THE PREPARATION OF SENIOR NURSE MANAGERS IN THE NATIONAL HEALTH SERVICE

Peer Group Exchange Seminars 1979-8
Further contribution to debate.

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A REPORT OF PEER GROUP EXCHANGE SEMINARS

1979 - 1980

FURTHER CONTRIBUTION TO DEBATE

February 1981

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The feminine and masculine pronouns have been used in this report though all statements refer equally to both genders.

THE PREPARATION OF SENIOR NURSE MANAGERS IN THE NATIONAL HEALTH SERVICE

1. INTRODUCTION

In June 1979 the King's Fund arranged a two-day seminar for nurse managers to consider the Report "The Education and Training of Senior Managers in the National Health Service" (Thwaites Report).

At the seminar, Dr Shirley Chater, Vice-Chancellor of the University of California, San Francisco, suggested a number of possible educational opportunities which might be appropriate for the preparation of nurse managers. One of these she described as a peer exchange seminar which would provide a forum where a group of nurses could discuss common problems, share ideas and learn from each other's experience.

Following the seminar a group of senior nurse managers and educators with a responsibility for management training met every two months at the King's Fund Centre. Each member of the group produced a paper on some aspect of the subject and the collected papers are presented here. Each paper served as a basis for discussion and the group members found that increasingly as time went on they were able to benefit from the process of analysing aspects of each other's experience. The members had had very different kinds of preparation for their posts and the jobs which they now hold vary considerably. What they had in common was an interest in the training of senior nurse managers with the result that the peer group exhibited a unique blend of detachment and sympathy which encouraged both honesty and understanding in the presenters. The group process has been of enormous value in helping individuals to see aspects of their jobs in a new light. They have learned from each other and they feel that the peer group experience, given the right mix of participants and the right terms of reference can be a very rewarding experience in itself.

2. SUMMARY

The Role of the Nurse Manager

In examining the management function in nursing today it is useful to follow the established practice of the profession and to review the precepts and examples of that archetypal nurse, Florence Nightingale. To do so is to become aware of an apparent paradox. Miss Nightingale is best known as the woman who through her nursing skills brought comfort to the troops in the Crimea; yet her effectiveness there was in large measure due to her managerial ability. Historical events can be interpreted in different ways according to the observer's own perspective and for various reasons it may have suited the profession to concentrate on Miss Nightingale's nursing ability. In fact her example illustrates the importance of two things which are of particular relevance to the discussion of nursing management today: the interdependence of nursing and managerial skills and the need for sound management policies to stem directly from an awareness of patients' needs.

There have been two main reasons why the truth of these observations has become obscured in recent years, with a resulting uncertainty about the particular contribution which nurses make to multi-disciplinary management. One was the rapid implementation of the Salmon Committee's recommendations and the other was the ensuing upheaval occasioned by the reorganisation of the National Health Service in 1974. The Salmon Committee's Report published in 1966 and the associated Mayston Report on Community Services, commented on the problem of "the incoherence of nursing administration" and these comments led to radical reforms both in the management structure of the profession and in the preparation of nurses for managerial responsibilities. It was largely because the recommendations of the two Committees had laid the foundation for nursing management that nurses were able to take their places as members of nursing teams at every level of the reorganised Health Service.

It is therefore particularly ironical that these changes came to be associated in the minds of many people with the separation of management from clinical nursing. Some of the proposed reforms, particularly the creation of a management hierarchy in the hospital and community nursing services, the disappearance of the traditional hospital matron and the need to select nurse managers by ability rather than length of service aroused considerable protest. The main reasons -

for the proposals, namely the need for a properly managed nursing workforce and for direct representation of the nursing viewpoint in decisions affecting the planning and delivery of health care, seem not to have been fully understood by critics. Nursing management, as defined in both the Salmon and Mayston Reports, was concerned with the creation of the right environment for the delivery of the best nursing care possible, the formation of policies to this end and the continual monitoring of standards. It was in fact doing what had been done in the Crimea over a century before by someone uniquely equipped with both nursing and managerial skills.

It is probable that the reforms in nursing management were introduced before the need for them had been generally understood by nurses directly involved in clinical work or by other professions in the Health Service. As a result the losses are often more readily acknowledged than the gains. The lobby to bring back the matron is a reflection of this and some idea of its strength can be gained from the fact that it has been echoed both in the Report of the Royal Commission on the National Health Service and in the consultative paper "Patients First". Because the nurse managers appointed to the new posts were under pressure to acquire new skills, there was, in the late 60s and early 70s, great emphasis on management training and the professional role of nursing officers at all levels received little attention. The traditional matron who was clearly identified as a nurse symbolised the unity of the profession. The desire for her restoration and the desire for greater recognition of clinical skills inherent in the demand for a clinical nursing hierarchy stem from the fact that the profession seems in danger of being dominated by management rather than clinical considerations. This tendency was exacerbated by the introduction of the reorganised Health Service which made increasing demands on the nurse managers who had to adapt to a new situation and to the demands of new jobs. Those working in teams of officers found themselves with far wider responsibilities than those of their previous posts.

One of the features of the nursing profession which is most noteworthy in this context is the fact that every nurse, whether operating at a clinical level, in education or in management, has behind her direct experience of patient care. This, in our view, should be regarded as a potential source of strength within the profession and particularly so for the nurse manager.

We believe that the role of the nurse in multi-professional teams is unique and that because of her background she can bring to the team an understanding of the way in which the health care system affects the individual patient in both hospital and community, wide experience of dealing with people and their problems and a detailed knowledge of the various activities which take place in the Health Service over a 24-hour period, which it would otherwise lack. Her professional experience is therefore potentially of great benefit to the team as a whole in ensuring that the implications of management decisions at patient care level are fully understood.

The senior nurse manager is the head of the largest group of workers within the National Health Service and her direct knowledge of the clinical situation is essential in setting standards and determining nursing policies. To a far greater extent than any of her team colleagues, the nurse is a professional leader both in the sense that she must be identified by nursing staff as their spokesman on nursing matters and that she must give direction to the nursing service as a whole.

The management functions of the senior nurse also differ from those of her management colleagues in another way, although this difference may be in degree rather than in kind. For example, the effective use of resources, particularly manpower, is obviously a much more demanding part of the nurse manager's job because of the number of staff and amount of money involved. In this context we welcome the initiative of the Royal College of Nursing in advocating a qualitative approach to the problems of establishing staffing requirements. The development of an effective two-way communication system and the effectiveness of the personnel function within the profession obviously become more complex and difficult as the size of the staff increases. Nursing lacks specialist support and advice on personnel matters at operational level despite the introduction of staff posts since the Salmon Report. The need to develop within the profession a nucleus of people with special skills and knowledge outside the clinical sphere is a problem which nurse managers face and this focuses attention on the educational aspect of their role. Again none of the other disciplines represented on the multi-professional teams has this direct and extensive educational function.

The role of the senior nurse manager is both unique and exacting. Efficient management of the nursing service which accounts for some 40% of the overall costs of the National Health Service is vital to the service as a whole. The nursing profession is facing another period of change and development during which it will require strong leadership. It is essential that the importance of management is appreciated by the profession as a whole and that the senior nurse manager's role is seen as a logical progression from clinical responsibilities. In this regard the introduction of the nursing process at clinical level provides a useful model because it requires for its success involvement of nurses directly engaged in clinical work, nurse managers at all levels, nurse educators and nurse researchers to work together to promote improvements in patient care. It demonstrates better than anything else the interdependence of the four aspects of the nurse's role. At the same time its successful use demands greater accessibility between the various groups of staff, more delegation of responsibility to the individual trained nurse and the development of a more democratic management style within the profession.

It is important however that the profession should recognise that its managers have potential strengths which should be exploited as well as possible weaknesses to overcome by the identification of individual training needs. Inevitably identification of the training needs of the nurse manager will mean that attention must be paid to the managerial aspects of the job because her previous experience is unlikely to have been an adequate preparation for these additional responsibilities. The profession must not however lose sight of the fact that, as a nurse learns to use the tools of management, she uses them as an extention of her knowledge of nursing and health services. The professional foundation of the job should not be abandoned due to a preoccupation with the managerial nature of the post she now holds.

3. CONCLUSIONS

1. The frame of reference for nurses in management is their knowledge and experience of nursing practice in a variety of National Health Service settings. Good management is necessary to facilitate the provision of adequate nursing care through appropriate nurse education. Nurses bring to management teams experience of a wide range of clinical nursing jobs, of working in multi-professional groups, of close involvement with people, of negotiating with other workers on behalf of patients and of establishing priorities within limited resources to safeguard patients.

2. The emergence of the nurse as an equal member of a multi-professional executive group in the National Health Service is a comparatively recent phenomenon. Nurses may have failed to appreciate the wide range of knowledge and abilities which they bring to management teams and may have been reluctant to make a contribution to management decisions which they alone can make. Nurses have knowledge of the community and social aspects of provision for the person under treatment or care; the wide range of therapeutic, support and nursing services which people require on a part-time and full-time basis, and the importance of public image and the public relations aspects of the National Health Service.

3. There has been a lack of appreciation of the fact that the nurse as a top manager is more than a manager of nursing services. She, like other members of the executive group, must make an equal contribution to the planning of health services. The corollary of this is that she needs preparation for this level of participation. In the executive group the nurse needs to exercise forward planning skills and to some extent her previous experience has been reactive which is the antithesis of this. Nurses are needed in top management posts to contribute their wide knowledge of patient/client needs to the planning of health services for the population to be served, to maintain within the executive group an awareness of the 24-hour, 7-day nature of the services some patients require; to prepare contingency plans for unusual events, for example, major disasters or industrial action; to ensure that appropriate nursing advice is available to all multi-professional teams and to bring a generalist's perspective to health service management.

4. The nurse in a top management post must also provide nursing leadership. In this respect she needs knowledge and skills to enable her to manage and develop nursing services; to develop nursing personnel according to their abilities, aptitudes, potential; to formulate nursing policies, to establish and monitor nursing standards, to foster research mindedness throughout the nursing service in particular and throughout the organisation in general; to represent the profession of nursing at local, national and international levels.

