KING EDWARD'S HOSPITAL FUND
FOR LONDON

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London, W.2.

Memorandum on Nursing Establishments

ROYAL COLLEGE OF NURSING
AND NATIONAL COUNCIL OF
NURSES OF THE UNITED KINGDOM

Henrietta Place London W.1

MEMORANDUM
ON
NURSING ESTABLISHMENTS

Report of a Joint Working Party
of
The Royal College of Nursing
and National Council of Nurses of the United Kingdom
and
The Hospital Centre
King Edward's Hospital Fund for London

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NURSING

King Edward's Hospital Fund
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WORKING PARTY ON NURSING ESTABLISHMENTS

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MEMORANDUM ON NURSING ESTABLISHMENTS

INTRODUCTION

1. This memorandum has been written as a guide to all those interested in hospital administration who may be involved in deciding their own hospital's requirements, and is intended to remind readers of points that must not be forgotten. However, it must be emphasized that it does not attempt to produce any quick and easy formula as an answer to the staffing problem of any one hospital. There is as yet no known answer to the often repeated question put to all nursing and hospital administrative organisations: "How many nursing staff do we require in this hospital group, hospital, ward or department?" Every hospital differs from every other in the services it offers to the public; it is in a different geographical environment; it caters for differing social groups and is differently planned, constructed and equipped. The staff which is obtainable and acceptable in quantity and quality at one hospital is unlikely to satisfy the requirements of another. Each hospital authority must therefore determine its own nurse staffing in relation to other requirements in the light of its environment, its design and the services it wishes to offer to the public.

2. Over the past ten years studies have been reported* which have attempted to analyse the nursing requirements of patients and the work of the nurse in the ward. Some research workers believe the answer lies in the number of hours of nursing the average patient requires in 24 hours; others in how nursing can be divided into basic, technical and ward organisation; and again there are those who like to divide the patients into groups, such as bedfast, ambulant and convalescent. None of these studies gives the complete answer. In deciding the needs of the few—perhaps a ward full of patients—the needs of the whole hospital may be overlooked. Fundamental problems may not have been taken into account; for instance, the requirements of nurse-training, differing size of wards, and the need to maintain adequate nursing cover for the whole hospital for 24 hours, especially during the night.

3. We advise our readers to look first at the national picture; the number of patients to be nursed in hospitals together with the number and quality of nursing personnel available throughout the country.

* See Bibliography (Page 31).

We would suggest following this with a study of the situation of the hospital within its own Regional Board area before having a close look at the local geographical and social environment of the group in which the hospital stands. Having put their own hospital into perspective, readers are then ready for a more detailed study of the hospital itself and the particular features which will influence the number of nursing staff required.

4. While the current facts and figures are being examined, it is necessary to look back over the past ten years or so and to watch for any trends which may be evident in the national and local statistics. Is the number of hospital patients increasing and the length of their stay decreasing? (See Graph 1. and Table A.) Are the numbers of part-time nurses continuing to increase? Is the local industry changing? Have transport facilities improved or become less convenient? What are the shortcomings in your own hospital with regard to recruiting and retaining nursing staff? All these factors and a number of others which have to be taken into account are discussed in the following paragraphs.

5. This memorandum is intended as an aid to estimating numbers of nursing staff required and not as a means of recruiting staff. Nevertheless the availability of suitable people to fit the posts and the capability of the hospital to recruit, must have some effect on the numbers required.

