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KING EDWARD'S HOSPITAL FUND FOR LONDON

KING'S FUND CENTRE

THE PERSONNEL NURSE - A DEVELOPING ROLE

QUO VADIS?

A Report of a Conference held at the King's Fund Centre
on Tuesday 3 July 1979.

Report by Pat Young

HOGI:FG (You)

THE PERSONNEL NURSE - A DEVELOPING ROLE

QUO VADIS?

While there are a number of Personnel Nurses in post throughout the National Health Service, and their presence is welcome, apparently no one has a clear idea of exactly what their function is. The purpose of this conference, as stated by the Chairman of the morning session, Nicholas Bosanquet, was to clarify the role of the Personnel Nurse, and to measure the success of their contribution to the Service. "The NHS has not got a good record as an employer," he said; "you Personnel Nurses stand or fall on your record for improving this situation.....Have nurses got a better deal out of the NHS than they have in the past? That is the real question before us today."

The first speaker, Miss Joyce Whitehead, Deputy Chief Nursing Officer, DHSS, gave an overview of the evolving role of the Personnel Nurse. She saw the conference as having two aspects, which were hard to separate; personnel management and its rapidly developing role in the NHS; and the developing role of the nursing profession and its need for personnel services.

The nursing profession had always been very involved in what is known today as personnel services and management, she said. In the old days, Matrons did not analyse their roles or jobs, but undertook a great deal of personnel work for their nursing staff. With the implementation of the Salmon Committee's recommendations in 1966, the newly created Chief Nursing Officer was given more responsibility for personnel information and services, and had to employ a Senior Nursing Officer or Nursing Officer as a staff officer with embryonic personnel responsibilities who worked closely with Principal Nursing Officers and Senior Nursing Officers in line management or specialist posts.

The NHS was also changing at this time, as hospitals were being grouped together both for economic reasons and to provide a more effective service. The problem of staffing became more complex, and to meet the need some hospital groups developed rudimentary Personnel Departments. The Hospital Group Secretary and his administrators had overall control, and the nursing profession continued to provide many personnel functions for nursing staff. At this time, hospital staff were not "unionised", and attempts at holding joint consultative committees met with more failure than success.

The NHS was jogging along, Miss Whitehead said, in a state of "benign hibernation", as if waiting for something. That something happened in 1974 when the Service was reorganised - the biggest single change in the largest organisation in the UK. Not only were the hospital and community services intergrated, but also a mass of staff with widely varying contracts, conditions of services, salaries, and superannuation arrangements. Staff previously employed by the local authority now came into the Health Service, including school nursing, and very few hospital groups remained unchanged. People holding senior posts in the old NHS even had to apply for newly created posts in this newly created structure. The Area Health Authorities were a totally new concept; everyone on the AHA staff were new to their jobs, and yet the AHA was the employing authority for the vast majority of staff working in the Area.

It was a near miracle that this reorganised structure worked at all, Miss Whitehead continued, and although the staff involved had worked extremely hard, it was not surprising that many unfortunate incidents took place. Ignorance and a lack of training accounted for many failures, and though there was no lack of goodwill, people's attitudes began to change. It was obvious that there was a need for a first-class personnel management.

The NHS was a long way behind industry and commerce in this respect, and had never developed a united, co-ordinated personnel department. Very few qualified Personnel Officers existed in the NHS. Because of its size and complexity, the nursing service had developed some personnel services and systems, and it was occasionally possible to find a hospital group with a Personnel Officer and a Senior Nursing Officer (Personnel) who worked together with a pioneering zeal and achieved great results.

It was considered that under the reorganised nursing structure, personnel services would be essential. It was obvious that when the reorganisation of the NHS came into effect, the numbers of nurses employed would increase, and the training needs and complexity of work would become more involved. Manpower information and planning would be essential, as would publicity, recruitment, transfers, protection, contracts, and all other matters affecting nursing and the costing of the services. The Regional and Area Nursing Officers would need these services.

Good personnel management would also be essential. In 1973 the DHSS informed health authorities that all groups of staff should have the benefit of the advice and support provided by specialist personnel staff, who should work together in a central department. This was achieved in some places, sometimes with the inclusion of a specialist nurse, but the views of nurse managers varied and so, in consequence did the structure of personnel departments and the work of the personnel nurse member.