5. More specifically in regard to the totality of her responsibilities, the knowledge and skills required by top nurse managers include interpersonal skills: for example, industrial relations, the social aspects of work, group dynamics, personnel work, appraisal and counselling, communication skills and the use of the media. She also requires analytical skills and abilities with regard to the collection and utilisation of objective data in support of cases being argued. She needs to have planning skills and the ability to set priorities and use time effectively and needs to develop political skills with regard to tactics, strategies and logistics. Her management skills should include an appreciation of manpower planning, budgeting and resource allocation, office skills and research resources. With regard to her responsibility for planning health services as a whole she will need to widen and deepen her knowledge of the National Health Service: for example, structure, including advisory and consultative machinery and the functions of other NHS managers and the nature of their work.

6. Strategies for staff development should include:

   a. good appraisal, support target setting and evaluation of achievement for all grades of nursing staff,

   b. opportunities for all staff to develop at their own pace,

   c. the identification of the potential of all trained nurses.

Potential for top management could be tested by planning areas of responsibility delegated from a more senior postholder: for example, budget management, forecasting, estimates and resource planning. This process could have a two-fold benefit as it will involve the senior manager in an analysis of the range and nature of her responsibilities and may help to define her own role more clearly within the context of corporate management.

7. If the initial identification of potential ability is borne out by performance with delegated responsibilities, the next stage could be a series of posts/secondments to widen the experience in a range of management jobs at various levels in the National Health Service.

8. A variety of approaches might be used for the preparation of top nurse managers. For example:

a. preceptorship schemes,

b. structured 'acting up',

c. self-appraisal, perhaps by diary-keeping and, analysis of the contents,

d. peer group discussion,

e. case conferences, casework learning or case comparison,

f. short subject-specific courses, for example, in budgeting, industrial relations or public speaking,

g. formal courses at advanced diploma or Master's level which may be unidisciplinary or multi-professional.

9. The responsibility for nursing staff development, which must be individually tailored, lies fairly and squarely with nurse managers. There is no single most appropriate method or package deal which will develop the nurse manager of the future. An important aspect in the preparation of nurses for posts in top management is wide experience of a range of jobs within the National Health Service plus specific educational activities aimed at the development of particular areas of knowledge and skill. In order to do this it is essential that present managers develop effective staff appraisal schemes and identify potential talent which may be developed by the appropriate delegation of responsibilities and career guidance.

4. PAPERS USED TO FOCUS DISCUSSION

ARE NURSE MANAGERS NECESSARY?

It seems unusual that a profession should question the need for one of its own members to be involved at the highest levels of management. The following reasons may be possible explanations why the nursing profession concerns itself with such questions:

1 there is fundamental ambivalence in the nursing profession about the role of non-clinical managers

2 nurses are generally unsure about the need for senior nurse managers

3 some health care workers may hold that non-nursing managers would perform the role more effectively.

THE CASE FOR NURSING QUALIFICATIONS

i. <u>The role of the senior nurse manager as professional leader</u>

The Thwaites Report (1977), emphasised the other aspects of the top managers role '.....the senior nurse in management is also a professional leader.' A distinction must be made between management and leadership. The former is concerned with the maintainance of established structures and the implementation of existing policies. Leadership on the other hand is concerned with changing structures and procedures for goal attainment, or changing the goals themselves i.e. leadership is concerned with innovation. (Hoyle 1972)

However able a non-nursing manager might be the role of professional leadership would be quite beyond his scope and capability.

ii. Nurse management involves a close working liaison with medical staff

'The nurse manager must have close liaison with doctors; otherwise, she might as well retire to the sluice room'. (Speakman 1979)

However difficult relationships might be from time to time between doctors and nurses there exists a special relationship born of the closeness of the goals of caring professionals. Lay managers could not negotiate on the level of trust that those from the caring professions can.

iii. Role of senior nurse managers as balancing and reconciling aims

The Thwaites Report (page 48) describes the role of the nurse manager as 'balancing and reconciling the values and aims of the organisation with the values and aims and professional aspirations of the nursing staff....'

It is questionable whether a non-nursing manager could attempt to do this without in-depth knowledge and experience of nursing.

iv. The senior nurse manager and the caring element

Whilst it may not be claimed that nurses have a monopoly on caring, it is beyond dispute that the form of professional training which they receive gives them a special perspective of the needs of patients. The same cannot be said of persons of any purely management background.

v. The argument put forward for the greater expertise of the professional manager in corporate planning is untenable

This argument is probably the main one put forward for the recruitment of professional managers. However, corporate skills are not only required by top managers at Region and District levels. 'Much work below the level is carried out by inter-disciplinary groups and training for the staff concerned in the relevant corporate skills is an important requirement'. (National Training Council 1979)

OPINIONS OF A SMALL GROUP OF NURSES WERE SOUGHT

The Sample

An incidental sample was used consisting of two readily available groups with similar backgrounds. There were 21 nurses from a course for a Certificate of Education and 9 nurses from various clinical specialties, working in Hampshire and Berkshire. All the nurses used in the sample either possessed or were studying for the Diploma in Nursing.

It is recognised that the samples are small and were not randomly selected. Generalisation of the findings is therefore done with caution. Nevertheless the outcome of the small study is interesting and provides some indicators of nurses' views and opinions on certain management issues.

Their mean length of time in post as ward sister/charge nurse was 4.34 years.

The majority had received preparatory management training: First Line Management Course 62%; Middle Management Course 10%; None 28%. But nearly 50% of those who had received preparation felt that it was not 'generally relevant' to their roles.

In response to a request to 'Indicate the degree of face-to-face contact which you had with the following grades of nurse manager in the year prior to coming on your present course', the following responses were obtained:

GRADE	NEVER	RARELY	FREQUENTLY	VERY REQUENTLY
NO	0	13.4	30	50 %
SNO	0	34	40	24 %
Div NO	13.4	64	17	6.7 %
DNO	40	46	10	0 %
ANO	84	13.4	0	0 %
RNO	94	3.4	0	0 %

Eighty per cent of respondents believe that a top nursing manager, at district level and above needed to be a nurse. Reasons for this belief were sought and are classified into five main categories, with examples from each:

a. requires knowledge and understanding of nursing needs

non-nursing people do not understand the peculiarity of the nursing profession; trained nurses should understand the needs of nurses.

b. requires awareness of problems in nursing

only a nurse can understand the problems current in nursing; to evaluate the problems it is essential that the manager has a basic grounding and working experience of nursing.

c. requires experience in nursing

has been through the system and therefore experienced all aspects; it would be impossible to negotiate in nursing matters and perform the role as a representative without the practical experience.

d. necessary for career prospects in nursing

provide career prospects for nursing.

e. professional autonomy

if the top manager is not a nurse it will put back professional progress 60 years.

DISCUSSION OF RESULTS

The majority of nurses in the survey were in favour of nurses being in top management posts. Most of them stressed the importance of a nursing background as a pre-requisite for effective functioning at these levels. The minority who did not feel the necessity for top managers to be nurses emphasised the lack of sufficient training for these posts and the fact that the top managers were out of touch with nursing. This may reflect an endemic insecurity amongst the nursing

profession with regard to the ability to perform effectively in any role other than that of bedside care. The only 'proper' managers or educators are often seen to be people outside the profession and the actual nurse manager or educator as an amateur dabbling in a field for which she is not really prepared.

The sampling procedure makes it unwise to extrapolate the survey findings to the problem at large. However, it is probable that many nurses would share the sentiments expressed by the respondents with regard to the necessity of having a nurse at top management level.

Viewpoint

The question of whether we need to have nurses in top management posts is paralleled by the one which questions the need for a director of nurse education to be a nurse. Why does the nursing profession waste time and energy exploring these questions when the really fundamental ones are ignored, namely, how can we best prepare our nurses to fulfil their roles in the top management and education posts. Nurses have a right to be included at all levels of decision-making. Indeed, they have a responsibility to the community at large to be so. Nursing is one of the most highly respected and trusted professions and must not hand over lightly responsibilities with regard to the maintainance of the best possible service for the individual.

In conclusion and to summarise, 'The ability to communicate with a patient, consultant and, relatives, are indivisable factors at the bedside. For the nurse manager, they have an added dimension; to communicate with nurses themselves and to build a bridge between the profession and the community so that each has a better understanding of the needs of the other'. (Speakman 1979)

THE NURSING PROCESS IN SENIOR NURSING MANAGEMENT

One of the claims made at the first seminar was that the steps of the nursing process are synonymous with the steps of the nurse management process. This assumption needed examining and the Royal Marsden experience was the model available to the group.

The structure and style of nurse management at the Royal Marsden Hospital has evolved and continues to evolve through the nursing process which is practised there.

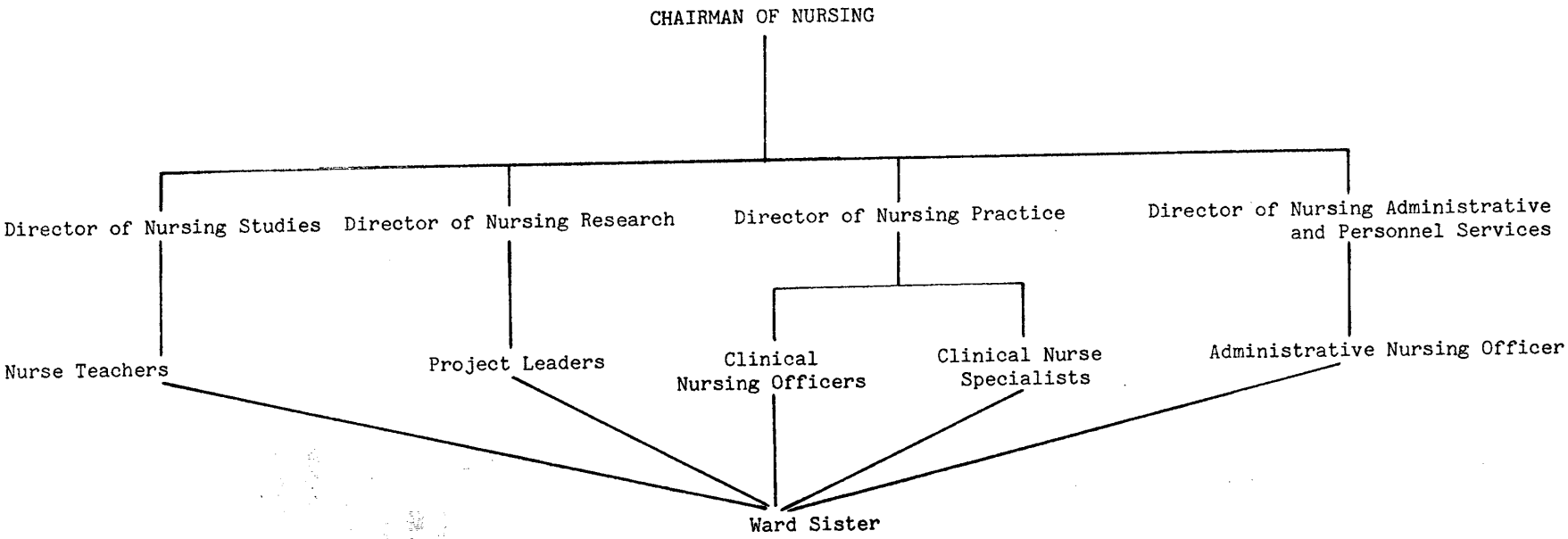
It must be recognised that the nursing process has no existence in its own right but is a dynamic way of thinking through plans. It is not a new recording system, nor a new organisational system to become eventually as ritualised, outmoded and inappropriate as the existing systems but an organic process. Nursing process is basically a nursing management tool, i.e. the identification of problems, the planning of specific short and long term actions to remove or ameliorate these problems, the method of implementing or applying solutions and, the evaluation of both the total programme and its constituent elements.