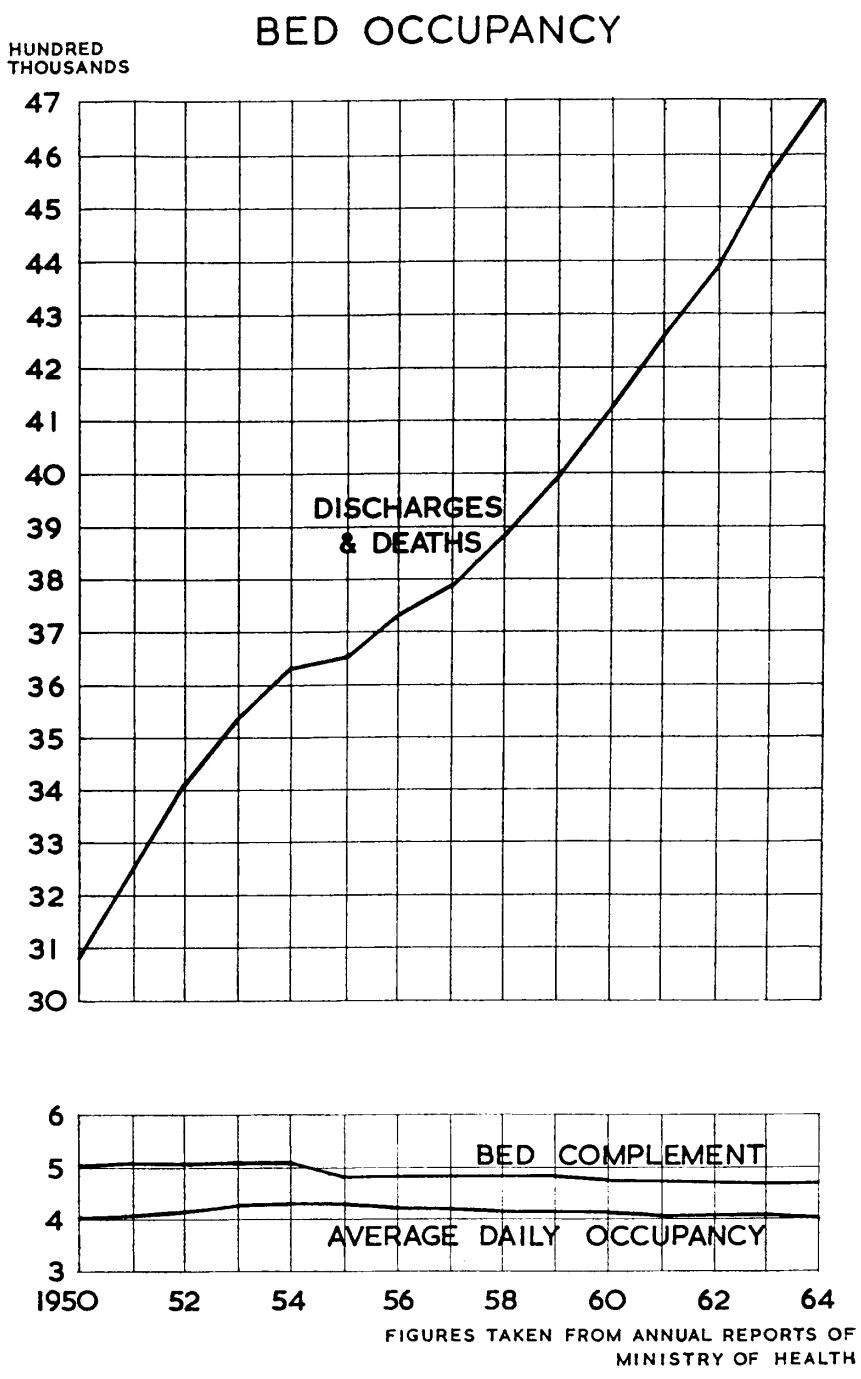
FINANCE

6. Money is always scarce, and the lack of it is probably the most frequent excuse for all manner of short-comings in methods of recruitment and retaining staff. It is not however the lack, so much as the unknown quantity, which makes planning a satisfactory nursing establishment virtually impossible.

7. Since the National Health Service came into being the authority to say how many staff can be employed in a hospital has shifted backwards and forwards between the Ministry of Health, the Regional Hospital Boards and the Hospital Management Committees. This shifting of responsibility as we see it, is linked with the uncertainty of how much money will be available from the Treasury each year.

8. Allocation of moneys and the nursing establishments are arranged differently in each Regional Hospital Board; usually money is granted to each hospital on the basis of the previous year's expenditure, plus

GRAPH 1


BED OCCUPANCY
HUNDRED THOUSANDS
47
46
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44
43
42
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40
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31
30
DISCHARGES & DEATHS
6
5
4
3
BED COMPLEMENT
AVERAGE DAILY OCCUPANCY
1950
52
54
56
58
60
62
64
FIGURES TAKEN FROM ANNUAL REPORTS OF MINISTRY OF HEALTH

the recognised allowances for growth and for salary awards. The matron who looks ahead in planning her nursing requirements and her intake of student nurses can only do so successfully if she is able to rely upon a sufficient annual allocation being made available for the purpose. Under present circumstances, however, the availablity of recruits and of money to pay for them is purely coincidental.