This was only six or seven years ago, Miss Whitehead pointed out; it was only five years since Areas came into being, and became the employing authority for most NHS staff. Six or seven years ago the number of qualified personnel officers could be counted on the fingers, and the number of nurses with personnel qualifications or experience was equally limited.

This new NHS baby is still an infant, but one which is developing its own personality, she said, very much influenced by its environment, its position in society, its surroundings and the people with whom it comes into contact. A fascinating situation had developed during the past five years based on both positive and negative requirements. First, before the reorganised service had had time to take its first deep breath, financial constraints were placed on management costs which inhibited the setting up of personnel departments, and the employment of expert personnel officers. The work had to be mainly carried out by untrained personnel staff. Some Regions and Areas had no Personnel Officer for the first three or four years of their existence. Others had a fully fledged set-up, but no finance to maintain and develop essential services. In some places there was a personnel nurse but no personnel officer; in others the reverse was the case. The majority of Districts had no personnel service at all.

Very quickly other problems arose. New legislation affecting employees snowballed; protection of employment, race relations, equal opportunities were but a few major items. Joint consultation, the development of participative management, staff interest in legislation, and union activities in industrial relations made heavy demands on personnel staff. Lord McCarthy's report on the Whitley Council machinery stressed that the NHS personnel function should be developed and its area of influence enlarged. It recommended that Whitley negotiations should be conducted at Regional and local level. Industrial disputes, often supported by industrial action, increased, although on a small scale for such a large organisation. NHS personnel staff had all been learning much from experience.

Full development of the personnel services had now become urgent, Miss Whitehead asserted. Both political parties had stated that the personnel function should be properly valued and utilised at all levels of the service. Everyone in the audience would agree with this, but would they agree on how the service should be developed, what the role of the personnel department should be, who should work in that department, what its relationship should be to the team of officers, and where it should be situated?

The work of personnel departments varied according to local organisation and resources, and the role of the personnel nurse varied in a similar way, Miss Whitehead continued. 43% of the total 800,000 NHS work force are nurses, which justifies the involvement of nurses in personnel work but what form should this take? Should the personnel nurse be outposted to the personnel department? Should she be a full member of the personnel team? Should she be a specialist in a general department, or a full member of the personnel team who happens to have a nursing background? Should man-power planning be part of her function? Indeed, are personnel functions set out clearly enough, and can they be clearly defined? Miss Whitehead hoped these questions would be answered during the day.

The three main issues, as she saw them, were as follows:

1. What is the role of the personnel department, and what are the functions which should be carried out by the departmental staff?

2. What information does the personnel officer need from the nursing staff, and is it better to have a direct nursing input to the personnel team?

3. What services do the nursing staff require from the personnel department? Do they get the services? And are the services more likely to be satisfactory if there is a direct nursing input to the personnel department?

These three questions must be answered before future needs are decided, Miss Whitehead said, but the needs of the near future are already apparent. Industrial relations would remain one of the dominant features of personnel work. The Whitley system would change; local disputes procedures would become more sophisticated; local policies on recruitment, advertising, agency staff, nurse banks, and retirement would continue. Further problems and changes would result from the report of the Royal Commission on the NHS. Finance would remain the controlling factor, and cost-effective use of staff would be essential.

The effects of the Health and Safety at Work Act had yet to be felt. Occupational health services should develop, and their relationship with both the personnel and nursing services would have to be clarified. The help of personnel staff would increasingly be needed by line managers, and nursing staff would expect more from the personnel department. Nurses, being such a large part of the NHS, could influence the way in which the personnel service develops.

Miss Whitehead concluded by saying that it was not for her to say what the future should be for nursing or personnel management. That was for the service personnel to decide, and to state clearly how it sees the personnel service in relation to the nursing profession and other staff. It was also for the nursing profession to state what personnel services it required, and the form they should take. Perhaps some of the problems would be identified at this conference, so that a step could be taken towards a more effective service.

The second speaker, Mr J. Robin Gourlay, Regional Personnel Officer for Wessex RHA, had some provocative things to say about the performance of nurses in personnel posts. "They attend lots of meetings, but they might as well be wallpaper for the amount they contribute", he said. In his view it was highly improbable that the most senior posts of Regional, Area, or even District Personnel Officer would ever go to a nurse, partly because of the constraints they placed upon themselves, and partly because personnel was very much an administrative function and part of the administrative hierarchy.