Nursing managers at the Royal Marsden recognised the need for change in existing systems. Not only the method of organising direct patient care but also that the whole structure surrounding and supporting clinical practice required a complete remodification if successful change was to be achieved. Present first line management training programmes appeared to fail at developing professional growth. Results seemed to indicate concentration on peripheral items of organisation rather than getting to the core of the professional development.

Introducing the nursing process at the Royal Marsden required well prepared nurses able to think for themselves and a recognition that relationships in clinical settings should be those of professional colleagues rather than the model of hierarchical supervisors.

NURSING STRUCTURE AT THE ROYAL MARSDEN

How it is seen to be developing



The concentration of initial attention to clinical practice by the introduction of a training programme for ward sisters and the establishment of a model ward, as well as the provision of a consultancy service to ward sisters by clinical nurse specialists free from hierarchical constraints; progressed to a review of the surrounding management structure and the roles of specific grades and individuals.

Two types of nursing officer

This review led to the establishment of two types of nursing officer. The first a clinical role model; the second, an administrative nursing officer.

At the same time teaching staff recognised their inability to teach the nursing process without more direct patient involvement. This recognition in turn led to the development of a greater presence of teachers in the clinical setting, resulting in the creation of joint appointments such as tutor/ward sister and clinical nursing officer/clinical teacher.

This inevitably led to the recognition by those in clinical practice, nursing education and management that they were lacking in knowledge and how to obtain it. This triggered off the creation of a nursing research unit which was seen as an integral part of the structure and not a peripheral extra.

At senior management level it became necessary to develop a management system that viewed nursing as a whole rather than in terms of its individual parts. A nursing management team was created based on consensus management principles covering practice, management, research and education.

The nursing management structure at the Royal Marsden has changed from a hierarchical structure to peer review groups with direct access to the management team. This emphasises professional accountability and an element of management by democracy.

IDENTIFICATION OF INDIVIDUAL NEEDS IN PLANNING MANAGEMENT EDUCATION

British top nurse managers now have executive roles but the 'team of equals' concept is new and is certainly very different from the traditional matron role. Professional self-assurance is developed however when nurses are clear that their role is concerned with the management of nursing as opposed to any other type of management.

The biggest single advantage bestowed on district, area and regional nursing officers by the 1974 reorganisation was that jobs were new and therefore roles were to some extent open to negotiation. For this reason lack of previous experience in line management could be seen to have had advantages as well as disadvantages. There was no blue-print or role-model.

Two members of the group who represented different routes of progression to top management, one via a staff post and the other through nursing education, prepared papers on the advantages and disadvantages, as they saw them, of the routes they had taken.

Paper one

Most people taking up a senior post for the first time must inevitably wonder whether they will be able to meet the demands of the job. In my case, this apprehension was increased by the knowledge that my career pattern had been atypical and that I lacked certain kinds of experience which most managers take for granted. The most obvious disadvantage I had was that I had never been in line management since my experience as a ward sister. On leaving school I took an arts degree followed by nursing and midwifery training. I practised midwifery in the community and in hospital before taking up a research fellowship in a university department of nursing studies. During this period I spent a year on a travelling fellowship in the United States and on my return became a lecturer in the department of nursing studies. After four years I took up a post as senior nursing officer (central administration) which lasted two years and was then appointed as district nursing officer.

In practice the lack of line management experience mattered less to me than it possibly did to my subordinates as it was counter-balanced by my experience in a staff post. This was the single most important piece of preparation that I had for a variety of reasons. It gave me experience of working in the National Health Service which I had not had for over eight years and it gave me a chance to catch up on the various changes which had occurred in my absence. Also, because initially I had time on my hands when I took up my central administrative post, I used it by going round the organisation which was totally new to me and finding out how the various disciplines contributed to the whole operation. On the nursing front I carried out a number of projects which involved contact with nurse managers at all levels and learned a great deal from them about the problems which they faced. The Salmon Committee's recommendations had been implemented quite late in this particular group and there was still a good deal of uncertainty about roles and relationships. It was possible to see the amount of disruption and disenchantment which this particular change had caused and its effect on the service as a whole. There was some resentment on the part of medical staff in particular about the creation of what they saw as a plethora of new posts which took able nurses away from the bedside. On more than one occasion a consultant, on being introduced to me, would launch into a diatribe against the creation of such a post as mine when the wards were short-staffed.

Since any nurse manager probably has to face this attitude sooner or later and has also to go through a process of self questioning and doubt, it was in fact another useful experience. The value of the contribution made by the nurse in a clinical setting is readily understood and immediately apparent to everyone. Patients in hospital have a low appreciation threshold so that nurses become accustomed to the feeling that they are doing a worthwhile job. Transition to management involves among other things accepting that the value of the individual's contribution is continually being questioned, both by oneself and others.

Perhaps the most useful opportunity afforded by the staff post was that of observing a top manager in action at close quarters and learning about her role and functions. I also learned a good deal about nursing policies and problems and the importance of being fully briefed before meetings. My boss would discuss aspects of her job with me and explain, if I asked, why she had taken certain decisions. This again was a useful experience, as was observing the relationship between her and her senior managers. I now believe that managment is more about relationships than anything else and the opportunity to analyse cause and effect in this sphere was invaluable.

The post also gave me experience in planning and commissioning which has stood me in good stead, in working closely with the school of nursing as secretary of the procedure committee, and in compiling reports on matters as diverse as nurses' cloakroom facilities and the use of linen at ward level. Without the confidence that the post afforded me it is doubtful whether I would have progressed to top management.

Another key experience was that of working in an academic department which gave me knowledge about current developments in nursing at national and international level, contacts with many key people throughout the profession and experience of teaching, research and public speaking. Because the nursing profession is still very ambivalent about university education one got used to supporting an unpopular cause, or selling the idea to people who knew little about it. This is an experience which many top managers will recognise, if not on that particular issue. I attended a senior management course at the Administrative Staff College after I had been in the district post for a year and a half. I was and still am critical of many aspects of the course but it gave me an opportunity to reflect on what I was doing and to discuss particular problems with interested people. Such a breathing space is important in top management where one is employed to think but has little time to do it.

What of the disadvantages? I think that perhaps a lack of experience in line management did have an unfortunate effect in that I tend to think that problems can be solved more easily than they are and I therefore become impatient if solutions are not reached. If this goes on for any length of time the individual is likely to become frustrated. Perhaps in top management you have to learn to live with this, while at the same time retaining your ideals. I have also felt the lack of experience in dealing with the media and indeed in public relations generally. There are so many controversial issues in the Health Service nowadays that most managers probably have to face a hostile public at some stage.

A lack of experience in committee work was a decided disadvantage and in fact at the beginning I found it very hard to speak effectively, if at all, in large meetings. There are still some situations where this is true and I think it is a deficiency that could be to some extent overcome with the right preparation. Similarly, a lack of knowledge of office management including the storage and retrieval of information, dealing with paperwork and using secretarial time effectively is probably a disadvantage which could be overcome fairly easily. I sometimes think that not enough attention is paid in management training to the acquisition of simple technical skills.

In trying to assess the advantages and disadvantages I had when taking up post, I am struck by the fact that many experiences give both and that this should be recognised. No one has the ideal preparation for all aspects of the job but it is important that we recognise that atypical career patterns may have their own value and that, conversely, the right kinds of experience may mean that individuals do not sufficiently analyse their own strengths and weaknesses.

Paper two

The tabulated summary presented to focus discussion upon the advantages and disadvantages of the route taken to top nurse management through nurse education. It is interesting to note that the disadvantages are things which could be corrected.

ADVANTAGES	DISADVANTAGES
1. Had no previous experience as a nursing service administrator.	No firm knowledge of the principles of nursing service and manpower planning.
2. Working knowledge of nursing practices and organisations in other countries: viz North America and Scandinavia.	Limited knowledge of financial management and budgetery control systems.
3. Quite prepared to change my mind and/or agree that I am wrong when there is evidence to substantiate.	Rather naive about industrial relations activities and trade union negotiations at local level.
4. Good grasp of the theories of organisation and social change.	Knew very little about the attitudes, functions and roles of non-nursing managers.
5. Knowledge of sociology and research. This has been useful in health care planning discussions and in fostering a critical approach to others' reports. It has also been helpful in evaluating the nursing organisation.	Did not have much practical experience of the group dynamics of committees.
6. Not afraid of contacting 'significant others' in government departments and statutory bodies for informal and confidential discussions.	Had never participated in a committee with medical colleagues.
7. Experience as a teacher. The 'teaching process' is transferable.	Had no previous experience or knowledge about capital planning.
8. A sense of humour. Firm conviction that the graveyards are full of indispensable people.	Belief that on one would really want to be devious in the NHS management.

ADVANTAGES	DISADVANTAGES
9. Belief in delegation with full responsibility and trust.	Had been rather ambivalent about the roles of nurse managers for most of my professional life.
10. Experience as a writer/journalist which has helped in report writing and 'speed reading' of reports and contacts with the media.	Very little experience of the 'sociable aspects' of nurse management e.g. host at receptions, lunches, attending Mayors' Dances, League of Friends' social events, and so on.

Comment

There was no collaboration in producing these papers. Discussion raised the question of the concept of elitism - fostering an educated elite. Not only may this be necessary to ensure the confidence required by the changes constantly inherent in society but also to foster confidence in self-expression in multidisciplinary meetings and in public speaking.