9. Nursing establishments in most cases cover nursing staff whose salary is fixed by the Nurses' and Midwives' Whitley Council. At least one Regional Hospital Board, however, has ward orderlies counted as nursing staff.

10. It needs to be remembered in the case of nursing tutorial staff, including clinical instructors, that the responsibility for salaries and establishment lies with the Area Nurse Training Committees. This is not so with the midwifery teachers, who come within the ordinary hospital nursing establishment.

11. The practice of including nurses in training in the establishment adds to the difficulties of budgeting for the service. Student nurses have to be taken into the school as and when they can be fitted into the teaching programme. Frequently there is an overlap when one group of students has to enter before those who entered three years ago are ready to leave; conversely, at times there is a gap between one qualified group leaving and a new group entering. This leads to fluctuation in the cost and the numbers of nurses on the establishment. Sometimes the change in the numbers of students in one year affects the next financial year, depending on the exact date of entry of certain groups of students; any student who leaves without completing her training cannot be immediately replaced and never by one of the same earning capacity. Whenever "freezing" in the nursing establishment includes the intake of student nurses, the effect is not only immediate but actually increases over the next three years because of the impossibility of replacing like with like. It is quite impractical to double the number of first year students in an attempt to balance the lack of third year ones.

12. Inability to predict the numbers of student nurses to be employed from month to month is a valuable argument for separating the cost of the school of nursing from the running costs of the hospital, perhaps even to the extent of having the money allocated for training through the Area Nurse Training Committees.