Mr Gourlay's brief was to look at the future of personnel management in the NHS, and the position of the nurse within it. He began by reminding the audience of the problems the NHS was continually facing: industrial relations disputes, low staff morale, shortage of resources, changes in the use of hospitals, improvement in long-stay patient care, and organisational structures, were all contributing to the confusion, uncertainty, and poor performance of NHS staff. Managers and personnel officers were reacting very much to the pressures of today, often without any guidance for their decisions. There was a crucial need to define clearly the personnel task within the NHS. Whatever decisions were made about the range of issues confronting the NHS management, there would be implications for the staff, and this was where the personnel officer had a crucial role to play in helping management teams provide a direction for that part of the organisation for which they were responsible.

Talking about the concept of performance, Mr Gourlay said that this meant getting value for money, so that the staff employed gave the best patient care possible with the technology available. About 75% of NHS expenditure was on staff, and if staff performance were improved only slightly, the actual value would be enormous. In order to set about this process, management had to be clear about objectives: the setting of objectives begins the process of providing a direction. But the problem with objectives is identifying them, and achieving a commitment to them.

It was essential that objectives should be set within the structure of a corporate plan, Mr Gourlay continued; a plan which indicates the sort of pattern of patient care and community care the NHS wants in, say, ten years' time. It was quite feasible to create such a plan, and personnel have two critical parts to play in it. The first is to provide the manpower input into the corporate plan: in other words, to indicate the approximate numbers of staff required to provide the sort of service envisaged by the

planners. The second is to anticipate the problems of staff employment for the future, and within the corporate plan draw up a personnel plan setting out the policies and procedures that will inform decisions on the problems of the future. These would include the changing nature of technology and its impact on employment, the changing industrial relations situation, and the relationships that will have to exist between management and trade unions in the future, the need to utilise staff more effectively because of their scarcity, the need for proper organisational structure within which staff can do their jobs. The personnel function was therefore concerned with two aspects of the problem: the quantative aspect to do with manpower numbers; and the qualitative aspect to do with employment practices.

The second problem facing NHS management was the difficulty of achieving commitment to the plan once they had it. This was where the skills of the personnel officer would come to the fore, as he would know about the technologies of organisational change and be able to facilitate such change. Mr Gourlay said he would not dwell on this particular process as it would require considerable explanation; he preferred to concentrate on where the personnel officer should be exercising these possibilities and functions.

He expressed his view as being that the role of the personnel officer in ensuring that a corporate plan is drawn up was so significant that he should be a member of the team trying to provide this sort of direction. He knew this view was frowned upon in many circles, but the achievement of objectives, and therefore the achievement of a plan for the National Health Service, would have such an impact upon staff that team decisions on these issues must be informed by the expertise of the personnel officer. He went even further to suggest that the personnel officer should have a direct executive role: responsibility for ensuring that the personnel policies that are drawn up within the corporate plan are actually implemented.

What was the nurse's contribution to all this, he then asked. It seemed to him that the personnel function required people with certain knowledge and skills, and it was not the unique prerogative of any one discipline to own these skills. Nurses could acquire these knowledges and skills as easily as anyone else. Furthermore, it was essential that the nurse adds her contribution to the personnel function as a personnel officer rather than as a nurse. The personnel services in the NHS were very underpowered; in the Wessex Region, for instance, there is a ratio of one personnel officer to 823 staff, whereas the ratio for a company such as Fords of Dagenham is one to 200. The magnitude of this difference must speak for itself, taking into account that the NHS is much more complex an organisation than Fords. So the more people with personnel management expertise, the healthier this will be for the National Health Service.

It was here that Mr Gourlay expressed his doubts about nurses ever being appointed to the top personnel posts - not because they are not well enough trained in personnel management but because of their natural diffidence poor performance as personnel officers, and the fact that the personnel officer is part of the administrative hierarchy. The future of the personnel nurse must therefore be within the personnel function as a whole, and management teams should remove any structural blockages to this happening. Personnel nurses must see that their performance matches that of their administrative colleagues - and they must speak up at meetings!

Mr Gourlay ended his stimulating and provocative talk by answering the Chairman's question, "What would success be for a personnel nurse?". The best personnel nurse would not be a personnel nurse, but a personnel officer, he said.

