurses' job satisfaction. At its most radical, this could include the reorganisation of in-patients' days, clinic hours, the timing of day case surgery and other procedures, as well as the

introduction of approaches to nursing work that enhance job satisfaction by giving individual nurses greater control over their own practice.

Improved 'back-to-nursing' training, and genuine career development opportunities for part-timers are needed as well. Changing entrenched working practices and up-grading terms and conditions of service will not be easy. It will be important for managers to work together with their staff and user representatives to ensure that these changes benefit both patients and staff.

Much of what needs to be done has already been identified (Dean, 1987). However, there are no clear signs at present of any concerted management action within the health service. Progress is decidedly patchy. Comprehensive implementation on a number of fronts at once is, however, essential if nursing shortages are to be averted in many parts of the country.

Nursing in the community: finding new skills and approaches

The potential of community nursing to meet many of the challenges confronting late twentieth century health care is considerable, but many community nurses remain shackled by out-dated role demarcations and rigid work patterns. The way in which community nursing develops will to some extent depend on the administrative structures which take responsibility for it, but the basic shape of what needs to happen is already clear.

The specialist skills available to community nurses need to be enhanced to allow them to offer high quality care, support and advice to people with health needs living at home and their carers. This may increasingly involve high intensity hospital-at-home work and care of the dying. In these and other aspects of their work, community nurses could be helped if current recommendations to permit nurses to prescribe drugs under carefully controlled conditions are accepted and implemented (Department of Health, 1989b).

At the same time, community nurses will need to consider the special skills that they have for supporting people with disabilities of all ages to live at home. These might include health checks and surveillance; assessments; more flexible forms of treatment, care and support; and care management. Community nurses will also need to consider what they have to offer to multidisciplinary psychogeriatric, mental handicap and psychiatric teams working in the the community.

The shape of the challenge

To some extent, the existence of the National Health Service has shielded health workers of all kinds from scrutiny of their working practices for forty years. In many areas, traditional divisions of labour and other demarcations have persisted unquestioned for long periods. Administrative reforms like the 1974 NHS reorganisation and the drawing and redrawing of health authority boundaries have had little or no impact upon them.

This will no longer be so in the 1990s. The content and effectiveness of health workers' contributions are coming under increasing scrutiny. Pressures to contain costs and the managerial culture that is developing following the introduction of the Griffiths reforms of the mid-1980s are both contributing to this, as is a more general questioning of professional expertise and status. Nursing has determined its own agenda to meet coming challenges, but it is as yet unclear how robust the Project 2000 strategy and the introduction of the new nursing will prove to be in the face of pervasive changes in the health and social policy climate overall. The fate of the reformist agenda will be influenced by factors outside nurses' control: levels of government spending on health, for example, will have an important effect on the amount of innovation and experimentation that can be sustained within the health service.

Future governments of all political persuasions will continue to exert strong control over public expenditure levels. This will be an unavoidable constraint within which nursing policy will have to develop. It will therefore be important for nursing leaders to convince health policy makers at all levels that the major changes presently being introduced into nursing offer the scope for significant increases in social welfare. In any competitive bid for society's resources, they must be able to demonstrate that nursing reforms constitute a high priority within a full social cost-benefit framework. This, rather than narrow considerations of cost containment, should be the guiding principle.

In a number of important ways, nurses may now have a novel and important opportunity to determine their own destinies. Nursing shortages together with new approaches to nursing work should contribute to a substantial re-evaluation of nurses' actual and potential contribution to health care in the 1990s. If this is to be positive for nursing, the occupation must transcend the limitations of its heritage and truly come of age. If it is to do so, it will be important for managers and other policy makers outside nursing itself to understand and support nurses' efforts to improve their contribution to British health services.

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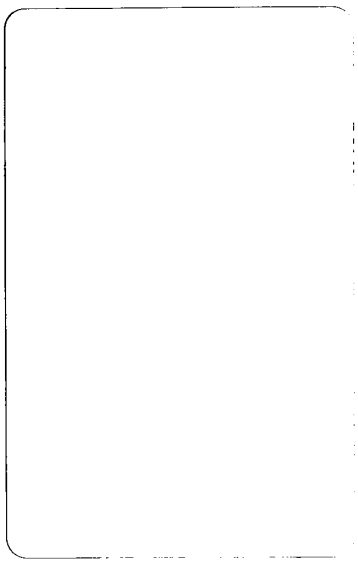

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