GRAPH 2

NATIONAL HEALTH SERVICE EXPENDITURE

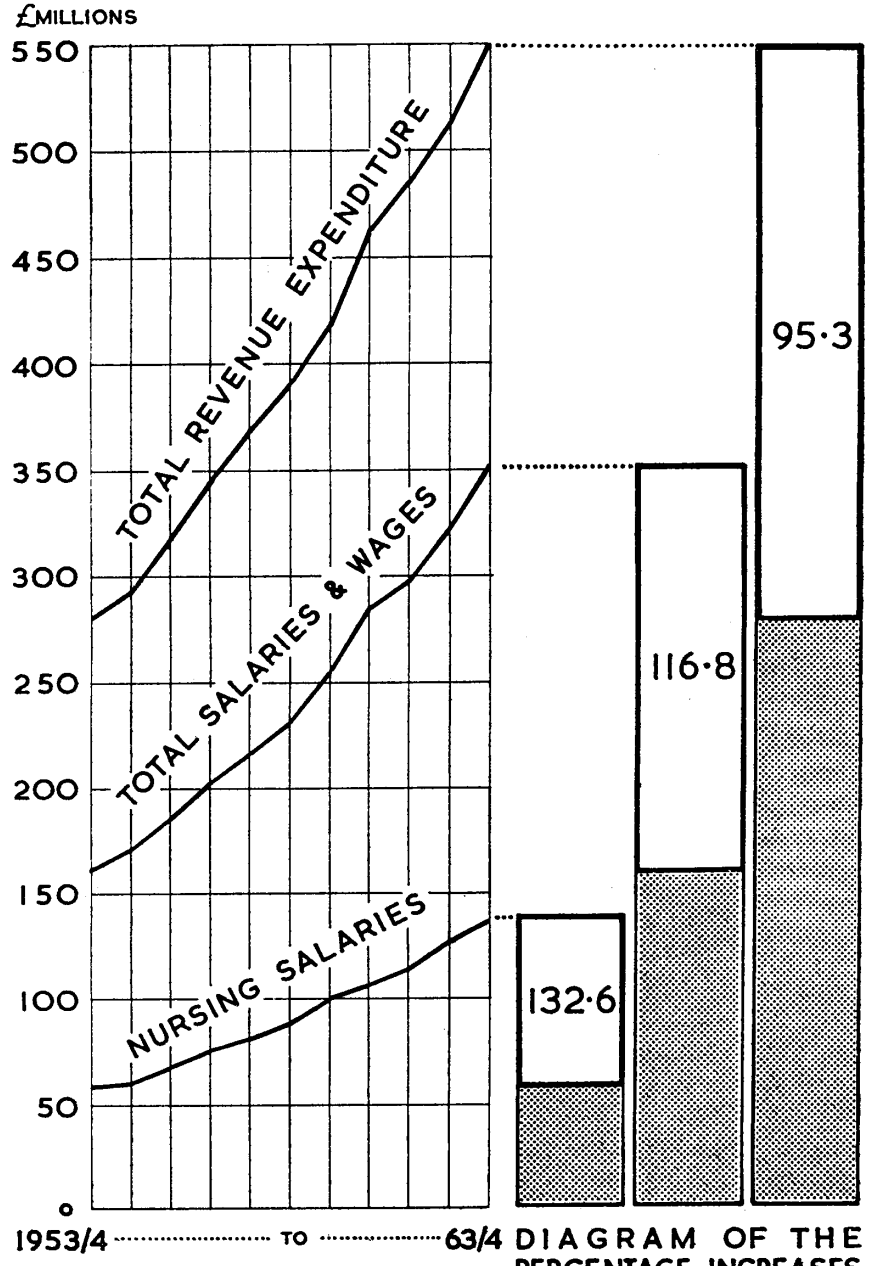


DIAGRAM OF THE PERCENTAGE INCREASES 1953/54 TO 1963/64

FIGURES TAKEN FROM ANNUAL REPORTS OF MINISTRY OF HEALTH

13. The cost of the whole hospital service over the past ten years has risen by 95·3% (a) (See Graph 2, and Table B). The cost of the nursing service in the hospitals has, however, risen by 132·6% (b). Furthermore, a comparison of the nursing section in relation to the total salaries and wages bill shows yet another increase. In 1953-54 nursing salaries were 36·5% of the total, ten years later this proportion has risen to 39·2%.

14. In 1964 there were 220,315 hospital nursing staff of whom 94,672 were trained nurses. (See Graph 3, and Table C). When thinking of the cost of the hospital nursing service, it is important to note the increasing numbers of nursing staff over the past ten years and to give consideration to the fact that by far the steepest rise is shown in the grades of what are termed Other Nursing Staff, i.e., nursing auxiliaries and nursing assistants.

15. These figures show quite clearly the need to consider seriously the maximum use of nursing skill and the possible revision of present nursing duties.

ASSESSING THE NEED

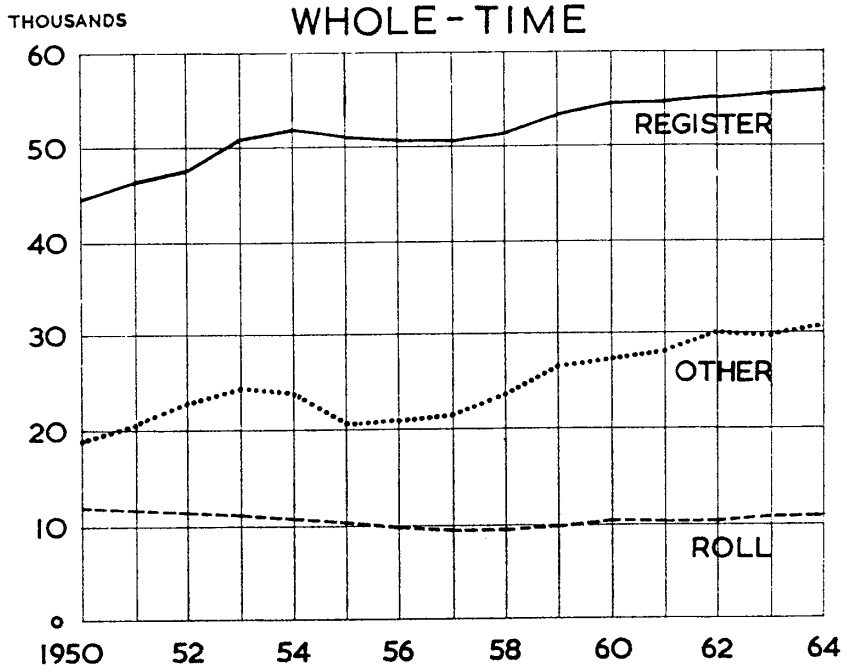
16. *Nursing Staff.* At the very outset before starting to recruit, hospitals need to be sure how much work is going to be allocated to trained nurses and to nurses in training, and how much to untrained staff. When new hospitals are being planned, this perhaps is a golden opportunity to think afresh about the type of staff required, relying mainly on trained nurses and other staff, and listing students and pupil nurses only in numbers relative to the amount of clinical experience likely to be available. Always, however, it has to be understood that certain limitations are set by the availability or otherwise of each grade of staff in a given geographical area or social community.