Putting the 'worm's eye view' of a personnel nurse, Miss Mary Gallagher, Area Nurse (Personnel) in the Bedfordshire AHA, described herself as a jack of all trades. In her Area there was one personnel nurse for 3,000 nurses. There was no Senior Nursing Officer (Personnel), no Nursing Officer (Personnel), so she was indeed a worm, being right down in the nitty gritty of the job.

Miss Gallagher said she got a fairly clear understanding and view of the real problems faced by the nursing organisation at day-to-day level. It was unfortunate at times that being so involved in day-to-day problems prevented her from playing a proper part in management and manpower planning as a whole. She was convinced that every District personnel department should have a SNO Personnel attached to it, who could make a contribution at District level.

Miss Gallagher thought that the way she had to spend her time - reacting to day-to-day problems - was not how a personnel nurse should, but for her there was at present no alternative. Giving an example of the sort of problems she had to deal with, she said there were 600 nurse learners in the Area school, and their confusing status as both learner and employee frequently gave rise to conflict. The role and functions of the trade unions in the school of nursing was a danger area; tutors were terrified of the very existence of trade unions, and this had a very serious effect on the performance of both tutors and learners. Miss Gallagher had to spend a lot of time trying to prevent this sort of conflict.

Miss Gallagher said she found it very difficult to try to assess the success of the personnel nurse: it was rather like the health visitor trying to assess what she had achieved in a given period of time. She agreed with Mr Gourlay's view that personnel departments should set objectives and contribute to operational planning. She thought it was very important to get a clear understanding of how the roles of personnel nurse and line manager relate to each other. It was not the role of the personnel nurse to fill space left by line managers, or to do the jobs they dislike doing. She did not have time to be concerned with the role of the personnel department as a whole, who should control it, and whether Region and Area Personnel Officers should have executive power. She was more concerned that personnel departments should have a team approach to their work and to the solution of personnel problems. The nurse had, in her view, a significant role to play and that role would be determined by how the role of the personnel department as a whole was defined, and to what extent management teams were prepared to delegate active authority to their personnel officers.

First and foremost the personnel team should know what the purpose of the organisation was, and in this respect the nurse in the personnel department had a lot to give, in Miss Gallagher's opinion. She reminded the audience that nursing was a major NHS activity; almost 50% of all NHS staff were nurses, and more than 50% of the work was done by nurses, so it was common sense to have a nurse in the department who knew how the organisation ticks seven days a week, 365 days of the year, day and night. Aspects of the organisation might be ignored if that point was not made from time to time. A nurse also knew about working relationships 'at the sharp end'; she knew how the cure and care teams operate and relate to each other, how they could

be affected very delicately by changes in policy. She emphasised the value of knowledge gained by doing; knowledge gained only from data was a very different thing.

Miss Gallagher ended by saying that she agreed that nurses should become qualified in personnel management; there was no place for a nurse without such qualifications in the personnel department.

From the worm's eye view to the bird's eye view, and what the line manager expects from the personnel nurse: Mrs A Poole, Area Nursing Officer, Surrey Area Health Authority, the last speaker of the morning, set out to answer three questions: Why do we need a nurse in personnel, and what are the constraints? What is the role? What of the future?

The need for nurses to enter the personnel arena arose because senior nurse managers became aware there was no one else within the organisation with sufficient expertise in personnel generally, and of the problems of nurses in particular, to undertake this role. Mrs Poole recalled that in the last financial year the NHS had spent some £4,500 million of which 70% approximately went on staff. In her own Area the revenue budget for the last financial year was £118-million, of which £67.8 was spent on salaries and wages for its 20,000 staff. Of that sum £33.5-million was spent on salaries for 10,000 nurses.

The only specific reference to the cost of personnel services in the AHA's accounts was some £67,634 for services in the Headquarters' accounts. The cost of personnel services did not figure in the District accounts, any staff engaged in this work being included under the heading "Administrator's office". This was the format for accounts which are submitted to the Region and to the DHSS, so that if an MP were to ask the Secretary of State how many people were working in personnel management in the NHS, and how much such a service was costing, he could not give an accurate reply. The Secretary of State could tell the MP the average cost of feeding a patient for a day, and what it cost to nurse a patient for a day, but he would find it difficult to give even an approximate cost of the personnel service in the NHS.