Highly expensive senior management courses may be of limited value if they do not serve to fill the gaps in knowledge and skills which cause problems within the job. So diffuse and everchanging are the educational needs that it may be of more value to provide secondment to acquire specific skills according to the individual's needs.

There is a distinctive argument for some formal research into the role of top nurse managers so that common core requirements may be identified for inclusion in education programmes; but systematic documentation, evaluation and review are essential to develop the profession's body of knowledge.

These two papers suggest that given ability and aptitude it is possible to 'fit' the individual to the job of top nurse manager and endorses the view that preparatory programmes need to be individually designed.

REALITY AND TRAINING NEEDS

Nurses have traditionally been promoted into administrative positions on the basis of their clinical capabilities. They have not been well prepared for the responsibility of managing a diverse work group nor for working within a team of professionals.

It seems likely that previous experience and educational background and opportunities must dictate very strongly the training needs of individuals - yet, are there some which may be identified and met before taking up a post?

Two members of the group with differing backgrounds and preparation wrote diary notes of the reality as they found it in the early days of their most recent appointment.

REFLECTIONS - THE FIRST WEEKS AS AREA NURSING OFFICER

Week 3

Monday

1. Meeting with all the consultants at one of the large hospitals. The Area Team of Officers went somewhat unprepared to this meeting. I had assumed that the others had a clear strategy and they didn't. Managing the concerted attack of 15 consultants is not easy and we probably put ourselves in an unwise situation.

2. Informal meeting with the three area nurses made me think as often before about the need for clear and workable systems of communication, even as in this case, within one office building.

3. Attended Community Health Council meeting which was predominantly informative but raised once more the question of the role of an Officer on this sort of occasion with members of the public and other professionals there.

Tuesday

1. ATO meeting. The health needs of ethnic minorities were discussed as well as the pressure group role of many groups involved with these minorities. Both from a health care point of view and from the more political point of view this whole subject raised questions.

   Also considered the question of tenders and financial responsibility of area officers - something of which I know very little and am conscious of being dependent upon the Area Administrator and Treasurer over this.

2. Child Psychiatry. A very complicated matter concerning the transfer of a rare clinical service from one health district to another. It is one of many similar issues which are very complicated by political pressures and vested interest groups and a difficult issue to join after perhaps two or more years of planning and discussion.

Wednesday

1. Part of the day overwhelmed by the amount of reading matter and this made me think of the whole question of organising one's work. Like many nurses I always find it much easier to spend time with people or visiting institutions than I do in organising paper work. My own natural reaction is to neglect the paper work but I know other senior nurses spend perhaps too much of their time on it and find it difficult to identify the important from the less important matters. The whole question of organising work of an administrative nature is something most of us find out by personal experience, presumably develop our own individual approach.

2. An interview with a reporter on the subject of nurses' uniform. It would be useful to have had some sort of

general discussion about what one says to the press and the differences between the professional press and the local or the national media.

Thursday

1. The Area Nurse (Child Health) spent some time discussing procedural problems faced by the health visitors on the subject of non-accidental injury. Most senior nurses must find themselves faced with very serious clinical problems in an area which is not part of their own clinical specialty. It is difficult always to know how best to find out the right sort of information in order to take a decision/give support with confidence although without the full background knowledge one would prefer.

Friday

1. A shortlisting meeting raised yet again the whole issue of selection procedures for which more training/ experience always seems needed.

2. Presenting the prizes at a teaching hospital. Prize-giving raises the question of the public speaking/ public appearance role for senior nurses. I have probably had more experience of public speaking than most but still found this quite a difficult occasion.

Saturday

1. A day seminar organised by four local CHCs and MIND expected me to make an 'official' summary as from the Area. The delicate combination of speaking publicly and giving encouragement to staff and local pressure groups raised itself with the anxiety of being indiscreet or over committing the Authority.

Week 4

Monday

1. A seminar on industrial relations - I have probably had more training and discussion opportunities on this subject than most and yet am still conscious of the enormous need which I feel. In particular I think the specific discussions of a case study nature with really able and experienced people is what I valued. In an ideal training situation I would welcome quite regular small group sessions on this subject sharing the experiences and yet being guided by someone in a 'guru' role.

Tuesday

1. An extremely difficult ATO meeting raised with me the whole question of one's personal and professional integrity during concensus management. I seem to have a continuous succession of officers coming to my office wishing to discuss the rather explosive meeting and all in a way asking to be supported in the role which they had played. Simple honesty did not seem to be the best answer as one still had to work again with all concerned.

Wednesday

1. Working in a politically sensitive area - a nursing officer has written directly to a Minister. The problems this gives me are both sorting out the matter she has raised, answering it to the satisfaction of civil servants, and explaining to her senior colleagues that this happened.

2. An orientation session with the Specialist in Community Medicine raised several issues. Firstly I am quite ignorant of the medical structure at Area level. Secondly I am ignorant of the nursing and health service

involvement in many institutions which are not our direct responsibility e.g. schools, nursing homes, and special schools. She makes me think also of the importance of senior officers going out and about and seeing such areas for themselves.

3. An orientation session with works department makes me conscious of my lack of real information about the planning system and even more the whole question of the capital works programme. It is complicated enough just to remember what plans are in progress and then there are further issues such as queries over VAT, size of fees etc.

Thursday

1. A monitoring visit to one of the long stay units - this is part of a programme drawn up by the ATO in the post Normansfield era. Going round these wards and talking with staff makes me conscious of two very big difficulties. Firstly the whole question of monitoring, what you look for and what you try to see and how you really satisfy yourself without making staff feel unsupported and untrusted. Secondly the whole question of going round clinical areas is a difficult one and it is not easy to speak to patients or even staff when they don't know who you are and even if you are introduced they don't really understand your title, and just simply how to talk to people who are ill about whom you have little information and who you do not wish to distress by thoughtless remarks.

2. A discussion with a DNO about industrial action. A fairly major grievance developed into a dispute involving many more hospitals than just our own. Locally the nurses obviously felt that negotiation had led to a 'climb down' and that their own position following reinstatement of some ancilliary staff was made extremely difficult.

3. The interruption to discuss industrial action led to a problem which I faced regularly in my last job, that of difficulty in timetabling my activities. It was not easy to decide between discussing industrial action with the DNO and possibly not going to visit a small unit where the sister had changed her off duty specifically and where the unit was threatened with closure, and arriving for shortlisting meeting.

4. An alternative approach to selection was interesting but still certainly no clearer.

Friday

1. A meeting of the senior nurses (District Nursing Officer and Area Nurses) raised several issues. The conduct of meetings of senior professional colleagues, the way in which information (often quite boring information) should be disseminated and discussions about quite major issues.

2. A hospital closure has left several senior nurses feeling aggrieved. This is my second experience of hospital closures and am conscious of the very real distress and bereavement feelings that many staff feel. It seems to me that currently each senior nurse goes through discovering this for themselves and there is no guidance for senior nurses on how to handle such a matter. In addition there is never any easy checklist or guidance on the actual mechanics of closing wards or departments quite separately from the personnel matters.

Saturday

1. Attending a Red Cross 'grand occasion' brings up the whole question of the public role and representative role of senior nurses.

Week 5

Monday

1. A visit to a hospital threatened with closure made me think yet again of the very complicated almost impossible way of managing this sort of situation. On the one hand, trades unions had made it very difficult for us to talk with staff, on the other hand many of them, particularly the senior staff were becoming demoralised partly just through lack of activity being left with a very run down hospital.

2. I went to have an informal discussion with someone outside our Area about the large psychiatric hospital which my Authority manages. I suspect for many senior nurses acquiring for the first time responsibility for one of these large predominantly long stay institutions it is extremely worrying and I think it probably should be. It is easier for me in that having been a member of my Authority for two years I have had a lot of general background information and opportunity to discuss some of the policy issues which have been raised. Someone who has had experience of consultancy work in this sort of institution kindly agreed to talk with me about the various ways in which we could approach the difficulties. It was a useful session for clearing my thoughts but certainly didn't produce any easy solution. However I suspect there is a big place for peer group slightly structured discussions about the common problems that many of these institutions share.

3. With the Area Administrator and one of our DMTs. I joined the Chairman of our Authority for a discussion with some local staff organisations about closure issues. Once again I felt that there were so many complex issues that briefing the Chairman was not at all easy. Presumably this is the sort of issue Speakman was referring to when he gave an additional payment to the administrators.

Tuesday

1. A session with the person in charge of the management training for most of the Area at the local polytechnic. An Area such as ours with such a large number of staff should really develop a clear coherent approach to staff development and training and we are undoubtedly better than many. However I feel that resources often make us leave too much in the hands of people who do not necessarily have the experience to know the real training needs of health care professional staff. I am sceptical too of the real value of much of the management training which we offer but perhaps we have to accept it as better than nothing in view of the fact that we have so few people who are really skilled and able to undertake a sort of on the job related training which I would like to see.

Wednesday

1. Interviewing for a senior post. A quite appalling experience in which I saw well qualified nurses perform really very poorly indeed. Nurses at all levels require much more experience and training in preparing themselves for interviews.

Thursday

1. I arranged to see a member of the Area Nursing and Midwifery Advisory Committee to help me prepare myself for the Area Health Authority meeting. Looking through the papers and trying to anticipate the sort of questions members would raise I found really very difficult and quite wearing. I wondered whether it would be easier in 6 months time when I would have much greater experience of the sort of issues which had led to various papers and minutes and notes.

Friday

1. Further interviewing, this time for an SNO in Psychiatry.

Week 6

Monday

1. AHA day! Our own briefing of the Chairman was not, I felt, really adequate nor was my briefing to handle some of the nursing issues which might have come up. The greatest impression I had though was how very negative we sounded and indeed how unable we are to achieve results as a team of officers at Area level.

Tuesday

1. I attended, as a witness, an Area appeal. The need to educate members of health authorities came over to me very strongly. I think this is particularly an anxiety of nursing officers because when members fail to understand the significance of bad clinical practice then they must put at risk the care and treatment, if not the lives of patients. I suspect nurses have not been forceful enough in the wake of the new legislation to stress this view to Authority members.

Wednesday

1. A discussion session on the problems of joint consultation in our Area. These very political issues with no real solution are perhaps particularly frustrating to nurses and doctors whose background and training is to decide on a course of treatment and then move in with all guns blazing to sort the matter out. These issues which hit stalemate through the pig headedness of various people, I find very frustrating.