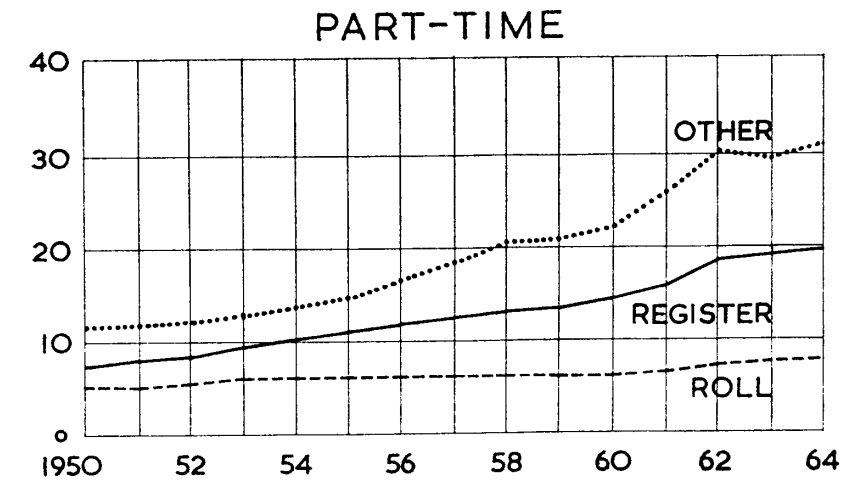
17. Investigations into the number of nursing staff required often fall short of the complete answer because the needs of the wards and departments have not been fitted into the needs of the hospital as a whole. Broad policy decisions have to be made at an early stage, within which departmental needs will have to be met but we would advise examining each ward and department separately before the necessary "cutting the suit according to the cloth".

(a) from £281,671,606 in 1953-54 to £550,169,767 in 1963-4
(b) from £59,152,069 in 1953-4 to £137,620,023 in 1963-64

GRAPH 3

NURSING STAFF EMPLOYED IN THE HOSPITAL SERVICE





FIGURES TAKEN FROM ANNUAL REPORTS OF MINISTRY OF HEALTH

18. The determination not to waste trained nurses whether registered or on the Roll needs to be carried into every department, office and the school of nursing as well as the wards. Other personnel, computer programmes, and all labour-saving services, should be brought into use to save senior trained nurses many hours spent at books and in offices and allow them to become more involved with direct patient care and student supervision.

19. The numbers of part-time nursing staff of all types have increased over the past ten years from 17·58% of the whole in 1954 to 26·71% in 1964 (See Graph 3). The greater the number of married nurses with families who become available and are willing to work in their local hospitals, the more we can expect the percentage of part-time staff to increase.

20. When planning numbers of nursing staff, allowances for holidays and absence due to sickness and so on, must be made. Estimating for this is further complicated by the necessity to use part-time staff, which emphasises the need for a planned holiday rota.

21. The number of hours each part-time nurse can give varies enormously, and may be anything from one to forty-one. It is not therefore sufficient to talk about full-time and part-time staff. To make estimating requirements more realistic, it is better to talk about hours of work for which a person is available. It should be possible for hospitals to have a graph showing how many of what grade of staff they require in each ward and department, hour by hour throughout each week. In this way it would be easier to come to some agreement with the part-time worker, whereby the hours of work she feels able to give to the hospital could best be fitted in to suit the hospital as well as her home commitments.

22. Married women are not only likely to be off sick themselves but also to be away when a member of the family is sick, and for maternity leave. Periods away from work for family reasons need to be recognised and allowed for by the inclusion of an adequate number of relief nurses in the total establishment.

23. In addition to the increase in the number of part-time and married nurses, there has also been a sharp increase in the number of non-resident nursing staff in recent years. It is commonly accepted, and must be recognised, that the morbidity rate among non-resident staff is greater than among residents. When employing non-resident

staff the question of transport needs noting to make sure it is possible for the nurse to travel at the hours she is expected for duty.

24. *Nurses in Training.* Many difficulties can perhaps be avoided, if, when staffing the wards and departments nurses in training are considered for what they are—apprentices needing supervision, whose periods of study away from the wards preclude them from full employment in the care of patients.

25. Although the hospital may decide to take a given number of students or pupils three or four times each year, there is no guarantee that this number will be forthcoming. It has been known for one hospital to recruit twenty student nurses on one date of entry and to find only three at the next. This presents an increasing staffing problem for the next three years and highlights the inadvisability of counting on student nurses to form the greater part of any nursing establishment. (See Paragraph 11).