This revelation prompted the question "what is personnel?" Answers could be legion, ranging from "a welfare function" to industrial relations adviser, with negotiation and manpower planning as additional extras.

Because the personnel function was so ill defined, the reorganised Health Service started, in 1974, with the Administrator firmly convinced that the personnel service was part of general administration. Training was considered unnecessary, and the person in post had little status. Many Administrators not only firmly believed that personnel work should be done by themselves and by line managers; some even actively discouraged senior nursing colleagues from establishing nurse personnel posts. This, then, was the first major constraint: acceptance of the personnel nurse by the management team, in a role requiring the support of staff and facilities that are the Administrator's responsibility.

Mrs Poole said she had had a battle with her own team to get the appointment of a nurse in personnel accepted; this was a post she considered second in importance only to a nurse in child health, whom she had had to appoint in 1974. She won her battle - possibly because it was easier to win a battle at Area than at District level, where there is the additional problem of objections from clinical colleagues, which are sometimes very difficult to overcome.

Summarising, Mrs Poole remarked that there is a personnel service, but one which is referred to in very low-profile terms by the DHSS. For instance, she regretted that the contribution made to personnel management in manpower planning, recruitment and training, did not feature at all in the section on personnel management in the otherwise very welcome first report of the Chief Nursing Officer, DHSS.

Moving on to her second question, Mrs Poole expressed her belief that the nurse in personnel works in partnership with the District or Area Personnel Officer. She did not agree to the establishment of separate Nurse Personnel Departments any more than of separate departments for nurses working in planning, child health, occupational health, or any other facet of the service. She believed the nurse should be totally integrated within the Personnel Department, developing the policies for that department and for the service as a whole. She should, however, remain accountable to the nurse manager - the Area or District Nursing Officer.

In her own organisation, Mrs Poole said, she had fortunately been able to see that her Personnel Nurse was sited in the next office to the Area Personnel Officer. She had also established that the nurse should be responsible for the personnel service in the absence of the Area Personnel Officer. Relationships had to be carefully considered, especially when the Personnel Nurse was dealing with non-nursing staff. In this situation the Personnel Nurse must report to and seek advice from the Area Administrator, rather than the Area Nursing Officer.

To be able to undertake these duties and responsibilities the nurse must be trained and competent. Mrs Poole said she believed that the Personnel Nurse at the Area was there to give specialist advice to the members of the Area Health Authority, and to other officers at Area headquarters, as well as specialist advice to District Nursing Officers and other nurses at District level. It was the Personnel Nurse who should deal with the Joint Staff Consultative machinery on nursing matters, and with any disciplinary grievance appeals involving nurses that are referred to the AHA.

Manpower planning is an integral part of the personnel function, in Mrs Poole's view, and it is essential that the Personnel Nurse should be numerate and able to compile and interpret statistics and produce manpower planning models. The relationship with the Area Nurse - Service Planning is inextricably interwined, and the matter of "who does what" must be resolved locally.

All changes in services where staff are concerned must be considered at the outset by the Personnel Nurse. This included scrutiny of and comment on District plans, and consideration of Regional strategic proposals. It was important that the Personnel Nurse, together with the other nurses at Area, should identify and develop the priorities on the deployment and development of all nursing services within the Area, and assist with setting priorities for the distribution of scarce and specialised nursing services.

Another important role for the Personnel Nurse was the monitoring of personnel activities in the Districts; but it must be remembered that the role is also a supportive one to District Nursing Officers, advising them on all personnel management matters.

Mrs Poole then tackled her third question: "Where do we go in the future?" by asking another question: "What does the nurse working at Area do? Does he or she remain in personnel, and if so in what capacity? Is it possible to return to line management from what is designated a staff post?" The answer depended on two factors, she said: first the individual wishes, potentials, and abilities of the post holder; and second, the developing scene in the personnel service.

There was no reason why a career should not progress either in line management or in the personnel field; the responsibility for the development of an individual lay between the individual and his or her manager. Many nurses in staff posts are suffering because the manager sees them as an "odd job" or support person. It was time the nursing profession rethought staff post roles and responsibilities. To Mrs Poole these were specialist posts supportive to the ANO or RNO, and to the authority as a whole; without them the Area Nursing Officer could not perform his or her duties.