2. Designated officers meeting - this meeting includes senior staff at Area with the ATO. This is the second of these meetings I have been to and I have felt quite shocked at the intensity of the aggression and hostility towards some Area Health Authority members and CHCs. No wonder the service is in such a state if we fail to understand that many of us are trying to achieve the same ends even though we might use very different ways and means of getting there. Also what came over was the general demoralization of quite senior members of staff who felt dismayed over fairly small cuts in their own services. It is difficult to explain in any satisfactory way what the Area Health Authority was trying to achieve and while it's convenient to blame things on the government and its economy there are bigger issues and I feel that it's still possible to generate feelings of optimism and in fact genuinely to improve the standards of care despite cutbacks in real resources.

3. Seminar on primary care problems in London made me aware of my ignorance about primary care and again how difficult it is when inevitably representing the Authority from a fairly senior point of view you know that your knowledge is very, very incomplete.

Thursday

1. A planning group meeting spent considerable time on bids made, particularly from voluntary organisations, for partnership monies. I found it extremely difficult to assess some of these rather way out bids concerned with feminist movements, ethnic minorities etc. and yet it seemed to me that large amount of tax payers money was at stake and that money was available to be spent in an area of considerable deprivation.

Friday

1. A very interesting meeting to discuss the appalling relationships within one of our health centres. I found myself, yet again, faced with a situation where people were basically saying doctors are impossible to control and there is nothing we can do about either their behaviour or their clinical practice (or both) and therefore we are dependent upon the nurses behaving and performing in a very different way. Intellectually I accept the reality of this sort of situation and yet professionally I feel very angry about it and think that the whole issue of medical practice and medical power is one that must take a lot of senior nurses' time and perhaps again an area where considerable peer group discussion and exchange of ideas would be of value.

Week 7

Monday

1. At a meeting between the ATO and the Planning Team we considered how to spend £280,000 of the Area's discretionary money. We had received bids from the three districts and it seemed to me we overturned these entirely and put in totally different bids, ones I happen to feel in sympathy with, but I wondered how much time had gone on firstly in the districts and then with our own planning team producing lists which were of no use to us whatsoever. How also does one determine priorities in such circumstances?

2. Finance group meeting and callover raised again the question of how to provide information for AHA members. Having previously been an AHA member I used to feel very frustrated at receiving large amounts of information in a way which I did not find easy to digest or understand.

Tuesday

1. Liverpool seemed a long way to go to deliver a talk. In fact I found the journey (2 hours 40 minutes each way) extremely useful opportunity to catch up with background reading and produced a great bag full of reports and circulars and papers which I had managed to read. Maybe contriving reading time is very important.

Wednesday

1. A continuation of my orientation programme was to meet the Health Education Officer. Health education is something that should be fundamental to everything that we do and yet often I think senior people in the health service seem to hive it off as being the responsibility of the Health Education Department. The opportunity to have a real onslaught on some of the major health issues is open to us all in nursing and need cost almost nothing and yet somehow we never pick up the challenge.

2. My first meeting with one of our DMTs. I was quite horrified at what I felt was our weakness in the face of their polite (teaching hospital) refusal to consider complying with our Area Health Authority's priorities. Hopefully the next reorganisation will bring an end to this stupid monitoring role otherwise how to be effective while only a monitor would surely be a major training need.

3. I joined a training seminar for newly appointed consultants to put across a nursing viewpoint and several issues bothered me. Firstly the obvious lack of harmony in many places between nurses and doctors who really ought to be working in harness as clinicians in the service. Secondly the blindness and the

stubbornness of consultants in recognising the resource realities facing the service. It really is time that the medical members of management teams earned their vastly superior salaries by tackling the problem of their consultant and GP colleagues.

Thursday

1. A session with the three District Nursing Officers to prepare our ground prior to a meeting which we have asked to have as nurses with the recently appointed Chairman of the Authority. Quite a useful experience for us all who have to really think what are the crucial nursing issues in order to explain them to someone who really is a very lay member of the Authority.

Friday

1. Callover with the Chairman of the Authority led to a discussion on complaints. I feel very strongly that the average complaint in the health service is handled incredibly badly and that we usually produce the most defensive and argumentative replies. Another example of the failure of nurses to insist on their professional role when administrators consider that they are the experts in this. I think there is a real conflict between the administrative view which is particularly protective of any legal action which might be taken and what should be the nursing view which is a continuation of our caring role in the light of an obvious failure in our care.

2. An informal meeting with a nursing officer from the Department of Health about a major policy change over caring for the elderly. Even more at the Department than in my current job you have to consider what is the 'art of the possible' something I suspect that I am not very good at.

The first diary, kept for five weeks, assisted in identifying nine training needs:

1. Formal information

In a senior post one is more likely to come into contact with clinical areas, other disciplines, administrative and legal matters of which one has had no previous experience. It is not easy to obtain objective information.

2. Consensus management

Joining an existing team is quite different from being one of a new team established at the beginning of the service. It is hard to see how self training needs could be met in this aspect and, maybe, it is more the opportunity to discuss and consider one's role in a team.

3. Organisation of work

Opportunities to learn about systems of office and information management would be quite valuable.

4. The public role

Firstly there is the figure head role in terms of social functions, prizegivings, voluntary organisations etc. Secondly, the question of relationships with the media.

5. Personnel matters

With such a labour intensive service the whole question of good selection of staff is important at all levels. Training in selection is most important. Industrial relations training is similarly of great importance, perhaps by a 'case conference' approach to industrial relations issues and/or by a regular meeting with a small group of senior colleagues discussing actual problems and difficulties.

6. Monitoring standards of care

There has been considerable activity throughout the country since the publication of the Normansfield Report in 'monitoring' activities by senior officers and by authority members. It is very simple to go and visit and walk around a long stay unit but, it is much harder to devise a way of doing this which is a satisfactory way of monitoring standards of care and yet which enables the majority of the staff in the institution to feel supported. This difficulty is at its greatest in the context of monitoring but, in fact, visiting any clinical area is not an easy task in terms of communicating with patients and staff in the most important ways.

7. Preparation and briefing

Time spent thoroughly discussing matters with one's colleagues before entering a controversial meeting or a public meeting is extremely valuable and yet it is difficult both to devote the time and the importance to this and also to prepare oneself in the best way for the sort of questions and difficulties which might arise.

8. Medical politics

The strength of medical political power in a 'teaching authority' was quite different from a non-teaching authority. There is a need to share these kind of problems with peers.

9. Staff morale

The leadership role of teams of officers is probably underplayed and yet is extremely important. There is certainly a need to talk through and consider and learn how to be sensitive and responsive to this neglected aspect of the role.

These reflections are reproduced for interest and consideration as to whether there is some way in which orientation might be arranged before doing the job. Certainly there is strong argument for helping new appointees identify gaps and ask for the appropriate learning experience.

It will be noted that there are many points overlapping those already discussed in the section on 'Identification of individual needs in planning management education' but one that is emphasised here relates to management visiting clinical areas. Visits may be multi-purpose but objectives need deciding and careful planning. Monitoring, unfortunately, seems to be a management tool not well understood nor efficiently used in the NHS and one which could be used for a variety of purposes with effect.

There are many common denominators to be found within the preceding papers. For example, the need for senior nurse managers to obtain social and political skills which will give them confidence and assertiveness when dealing with other disciplines. They must be provided with knowledge of the politics, strategies, tactics and logistics necessary for effective operation in a political institution, when the environment consists primarily of other political organisations.

What knowledge may be offered in formal study?

How does this help in achieving confidence?

The group discussed a management studies course offered at the University of Edinburgh and related the content with subsequent experiences of one of the first students on the course:

REFLECTIONS - FROM MASTERS COURSE TO SECOND-IN-LINE AREA POST

Month 1

Felt very apprehensive as I arrived at the office to take up a post which was, in spite of close study of the job description an unknown quantity in terms of experience or observation. My apprehension deepened when I found in my office a list of meetings which I would attend on a regular basis - some of them, fortunately, on a quarterly basis only. Some of the names meant nothing to me and having to seek

elucidation of e.g. CRASH (Consortium for the Relief of the Adult Single Homeless) did nothing for my morale. An orientation programme had been arranged which stretched over the first three weeks of the month but did not occupy all my time. Basically this consisted of meeting people within the Board Office and visiting the psychiatric hospitals and units with the Chief Area Nursing Officer (CANO). The assumption was made, wrongly, that I would be familiar with the geriatric services which are provided in twenty three sites in the city.

I found myself taking at least one file home every night in order to prepare myself for a meeting next day, largely because of the redevelopment of our old psychiatric hospitals and planning of new geriatric and psychiatric accommodation. I felt very thankful for the planning elements in the course I had just completed. Overall impression at the end of the month was that in spite of the voluminous files on all of these projects, I still found that the reasons for decisions taken were not clearly stated and that all the early meetings started with MY question time.

Month 2

Entire first week of this month taken up with the Scottish Hospital Advisory Service (SHAS) visit to all geriatric services in Eastern District - an illuminating experience as I had no previous contact with SHAS except reading their reports. Impressed by depth, breadth and thoroughness of the investigation carried out by the team but feel that some of their criticisms and recommendations are a bit unrealistic. Felt fortunate in that having worked in the Eastern District prior to going to Area I knew places and people fairly well, though saddened a little by the realisation that to some people I was now one of 'them'.

Threat received from neighbouring Health Board Consultant Psychiatrists that psychiatric services traditionally provided by them to part of my Health Board population would cease on a specified date. Discussion started on rationalisation of catchment boundaries within the Area.

Attended my first meeting of Education/Social Work/Health Board Liaison Group, and felt rather horrified at the level of discussion. Social work boundaries are different from ours, producing some difficulties about who liaises with who, at fieldwork level. Much discussion at various meetings during the month on the 'Timbury' report - recommended that Health Board should use one of the crash programme 30-bed units in this way on an experimental basis. The threat to the psychiatric services was removed, at least temporarily, by a letter received from the Secretary of the previously mentioned Board which said the withdrawal of service would take place only after consultation - strong feelings that games are being played at various levels and between a number of groups. Contributed to a psychiatric policy paper (much wider than catchment area question) which was submitted to Policy and Planning Committee.

Month 3

Beginning to get the feel of the Health Board - there is still a good deal of nostalgia for the Western Regional Hospital Board among the Board staff on the administrative side. Possibly some justification for this feeling that planning was more effective on a larger scale when the dispute over psychiatric boundaries is considered, bearing in mind that Board staff would not see or experience the disadvantages of the tripartite system. The CANO and two of the other ANOs have community backgrounds but the staff here are still very hospital orientated.