26. *24-hourly Nursing Service.* There is no greater constant anxiety for the nurse administrator than the need to maintain an adequate 24-hourly nursing service covering all wards and departments. As well as planned holidays and sickness allowed for in the nursing establishment, there may be the epidemics of, for example, influenza or gastro-enteritis when a third of the staff may be sick, the sudden emergencies caused by the acutely sick patients and the private tragedies which send staff members hurrying home to their families.

27. It is likely that, if an analysis was made of the staff who relieve in such emergencies, student nurses would be found to be the most frequently used to replace both trained and untrained staff. This adds to the mental stress and strain for the student, who may be called upon to relieve sister one day and an absent orderly the next. This uncertainty and inconsistency could be a contributing factor to an increased morbidity rate among student nurses at the end of their second year, as was found in Eve Bendall's study. (1)

28. We would recommend that when establishments are being considered, the percentage allowed for sickness, absence and holidays should be clearly divided, allowing for trained, in training and auxiliary nursing staff to relieve only within their own staff category.

29. *Care and attention to the patient.* All staff employed in a

(1) A survey of wastage, sickness and allocation among student nurses. Nursing Times, 4th June 1965. pages 760-763.

hospital share indirectly in the care of the patients, but only those who come into direct daily contact with the patients and the nurses are the ones whose work can be said to affect the load of the nursing staff (2). These people (1) give direct care and attention to the patients; (2) man the central services, and (3) share in the work of the ward or department.

30. *Direct care* and attention to the patients is given by medical staff, therapists and technicians, as well as by professional and voluntary social and welfare workers. Because the ratio of patient to staff is greater in these fields and because they do not expect to be in attendance throughout each 24 hours, these specialists depend upon the nurses to assist, to continue with, to expand and to complete their work.

31. The ability to be Jack-of-all-trades and take on the role of others for the benefit of the patients is perhaps the new essence of nursing. When working out numbers of nurses required, the help given to other staff needs careful consideration.

32. In departments such as out-patients, and theatres, it is the number of sessions at which nurses are required, rather than the number of patients which will affect the total number of nursing staff required. For example, one operating theatre used for two surgeons each operating for one session a week and otherwise merely kept for emergencies will require less staff than the same operating theatre, were ten surgeons each to use it for one session weekly.

33. The number of medical staff can at times increase the number of nursing staff required. There is more work for the nursing staff in a ward which has two consultants each looking after twelve patients than in one where one consultant looks after twenty-four patients. In contrast, the more physiotherapists there are the less they will rely on the nursing staff to give the patients their treatment out of normal working hours and at the week-ends. A resident chaplain may mean more work for the nurses; because he is resident he will be in a position to conduct more services in the wards, the nurses' work in preparing for which is considerable. In contrast, the school mistress who can arrange for a student teacher to come to the ward in holiday time relieves the nurses for a certain amount of time which would have been spent in supervising children's play.

(2) Scottish Home & Health Dept. Health and Welfare Services in Scotland. Report for 1962, pages 67-71.

34. *Central Services* such as central sterile supply departments or central linen services can be shown to save nurses' time but only if they are adequately manned and effectively run, bringing the services to the wards and departments. Any time spent by the nursing staff going to the source of supply to collect material or information is time lost.

35. Unfortunately the time saved by each service in each ward can only be measured in minutes scattered throughout each 24 hours so that it is difficult to show a direct saving of whole or part-time staff. These services do however conserve the nursing skill and allow the nurses to spend more time in the ward with the patients and less in the ancillary rooms.

36. There is an obvious effort being made in many hospitals to relieve nurses of their non-nursing duties, but the need to bring other personnel into the staff of the ward or department cannot be considered independently of the number and completeness of the central services. How many porters are to be allocated to out-patients and how many are to be at the beck and call of the ward sister? How much of the reception and escorting of patients is to be undertaken by medical records office staff? Is the daily cleaning of the hospital to be a central service or is each ward and department to take responsibility for this?

37. Where nurses have been in the habit of serving meals to patients, the service of food direct to the patients from the kitchen by the catering staff has been said to show a great saving of nurses' time. This example demonstrates very clearly the necessity to consider the staffing requirements of the whole hospital at one time and to dovetail the needs of one service with another.