Mrs Poole said she would end by saying where she thought the personnel service was going. The personnel function must be developed and staffed by trained people who can assist line managers to do their jobs, she said: assist, but not take away from them the personnel element in their job. She believed the Personnel Officer of either the RHA or the AHA should be directly accountable to the Authority and not through the Administrator. She had given much thought to whether the Personnel Officer should be a member of the Regional or Area Team of Officers, and had decided the best compromise would be for him not to be a member of the team but to have the right to attend team meetings when they were discussing matters affecting the personnel service.

If the personnel service is developed by an increase in the number of trained staff, would there still be a need for a nurse, asked Mrs Poole; answering herself in the negative. The needs of nursing must be maintained, she went on, but we must be sensitive to changes happening both in nursing and in the whole service. Nursing staff and managers would continue to require the support and advice of a Personnel Nurse in implementing all the changes that are on the horizon, so nurses would still be needed in personnel departments for the foreseeable future. If they tried to play a separatist role, their contribution would be neither effective nor co-ordinated, particularly in the field of industrial relations.

The National Health Service, which employs many thousands of people and costs many thousands of millions of pounds has for too long been run without a corporate personnel strategy. Mrs Poole urged her audience to insist that a strategy be prepared, not only for the delivery of the service but also for those providing it. "Let us redefine and reaffirm the contribution of the nurse in supporting her colleagues and thus establish and maintain the rightful place of the nurse in personnel", she concluded.

(Job description for the Area Nurse - Personnel for Surrey AHA is attached).

In the afternoon session, which was chaired by Trevor Clay, Area Nursing Officer, Camden and Islington AHA, the delegates divided into groups for syndicate work on six questions relating to the subject under discussion. Their conclusions were as follows:

1. What can be done about the shortage of resources for personnel departments? What can be done to improve and make the best use of existing resources?

There was general agreement that a closer look should be taken at what resources are available, and how they are being used, in order to assess whether or not resources are adequate to meet needs. If it is accepted that resources are limited, personnel departments should concentrate on training and advising line managers and senior managers in personnel matters, conserving their own forces for specialist aspects of personnel management such as manpower planning and industrial relations. One group added that if SNO posts were "unfrozen", this would allow more flexibilty.

2. Should the role of the personnel nurse (at each tier) be more closely defined and, if so, how?

It was pointed out by one group that a broad outline of the role of the personnel nurse is given in HRC 73/37, but it was again generally agreed that the role should be more clearly defined, though this would be difficult, as the role varied so much in different situations. It was suggested that career development for the nurse might influence the way in which the job was structured: should we attract people away from line management for two to three years, who will then return to it, or should we offer a limited career in personnel? Another group thought that as the role was developing it would be difficult to define it closely, but it would be helpful if the function of the personnel nurse at Region, Area, and District levels could be generally defined.

3. Should the personnel nurse in the personnel team work as a generalist in the personnel function, or as a specialist in nursing matters? Should he/she work as a specialist, for example, in manpower planning or industrial relations?

Again there was general agreement that the personnel nurse should work in the personnel team as a generalist rather than as a specialist. It was thought that nurses had more to offer than they gave themselves (or were given) credit for. There were some nurses who might want to transfer from nursing to a specialist personnel role, though not everyone agreed that this would work; other disciplines might resent having to take advice on industrial relations or manpower planning from a nurse. A Works Officer was quoted.

4. Many nurses have a mixed job which includes the personnel function. Is this a sensible arrangement from the point of view of the Personnel Department? How can a personnel nurse's other responsibilities be reallocated more efficiently?

Groups were unanimous that a mixed role is very unsatisfactory; it was inevitable that the personnel function would take second place to other duties and responsibilities. It was suggested that management needed to be educated as to how to make correct use of personnel staff.

5. How should an integrated personnel service develop and how should it relate to management?

It was considered wasteful to set up a separate nursing personnel service: the personnel nurse should be a member of the personnel department, with an advisory role, though in practice the role would sometimes be executive. Total integration into the personnel team might be difficult, as the personnel nurse would still be accountable to the senior nurse manager, rather than to the Personnel Officer. One group drew attention to the salary differentials, which are considerable. Another group said that an integrated service depends on the goodwill of the people involved, particularly for the personnel nurse going into the personnel department as an "interloper". She must be ready to lead, and also be ready to be led.