The consultative documents 'Structure and Management of the NHS in Scotland' and 'Patients First' (nice snappy title) appeared, causing consternation all round. I have been aware of some territorial defensiveness among the DNOs (except one) since starting here, now intensified. Consultation machinery established - a sub-committee of the Board to start taking evidence from Districts and other interested parties. Should ANOs produce a paper for submission?

Two of the 30-bed units are handed over this month and four wards adapted from maternity to geriatrics used for transfer of patients and staff from a hospital which is scheduled to close in 1981.

Month 4

'Structure and Management' continues to cause high feeling, though soon superseded by the report of the Clegg comparability study. Strong feelings among my colleagues that any credibility ANOs had depended on salary levels, since this work does not have high visibility and that this has now been destroyed. Find myself becoming more deeply involved and interested in planning, probably feeling that this is a concrete investment in the future which removes me to some extent from the 'aggro' all around at present. A major constraint which I had not anticipated and, for which I doubt if I could have been prepared, is the fact that two of our psychiatric hospitals, both overdue for major redevelopment, have between them three listed buildings which are a planner's nightmare.

Have been co-opted on to a working party of the National Nursing and Midwifery Consultative Committee (NNMCC) to comment on a draft report from the Mental Health Programme Planning Group on the future of psychiatric services in Scotland. Torn between feeling that it is useful to have members of the group who produced the report present in order to explain the thinking behind some of the recommendations and feeling that their defensiveness over any criticism made is counter-productive.

Month 5

Invited the District In-service Education Officers to send representatives from each District to review a geriatric care training kit which had been issued by the Scottish Home and Health Department (SHHD), in order to ascertain whether NOs would find it useful in the clinical areas. Good response - about fifteen at each showing.

Spent most of the first two weeks starting off a replication study on the Process of Nursing in one psychiatric hospital, by issuing and explaining 200 questionnaires to staff. Enjoyed getting to know the staff a little better and exploring the practice of psychiatry in this hospital.

Had two fascinating weeks leave in Israel which included being disappointed by headlines in the Jerusalem Post 'Govt cuts health budget by 6%' (might as well be at home); made envious by 'Eron', a psychiatric crisis intervention service-phone numbers publication (nothing like this in Scotland), and being rather excited by being at Ben Gurion airport on the way home when the Egyptian and Israeli Ambassadors met. Found an 87% return of the questionnaires awaiting me which was nice, and a tragic event involving a patient in one of our psychiatric hospitals, which wasn't. This may well be the stimulus for a full-scale enquiry, which we have so far managed to avoid.

Month 6

Most exciting happening this month is the formation of a psychiatric policy group of Board officers to work on strategies for implementation of the policy document recommendations - my opposite number a Community Medical Specialist (CMS), an administrator, an accountant and myself, with input from the information services CMS, as necessary. It seems that nothing like this has happened before in our Health Board so must try very hard to make it work.

We appear to be approaching the end of the financial year with overspending of the order of two million so efforts are being made again to identify means of saving on revenue expenditure. Visited three small hospitals in need of major repair in one District, to see whether redistribution of beds and possible closure of one or more would reduce costs. Find myself very ambivalent - it would certainly make financial sense to close at least two of them but, the loss of the homely atmosphere and local community involvement can't be put into money terms. Evidence coming in on re-organisation appears to be strongly in favour of retention of the District level of management, and some suggestion is made that Area is unnecessary, in spite of the clear direction in 'Structure and Management'.

Looking back over these six months I'm still undecided whether this has been the right move for me. The most enjoyable events have been those in which I reverted to my teaching capacity - invitations to speak on In-service Education programmes, Community Services Agency management courses, etc. I'm still convinced that nurses should be involved at the highest levels of administration of the NHS but one of the difficulties in this Area is convincing other people of this need,

particularly doctors and administrators. I get very frustrated at the low priority given to psychiatric services by members and officers of the Board and, despair of getting some of our decision-makers to understand that we have progressed beyond 'abandon hope all ye who enter here'.

Comment

On reflection the student agreed that she had been prepared for the job description. The planning and development elements of the post had been well covered but the psychological preparation was not and could not have been planned. Initially she had received support from a colleague she had known for sometime. This seems to underline the concept that education must continue or take place after the appointment to a post. A preceptorship attachment, outwith the place of employment, might be a useful consideration.

EXPECTATIONS OF SENIOR NURSE MANAGERS

It is reasonable to assume that staff expectations of the role of senior nurse managers are demanding and divergent. A subjective view of the role of the district nursing officer was examined, as seen from senior nursing officer level.

ROLE TASK AS DEFINED IN 'GREY BOOK'	SKILL REQUIRED	KNOWLEDGE REQUIRED	COMMENT ON OBSERVED EFFECTIVENESS
Manages : 1. Integrated community and hospital nursing services	Co-ordinative	Function - general Problems - objectives of specialties in district	Bias generally evident dependent upon past clinical experience, i.e. hospital and community.
2. Nursing budget	Interpretive Financial - some Mathematical	Funding processes Budget requirements	Extreme minute control to a very time consuming extent.
3. Assesses nursing needs	Analytical	Actual need of client groups	Dependent upon feedback abilities of SNO/Div NOs. Problems in relating available resources to actual needs.
4. Controls nursing performance	Behavioural	Related to those of personalities dealing with actual plans	Poor area of management, some fear of confrontation.
5. Deploys against approved plans	Manpower planning	Manpower information	Other than operational plans - ongoing objectives in quantified terms sadly lacking.
6. Initiates formulation of nursing policies. Maintains surveillance and evaluates effectiveness	Motivational Evaluative Observational	Objectives to be met by initiation	First aspect developed well. Latter aspects, especially evaluation - poor.
7. Ensures co-ordination of nursing services with nurse education	Co-ordinative	Nurse education programmes/service needs	Generally achieved although not always achieving a balance between need of service and education.

8. Identifies opportunity to improve quality of nursing services and care	Observational Analytical	Desired quality - quantification tools	More subjective than objective although quantification techniques are rapidly developing.
9. Ensures appropriate use of personnel services by nursing managers	Persuasive Counselling Evaluative	Services available Abilities of nurse managers	Developed well especially those industrial relations related. Ongoing training opportunities not as well developed. This area sometimes compounded by DNO's own 'personality'.
10. Ensures effective operation of staff appraisal and training schemes	Developmental Educational Evaluative	Appraisal scheme in use Other methods available Training tools/ Development tools available	'Lip service' only paid to this area. Generally failure in evaluation of training activities. Poor use made of organisational opportunities.
11. Provision of career development	Developmental Educational Evaluative	Opportunities within own area - opportunities generally	'Lip service' only paid to this area. Generally failure in evaluation of training activities. Poor use made of organisational opportunities.
12. Investigating nursing aspects of accidents	Analytical Behavioural	Circumstances of accident or complaint	An area of routine tasks performed as and when necessary.
13. Participates in development or corrective action in respect to (12.)	Strategic	Effects of strategy	Generally this involves a directive to 'do something'.
14. Establishes and reviews links with CHC and voluntary bodies	Diplomatic Oratory Persuasive	Role - function and contribution of appropriate bodies	Links are generally already established-some professional protection evident.
15. Ensures the provision of support services for nursing	Corporate Political Communicative	Support required - feedback of effect on provision/lack of provision	An area where it is not evident to others that this is a task that is consciously undertaken unless where crises occur.

ROLE TASK AS DEFINED IN 'GREY BOOK'	SKILL REQUIRED	KNOWLEDGE REQUIRED	COMMENT ON OBSERVED EFFECTIVENESS
Manages:			
16. Advises on implications of service proposals for nursing	Communicative Analytical Manpower planning Corporate	Service proposals	This task is evident in performance of DNO role - however adverse and probably more subjective than objective.
17. Maintains professional standards and quality of care of patients	Decision making Observational Objectivity Communicative	Required standard and quality of care Available tools of quantification	DNO identified as professional head for this purpose within team - subjectivity generally the rule - differences within profession as to whose 'real' role this is.
18. Participates in formulation of district plans	Planning Corporate	Planning system - objectives of health district	An area well established.
19. Establishes priorities	Communicative Decision making Objective setting	Objectives to be met Available resources	Priorities change, depending upon other needs. Shortage of explicit objectives.
20. Identification of nursing needs in light of service and educational requirements	Analytical Interpretive	Requirements to be met	Needs of nursing and requirements of service and education not always compatible - not well managed.
21. Ensures participation of nurses in multi-disciplinary team working	Communicative	Team working Ability of proposed participant	Very poor briefing of members serving by DNO (or others). A poor area of communication.

Comment

It will be noted that the role task has been quoted from the Management Arrangements for the Reorganised National Health Service (1972), although it seemed a sterile anomaly to spell out roles before they were established and this may well underline the need to examine the role of senior nurse managers more scientifically through formal research findings. It is important to recognise that senior nurse managers should not feel that they are poor substitutes for professional administrators. They should not feel guilty, nor concern themselves too much with the minutiae of long term planning but have a global view of convergent perspectives and the day to day priorities which may be expanded into whole concepts. There are political variables, statutory and otherwise which require skilful manipulation and the recognition/handling of such problems could well be explored in training.

The need to identify the unique professional role of interpreting nursing to other team members is paramount and this implies definite continuing professional education but little has been done to meet this. The clinical practitioners must be reassured of the accuracy of this interpretation to the management team and some form of self-monitoring is required where problem-solving is seen as an emerging process that prevents the status quo and involves the expectations of others. Sharing problem-solving situations with immediate subordinates, ensuring they are informed and discussing career development is essential in a leadership role. This requires an underlying knowledge of transactional analysis and counselling.

THE ROLE OF PROFESSIONAL ADVISORY MACHINERY IN NURSING MANAGEMENT

Industrial democracy demands participative management but nurses harnessed to a hierarchical system have been ambivalent towards this type of initiative. One of the group had examined the machinery set up to enable such an approach in 1974/75 and supplied the following paper which pertains to England and Wales.

Background

Prior to 1974, little or no advisory machinery for nurses existed in the NHS, certainly not at grass roots level. The terms of reference in the model constitution issued at the end of 1973 used the expression (in connection with the authority which the committees were to have) "to advise the Authority and its Nursing Officer in any matters it thinks fit" connected with professional nursing. These committees were to operate at statutory authority level (i.e. Region and Area) and the Authorities were asked to recognise them formally.