38. *Those who share in the work of wards and departments.* It is difficult to describe or enumerate all the people who can be employed with the nurses, to varying degrees, in the care of patients. None of them can be discounted when considering the numbers of nurses required because these assistants are largely doing the work which in the past has been done by nurses and many of them are under the supervision of the ward or departmental sister, whether or not they are counted as nursing establishment.

39. Apart from the nursing auxiliaries who are a growing body of people in the hospital service (paras. 14 & 15), there are three other categories of staff—(1) domestic assistants, (2) ward orderlies and

(3) the people whose names are various but perhaps would be most readily recognised as ward or departmental clerks. These categories may not be employed by the matron, but all are responsible to the sister-in-charge while at work. The troubles to be overcome in serving two masters are seldom recognised and in consequence a harmonious ward or departmental team is hard to achieve. Further difficulties arise when any member of these categories of staff is away and the essential work has to be divided among the nursing staff.

40. One way to overcome the problem of having such an unintegrated staff in the wards and departments is to visualise the whole hospital as a hotel where all the guests are in need of medical and nursing attention to a greater or lesser degree; then to bring all the non-nursing personnel, be they domestic, orderly or clerk, under the one local leader responsible to the sister for the hotel or housekeeping services of her ward or department. Economy of nursing and domestic staff can be found where all the non-nursing personnel work as a team, all able to undertake and share all the non-nursing duties without calling upon the nursing staff for relief(3). This again illustrates the need to consider the staffing needs of the whole hospital and not the nursing service in isolation.

41. Trained Nursery Nurses are required to take charge of children in creches. They can also usefully be employed in children's wards and in maternity units. At no time should they be considered as part of the nursing establishment because of the limitations of their qualifications, but they can be relied upon to relieve nurses of non-nursing duties connected with the younger age group of patients.

42. *Grouping of Patients.* The patients are the people for whom the hospital exists and for whom it is necessary to provide a skilled nursing service. Too often the first question asked of any hospital is how many **beds** has it? It may be the size and design of the ward which controls the number of beds in it and frequently the number of nurses required for each ward is estimated on the number of beds. The traditional pattern of providing full nursing facilities for all types of patients in these beds regardless of their need is very wasteful of skilled nursing time.

43. Medical and surgical consultant staff have an agreed number of beds for which they are responsible. It is usual for their convenience

(3) Ward Housekeepers. An experiment on delegated authority at Whittington Hospital, Highgate. Nursing Times. July 26, 1963. November 20, 1964.

to have their beds grouped in one ward or as few wards as possible. Frequently the number of their resident patients is above or below their allocated number of beds, and thus over-crowding of some wards while others have beds to spare, is a frequent hospital dilemma(5). The patients are the greatest sufferers from overcrowding. Besides being cramped for space and short of adequate furniture they have a reduced standard of nursing care. It has often to be that nurses from less crowded wards are borrowed for the over-full ones. This breaks up the team spirit and is not conducive to good nursing. The use of admission or emergency wards where all emergency patients can be admitted, not only makes the wards pleasanter for the patients, but makes the staff required in each ward more predictable.

44. Although an increasing number of hospitals are becoming interested in progressive patient care, there are still many using more traditional ways of grouping patients under each consultant. They are frequently grouped according to age, sex, disease, surgical operation, or length of stay (e.g. five-day wards).

45. Whether the physician or surgeon uses his beds for general diseases or one particular specialty it should be possible to measure the average severity of the patient's disability, his dependency and length of stay, then consequently the average amount of care, his patients collectively require and this then should be the basis for determining the number of staff required in each ward or department. The reasons behind variations in treatment and length of stay from one ward to another can then be understood and allowances made. Such a study has been undertaken in a gynaecological ward by the Oxford Regional Hospital Board (6). We have reason to believe that the patients' average length of stay is still decreasing (see Graph 1). The number of patients admitted to wards week by week has an effect on the work load of the staff. This is especially noticeable in a surgical ward where complete nursing care is required, pre- and post-operatively for each patient.

46. As the concept of a hospital changes from one of X beds divided among Y specialties to a picture of a centre for healing of individual people, the grouping of patients will no doubt change considerably. Perhaps the number of out-patients will increase and they may come

(5) Extra beds in hospital wards. Rcn Survey. Nursing Times. Dec. 31, 1965, page 1796.

(6) Problems and Progress in Medical Care. Nuffield Provincial Hospitals Trust. O.U.P. 1964.

for the day or visit for several days running, instead of as now often happens, for one consultation, before being put on the waiting list for admission. The balance of nursing and non-nursing staff required for these patients will be different from that in the traditional wards and departments and the establishment therefore should be flexible and subject to revision to keep abreast of new developments.