6. How do you think the personnel function should develop? What supporting staff and systems should personnel nurses have to enable them to carry out their functions?

It was generally agreed that the personnel function should develop into the specialist areas of industrial relations and manpower planning, training line managers in personnel techniques, so that resources are conserved for use in developing the specialist areas. All groups thought that adequate secretarial help was a top priority in the supporting services required, as well as improved systems, and a good information retrieval service.

(Job description for Area Nurse - Personnel as mentioned on page 9).

SURREY AREA HEALTH AUTHORITY

AREA NURSE - PERSONNEL

The Area Nurse - Personnel is accountable to the Area Nursing Officer. She will, however, be a member of the Area Personnel Department which will be headed by the Area Personnel Officer; she will work within the agreed policies of that Department and will contribute to the formulation of general Area Personnel policies.

She will provide advice to the Area Nursing Officer on all personnel matters relating to the Nursing Service, including manpower planning. She will collaborate with the six District Nursing Officers and give specialist advice to them when required. She will support Senior Nursing Officers (Personnel) at District level whom she will monitor and to whom she will give advice and assistance across the full range of their activities. She will participate with other officers at Area level in the review of District plans and will contribute to the evaluation of plans and budgets with personnel implications.

DUTIES AND RESPONSIBILITIES:

1. The Provision of Advice to the A.H.A. and to Officers

1.1. Provides the ANO with advice on all matters relating to nursing personnel, manpower planning and deployment so as to enable the ANO to advise the AHA.

1.2. Examines and evaluates the nursing content of District plans relevent to her subject responsibilities.

1.3. Co-ordinates nursing functions with other activities at Area level and reports to the Area Nursing Officer.

1.4. Identifies and develops priorities in conjunction with other Nursing Officers (Area) on the deployment and development of nursing resources within the Area.

1.5. Advises the professional Nursing and Midwifery Advisory Committee as appropriate.

1.6. Assists the ANO, with other Nursing Officers within the Area, to identify and develop priorities for the distribution of scarce and specialised nursing services.

1.7. Compiles, interprets and advises on statistics and all aspects of nursing establishments.

1.8. Attends meetings as required by the ANO and provides advice on the subjects allocated to her post.

1.9. Formulates Personnel policies in conjunction with the Area Personnel Officer.

1.10 Assumes responsibilities in the absence of the Area Personnel Officer for the Area Personnel Department and advises the ATO and DPO's in all personnel matters accordingly.

1.11 In the absence of the Area Personnel Officer, acts as Management-Side Secretary for the A.S.C.C.

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2. Participation in the Planning of the Health Care Services

2.1 Advises the Area Nursing Officer from her own specific knowledge in the formulation of policies and plans such that the establishment of priorities for the Area can be determined and guidelines for the DMT's provided.

2.2 Participates and advises the Area Nursing Officer in the review and challenge of District plans and budgets.

2.3 Participates in the multi-disciplinary planning teams to review specific needs related to her subjects.

3. The Provision of Nursing Personnel Services in the Area

3.1 Monitors the provisions of Nursing Personnel Services and policies within the Area.

3.2 Supports and advises the DNO's on Nursing Personnel Management, staff deployment and manpower requirements and interprets Area policies in this field.

3.3 Arranges secondment for Student Health Visitors and others as appropriate in association with the Area Nurse-Child Health and the Senior District Nurse Tutor.

4. Miscellaneous

4.1 Participates as a member of the Regional Team of Personnel Specialists in the formulation of Regional policies and interpretation of national agreements and guidance.

4.2 Participates as a member of the Regional Team of Area Nurses - Personnel in formulation of policies relating to nursing personnel matters and training.

WORKING RELATIONSHIPS:

Accountable to:	Area Nursing Officer
Outposted to:	Area Personnel Department
Manages:	Senior Administrative Assistant Any staff specifically engaged on any of the nursing subject allocated to the post, including any such staff seconded to the Area.
Relationships:	AHA and its officers Area Personnel Officer and staff of Department. Area Nurses - Service Planning Child Health Local Authority (Liaison) DPO's and SNO's (Personnel) Regional Nurse - Professional Education, Development and Personnel. Regional Nurse - Strategical Service Planning and Management Information.

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