Apart from isolated elements of allowing clinical nurses to participate in decision making which happened prior to 1974, the only advisory mechanisms were at national level, with the Standing Nursing and Midwifery Advisory Committees. These consisted of appointed members from England and Wales and at local level, groups of Matrons (prior to the implementation of the Salmon recommendations), meeting together to advise their Hospital Management Committees or Boards of Governors, where more than one Matron was in post, in say, a large group of hospitals under the same governing body.

Not only was the notion of grass roots advice new, it was to a large extent unexpected and in some quarters - usually senior nursing management - very unwelcome. It should also be said that it was greeted with puzzlement and sometimes apathy by the grass roots nursing staff themselves. The original members of the local (Regional and Area) committees set up in 1974 were chosen by nursing management and elections were planned to take place subsequently.

Structure and Working of the Committees

It cannot be said that the committees have caused more than a ripple, either within or without the profession. Apart from this writer's study in 1975 the National Steering Committee knows of no other work which has been undertaken to study the effectiveness or compare/contrast the new participation mechanism in nursing. There have been two occasions in the past six years when local committees have been asked to communicate with the National Staff Committee (NSC) regarding their problems and progress. The most recent occasion was prompted by the publication of the Government Consultative Paper 'Patients First'. The document referred to the need to review the advisory machinery generally (perhaps taking its cue from the Report of the Royal Commission on the NHS published in 1979).

The present review has generated a significant response which was analysed in the summer of 1980. The NSC are planning to organise a seminar at which members of committees and Regional, Area and District Nursing Officers will be invited to discuss certain key areas with regard to enabling the committees to achieve maximum effectiveness. Such discussion will include:

1. Elections and whether they are appropriate and cost effective.

2. Administrative support for the committees.

3. Communication by the committees with the Authorities (and their Nursing Officers) on the one hand and with their 'electorate' on the other.

4. The political impact which the committees themselves are beginning to be aware of; especially the relationship between the Advisory Committees and nursing management. This includes such questions as how the one can best support the other and how political 'clout' and pressure can be fostered for professionalism in nursing.

N.B. Very few problems of confusion in roles of the committees concerning conditions of service matters have apparently occurred.

5. The draft new model constitution will be available for comment. The aim will be to allow more local flexibility based on certain principles which the constition will contain.

Conclusion

The possibilities for really effective participation by all grades of qualified nursing staff (and students) and yet for nursing management to have a valuable asset seem clear. It is equally interesting to speculate on why such minimal impact has been felt in the service so far. One thing is clear from the present feed back being received by the NSC; this is that the profession (in the shape of the staff organisations) and the committees themselves, wish the notion of greater participation to be furthered. The question to be faced is how this can best be achieved.

Comment

The main issue highlighted by this material is the need for nurse managers to appreciate the way in which such groups might be used to advantage. Paradoxically, they may be interpreted to have both task force and advisory roles, yet their importance as committees that advise Health Authorities must not be forgotten. They provide a forum for nurses to represent their views, which in itself is excellent education; but which may constitute a threat to management because they focus on concerns that management should have identified previously. However, the capacity of advisors to earn the right to share in decision-making depends on their ability to fit in with the organisation and to understand its requirements and problems. Advisory machinery could be a way of providing an awareness of the many facets to the system, as well as a focus for fostering a climate of optimism by managers. Herein lies the nub of the managers responsibility - to provide a method by which solutions to problems may be identified on the 'shop floor'.

Peer group examination is usually better received than solutions imposed from above and the involvement of nurse clinician with nurse manager should contribute to effect change and allow more accurate information and more variables to be considered at multidisciplinary level. Nurse management needs practitioners who are able to speak advisedly.

5. PREPARATION OF SENIOR NURSE MANAGERS

When the working party under the chairmanship of Dr Brian Thwaites produced its report in 1977, it was given the title 'The Education and Training of Senior Managers in the National Health Service'. It must be pointed out, however, that there is by no means a consensus of agreement regarding the meaning of or use of these terms. The major distinction as seen by educational philosophers lies between the breadth and understanding characteristic of education, and the more limited, specific nature of training. 'Education implies that a man's outlook is transformed by what he knows'. (Peters 1967) Training, according to Peters, always suggests confinement, and he elaborates the indications for it:

a) When there is some specifiable type of performance that has to be mastered.

b) When practice is required for the mastery of it.

c) When little emphasis is placed on the underlying rationale.

The current position with regard to the use of the terms education and training has been summarised as follows: 'Those working in educational institutions have become very sensitive to the difference between working towards the concept of the 'educated man' and having more limited and specific goals, for which they use the term training. We distinguish between educating people and training them because for us education is no longer compatible with any narrowly-conceived enterprise'. (Hirst and Peters 1970)

Thus, we prefer to use the term 'preparation' and, take this to include education, training and life experience.

SELECTION OF SENIOR NURSE MANAGERS

Any exploration of the preparation of senior nurse managers must, of necessity, include the crucial area of selection, since preparation needs cannot be seen in isolation from the personal capacity of the individual manager. Over the course of the peer group, a range of

qualities have been identified as being desirable in any senior nurse manager. Personal warmth, sensitivity and compassion are invaluable qualities when dealing with people, whilst a sense of humour is a great asset in any aspect of management. Great leaders are invariably referred to as 'charismatic' but the importance of this quality in any leadership role should not be overlooked, since it has direct bearing on the influential and persuasive skills so useful in senior nurse management.

Self-awareness and self-confidence are qualities which enable the senior nurse manager to admit that he or she was wrong about an issue, without feeling loss of status. They also facilitate delegation with confidence and trust and make it much easier to contact other senior professionals for informal discussion about problems or issues.

The identification of personal qualities on paper is a simple enough exercise but serious problems emerge when attempting to use them as components of a selection procedure. How are such qualities to be identified in a candidate? Indeed, are we even sure that one person's perception of constructs like warmth or charisma is similar to another's? We feel that there is insufficient knowledge about the whole process of selection for senior nurse management and strongly recommend that serious attention is paid to it as an urgent priority.

IDENTIFYING PREPARATION NEEDS

A number of preparation needs have emerged repeatedly in both group members' papers and in subsequent discussion and, not surprisingly, they are similar to the lists of 'training needs' commonly identified in management textbooks. It must be recognised, however, that within any such list there will exist certain priorities which are more important to some management areas than others. In the case of senior nurse management we have identified several preparation needs which we consider to be of high priority and these are outlined below.

Leadership Skills

The importance of leadership in any organisation is well documented and studies indicate that there is no single personality automatically associated with leadership. Rather, it is very much the interaction

between the personal qualities of the individual and the task of the group. Nevertheless, it is possible to prepare some individuals for a leadership role and this is particularly pertinent to senior nurse managers, since their role involves leadership of the profession as well as of the organisation.

Group Interaction Skills

These include knowledge of the dynamics of group interaction and the skills necessary to function efficiently in group settings. Familiarity with techniques such as transactional analysis can be useful in providing insight into interaction in team situations and industrial relations negotiations. The ability to be assertive without being aggressive is an invaluable skill, in that rights can be upheld without becoming emotional or judgemental. The advisory and consultancy role of the senior nurse manager requires counselling skills for its effective execution and, in addition, it must be emphasised that political skills are an acceptable and necessary part of this role.

Setting Goals and Priorities

This consists very much of balancing and reconciling the values and aims of the organisation with those of nursing and related staff, and this in turn requires sound conceptual skills and the ability to monitor standards effectively.

Increasing Conceptual Skills

It has been pointed out earlier, this is an essential aspect of the senior nurse manager. The term 'fluid inquiry' implies encouragement of conceptualisation and the art of inquiry, whereas, 'stable inquiry' denotes adherence to procedure books as a guide to practice. We concur with Thwaites that increasing conceptual skills are gained mainly from experience of higher education.

Knowledge of Communication Networks

Whilst accepting that communication skills per se are vital for the senior nurse manager, we feel that it is also important to emphasise the vital nature of communication networks. Possession of this knowledge will ensure that a minimum of delay or misinformation occurs within the organisation.

SOME STRATEGIES FOR MEETING PREPARATION NEEDS

Whilst accepting that responsibility for management curricula rests mainly with the institutions concerned with teaching them, we have, nevertheless, identified some strategies which should be useful in such curricula. Our experiences in the peer group over the past 15 months have highlighted the importance of having opportunity to meet and discuss mutual problems and issues with peers. We are suggesting that the use of management peer groups could lead to greater job performance and satisfaction within the organisation.

A number of peer group members have kept diaries of their daily activities, finding this a useful exercise from the point of view of self-evaluation. A great deal can be learned from the careful analysis of one's own diary, particularly for evaluating management actions and decisions in the light of their subsequent effectiveness.

Preceptorship programmes could provide another strategy for meeting preparation needs. This kind of programme involves a planned one-to-one pairing of a new appointee with a carefully chosen mentor who has worked successfully in a similar senior management position. Such a mentor in nurse management would be a person who is expert in health care delivery, and has shown excellence in management, teaching ability and community leadership. This pairing involves not only observation by the appointee, but a planned two-way exchange of approaches and evaluation. Ideally the nurse selected to act as a preceptor would have the ability to integrate education and work values so that realistic strategies for resolving conflict could be developed. Such a relationship would allow the new appointee to work and identify with a competent role model who is involved in the daily decisions and processes of corporate management and able to find job satisfaction rather than frustration within the role. This would give opportunities to identify experiences which the new appointee lacks or in which she needs more exposuré and provides space for discussion on topics pertinent to her current activities.

This increases the relevance of the information received and its retention as well as shifting the orientation responsibilities to the preceptor. These responsibilities should include planning, teaching

and modelling for and evaluating the work of the appointee. The preceptor should be an outside arbiter as there needs to be freedom for honest discussions and analysis in a situation where the 'boss' relationship is not threatening. Such role models will be few and raises the question of who will select them.

At the University of California, San Francisco, preceptor is an academic title awarded to 'clinical professors'. Candidates are rigorously selected and normally hold positions of director of nursing. Nursing administration students are attached to them during their fieldwork experiences. Preceptors receive all academic 'perks'.

It is interesting to note that the National Nursing Staff Committee (1980) are now appointing 'facilitators' who will have a role very similar to preceptors.

In the previous section on identifying preparation needs, a whole range of interpersonal skills were outlined. Most of these skills cannot be gained from traditional didactic courses but must be experienced first-hand in various types of group based activities. For example, encounter groups, T-groups, assertiveness training groups and transactional analysis groups.

So far we have omitted to include any reference to formal courses in higher education. However, we feel that these have an important part to play in preparation for senior nurse managers by helping to develop conceptual skills.

Provision of on-the-job experience, but in a wider role than the line posts, may help the new appointee to develop greater awareness and confidence in his or her new role. For example, a staff post for a limited period could provide experience of counselling, acting-up for senior officers and general 'problem-solving' on a day to day basis, all of which would be invaluable to him or her on returning to the line post.

6. REFERENCES USED IN THE COURSE OF DISCUSSION

BAILEY, June T. and CLAUS, Karen E. Decision making in nursing: tools for change. Saint Louis, C.V. Mosby, 1975. pp. ix, 167.

BENNER, Patricia and BENNER, Richard. A troubled sponsorship: the new nurse's work entry. New York, Tiresias Press, 1978.

BLENKINSOP, Dorothy. Nursing within the reorganised health service. Queen's Nursing Journal, vol. 17, no. 12. March, 1975. pp. 261-262.

CHATER, Shirley S. A conceptual framework for curriculum development. Nursing Outlook, vol. 23, no. 7. July, 1975. pp. 428-433.

CLAUS, Karen E. and BAILEY, June T. Power and influence in health care: a new approach to leadership. Saint Louis, C.V. Mosby, 1977. pp. xii, 191.

CLAUS, Karen E. and BAILEY, June T. editors. Living with stress and promoting well-being: a handbook for nurses. Saint Louis, C.V. Mosby, 1980. pp. xii, 175.

CLAY, Trevor. The role of nursing and midwifery advisory committees in the reorganised National Health Service (PhD thesis). Uxbridge, Brunel University, 1976.

DARBY, Caroline. A lonely life at the top. Nursing Mirror, vol. 148, no. 17. 26 April, 1979. pp. 22-24.

DARBY, Caroline. A man in the middle. Nursing Mirror, vol. 148, no. 18. 3 May, 1979. pp. 21-23.

DAVIES, Celia. Re-writing nursing history. London, Croom Helm, 1980.

EDWARDS, Elizabeth A. The nursing service in North Lothian. Nursing Mirror, vol. 146, no. 19. 11 May, 1978. pp. 21-23.

FROST, W. NHS reorganisation from the point of view of nursing. Midwife, Health Visitor and Community Nurse, vol. 12, no. 12. December, 1976. pp. 397-400.

GRAVES, Desmond. The manager's job and management development. Personnel Review, vol. 5, no. 4. Autumn, 1976. pp. 11-16.

GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Management arrangements for the reorganised NHS. London, D.H.S.S., 1973. pp. 1-16. HRC(73)3.

GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Management arrangements: nursing and midwifery management structures. London, D.H.S.S., 1974. pp. 1-8. HRC(74)31.

GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Review of top posts in the National Health Service. Report to the Whitley Councils. (Chairman, A.J. Speakman.) London, D.H.S.S., 1979. pp. 81.

GREAT BRITAIN. MINISTRY OF HEALTH and SCOTTISH HOME AND HEALTH DEPARTMENT. Report of the committee on senior nursing staff structure. (Chairman, Brian Salmon.) London, H.M. Stationery Office, 1966. pp. vi, 205.

GREAT BRITAIN. PARLIAMENT. Report of the committee of inquiry into Normansfield Hospital. (Chairman, Michael Sherrard.) London, H.M. Stationery Office, 1978. pp. xiv, 464. Cmnd 7357.

HIRST, P.H. and PETERS R.S. The logic of Education. Routledge and Keegan Paul, London, 1970.

HOYLE, E. Problems of curriculum innovation. Bletchley, Open University Press, 1972.

KING EDWARD'S HOSPITAL FUND FOR LONDON. The education and training of senior managers in the National Health Service - a contribution to debate. Report of a King's Fund working party. (Chairman, Dr Bryan Thwaites.) London, King Edward's Hospital Fund for London, 1977. pp. 100.

KING EDWARD'S HOSPITAL FUND FOR LONDON. KING'S FUND CENTRE. The education and training of senior nurse managers in the National Health Service: a report of a two day seminar to study the Thwaites Report, held at the King's Fund Centre on 27 and 28 June, 1979. London, King's Fund Centre, 1979. pp. 15. KFC 79/179.

KRAMER, M. and SCHMALEMERG, C. Path to biculturalism. Wakefield, MA., Contemporary Publishing, 1977. pp. 23.

LANCASTER, Arnold. Nursing and midwifery source book. London, George Allen and Unwin, 1979. pp. xiv, 289.

MARGERISON, C. How bosses grow successors. Management Today, August, 1980. pp. 21-25.

MOORES, Brian. Making use of the tools which are available. Health and Social Service Journal, vol. LXXXX. no. 4691. 2 May, 1980. pp. 578-582.

NATIONAL TRAINING COUNCIL FOR THE NATIONAL HEALTH SERVICE. Management education and training in the National Health Service. London, National Training Council, 1979. pp. 17.

Nurses and the new health service: details and aims of the reorganisation. Nursing Times, vol. 68, no. 37. 14 September, 1972. pp. 1166-1168.

Nurses in the new NHS. Regionwide, no. 5. December, 1972. pp. 1 and 4.

OWEN, J.L. A national trainee in the RNO's office. Hospital and Health Services Review, vol. 75, no. 2. February, 1979. pp. 48-50.

PETERS, R.S. The concept of education. Routledge and Keegan Paul, London, 1967.

ROYAL COLLEGE OF NURSING OF THE UNITED KINGDOM. Standards of nursing care: a discussion document. (Chairman, Miss S.M. Quinn.) London, R.C.N., 1980. pp. viii, 22.

SCHWAB, Joseph. Structure of the disciplines: meanings and significances. FORD, G.W. and PUGNO, L. editors. Structure of knowledge and the curriculum. Chicago, Rand McNally, 1964.

SLATER, Carl H. editor. The education and roles of nursing service administrators: a collection of papers from three conferences. Battle Creek, W.K. Kellogg Foundation, 1978. pp. 103.

SMITH, James P. Nursing managers need education too. Journal of Advanced Nursing, vol. 5, no. 3. May, 1980. pp. 243-244.

SMITH, James P. The functions of the nurse in an integrated National Health Service. Journal of Advanced Nursing, vol. 4, no. 4. July, 1979. pp. 439-452.

SPEAKMAN, Jim. Some views on nursing management. Nursing Focus, vol. 1, issue 1. September, 1979. pp. 13-14.

STEWART, Rosemary. and others. The district administrator in the National Health Service. London, King Edward's Hospital Fund for London, 1980. pp. vi, 212.

WHITE, Don. Management development: problems and progress, Nursing Focus, vol. 1, issue 9. May, 1980. pp. 354-356.

7. A P P E N D I X I

EDUCATIONAL RESOURCES: provision and take-up

At the moment there are broadly two forms of management education available to nurses. There is that which the nurse follows in a completely voluntary capacity and that provided under the auspices of the Department of Health and Social Security in the form of first-line, middle and senior management courses.

We examined the situation with respect to 'voluntary' pursuit. In order to ascertain the extent to which qualified nurses had availed themselves of opportunities to acquire formal management training we wrote to all those university departments which offer postgraduate courses in management or business studies and to all polytechnics and other further educational institutes offering the Diploma in Management Studies (DMS). This latter is a course embarked upon annually by some 4000 students, 12% of whom follow it on a full-time basis for a year. Most (60%) are, however, registered on a combination of day release and evening study and some 18% on a completely part-time basis of two evenings per week over a three year period. Dealing with this qualification first, replies were received from 28 of the 66 institutions empowered to award it. Not all were able to provide information relating to the full history of this involvement but the best estimate possible is that over the past five years 39 nurses have secured the DMS qualification on a part-time basis. In addition to the 'routine' DMS two institutions - the Thames Polytechnic and the Polytechnic of Wales awarded a DMS with a Health Service orientation. The average annual intake of nurses to these two courses taken together is close to ten.

When we considered the Master's degrees we noted that with the exception of the Henley/Brunel programme, which averages one full-time and one part-time nurse registrants, the scene is almost exclusively the province of Edinburgh University, which offers an M.Sc/Diploma in Nursing Administration, the Institute of Health Studies at Hull with an M.Sc, and Aston with a one year course which started as a Diploma in Nursing Administration in 1967. In 1969 this became a Diploma in Health Service Administration and in 1976 it was accorded M.Sc status (Public Sector Management/Health Services Option). Edinburgh and Hull produce around six and two graduates per year whilst Aston has, over the fourteen years, produced ten each year.

Thus the overall picture would appear to be that some nineteen nurses procure a 'postgraduate' management qualification each year at the reporting institutions on a part-time basis. The corresponding figure for full-time registrants is also nineteen. It is unlikely that any of the non-reporting institutions would boast figures close to those prevailing in the few dominant institutions. Overall, therefore, one must conclude that out of some 14000 nurses qualifying annually less than 50 elect to secure a qualification concerned with management.

In view of the emphasis upon the place of management in nursing and the fact that in excess of 9000 SRNs hold position above the grade of ward sister, such a relatively low take-up rate provides food for thought. Does it indicate that the skills and knowledge to be acquired on such courses are perceived to be irrelevant? Are they thought to be too orientated to industrial/commercial organisations? Does the average nurse manager not feel the need for such concepts? Clearly, a substantial research project would be required to answer these and a host of other questions. It appears clear from the figures that if the course is seen to be health related then it attracts applications from nurses in more substantial numbers. A traditional school of management education thinking would hold that this specialisation could lead to the elimination of an integral feature of management courses, namely the cross-fertilisation of ideas from different sections of the economy and different functional specialists. An equally powerful argument would be put forward supporting the specialised approach based upon the proposition that a number of management concepts can be better understood in context.

Perhaps the future lies in programmes which combine the two approaches. Certainly, one inevitable development in this field will be the increase in part-time Master's programmes in management which are already offered at several universities. The combination of day release and evening study appears to satisfy the employee that his employing authority feels that the activity is sufficiently valuable to warrant time off and likewise the evening commitment serves to indicate the employee's motivation. This will undoubtedly be the growth area in the 1980s and the universities will naturally be looking to large organisations such as the NHS for recruits to these programmes.

Many institutions are making it easier for non-graduates to follow Master's programmes, a key element in the selection process being the possession of a respectable score on the Graduate Management Admission Test (GMAT). It is to be hoped that a few of these institutions might see their way to offering a programme featuring a combination of general and special study which would be perceived to be of value to an aspiring nurse manager.

8. A P P E N D I X II

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