47. We recommend that the most important guide to the number of nurses required is the number of patients attending the hospital, how many of them are to be resident and to what degree they are likely to require nursing in addition to all the other facilities which should be available to them.

48. *Progressive Patient Care.* When the patients are considered first as individuals requiring the attention of a nurse to varying degrees, they then begin to fall naturally into groups depending upon the degree of nursing required. A patient can pass through the stages of needing 100% nursing care to being able to receive full hotel care with nursing attention in addition, and finally he may require hotel services only. A patient will not necessarily need all three categories of care, but it is essential that they should be available should he require them.

49. Some hospitals may decide to practise progressive patient care only within each separate ward, others within each unit of the hospital while some may adapt the whole hospital, so that all patients are admitted to wards according to the amount of care they require. Other hospitals again may decide to centralise only the intensive therapy and leave the rest of the patients to be nursed in the traditional wards. All variations of progressive care require different assessment of staffing needs, depending upon the grouping of patients and so the policy of the hospital needs to be known and well understood before the nursing requirements can be estimated.

50. Apart from the fact that medical staff are likely to assess the patients needing intensive therapy, progressive patient care is really a nursing matter and could perhaps be as well called 'decreasing nursing care'. We would suggest that the sister or nurse in charge of a unit or ward is best able to judge from day to day the sort of care, nursing or otherwise, each patient requires and that the grouping of the patients should be her responsibility. It should be the responsibility of the domestic superintendent or the hotel service supervisor to ensure that there are sufficient staff to undertake the non-nursing duties. This once more illustrates the need for the services to work together when estimating staff required.

51. *Hospital Buildings.* The majority of hospitals are purpose-built, although everyone can no doubt name some notable exception. The problem always present is that the function changes more rapidly that the building deteriorates so we continually have to be keeping new wine within old bottles. Again one suspects that the patients suffer most from an inadequate building, but it can also make for staffing difficulties and extravagances which have to be allowed for. Today architects are asking for as much flexibility of function as possible to be written into their brief to allow for flexibility of design. This of course, calls for flexibility in staffing establishments.

52. Numbers of staff relate more to the function than to the design. When deciding on the care given to patients one should decide the number of patients in each ward or department who will, for various reasons, be likely to need the privacy of a single room; which patients can be grouped; what size the group can be, and what anciliary service rooms are necessary for these patients. The staff required depends, not only on the way the patients are grouped, but on the reasons behind the grouping. If, for example, the single rooms are to be used for the patients needing only hotel care before discharge home, the staff required will vary greatly from occasions when the rooms are used for patients critically ill or too disturbing to have in the ward with other patients.

53. As with the whole hospital, the function or structure of individual wards and departments may change from time to time and although the staffing may initially have been satisfactory it will need to change as the needs of the patients or the alteration of the structure dictate. Always we anticipate the needs of the patients will outweigh the effect of design on the staff required.

54. For many years large hospitals have been built with well spaced departments spread over a considerable area, but only recently has the time taken to get from one section of the hospital to another become a subject for discussion. Architects today study very carefully the relationship of one department with another and place each as conveniently as possible, so perhaps distance between departments should not be counted as a major factor when deciding numbers of nurses required.

55. Thanks to the influence of the Division for Architectural Studies

(7) Studies in the Function and Design of Hospitals. Nuffield Provincial Hospitals Trust. O.U.P. 1955.

of the Nuffield Foundation(7), nurses in this country have more opportunity than perhaps any in the world, to share in the planning and equipping of new hospitals, through their appointments to planning and project teams. They should, therefore be in a position to weave the nursing policy and staff requirements into the design of the building as it is conceived.

56. *Nursing Policy.* Assessing the need is the most complex of exercises to be undertaken when preparing nursing establishments. There are so many factors which affect the work of the nursing staff but cannot clearly be stated to reduce the number of nurses required. The deciding factor is perhaps the care the patient needs and who is the right and proper person to be attending to him.

57. Time and time again discussions of the number of nurses required ends when the question is put "What is nursing, anyway?" The discussion then changes and lists of tasks are given as nursing one minute, and contradicted the next.

58. There is an art or a skill in caring for people who are mentally and physically sick. Whenever this skill is practised, the patient is being nursed.

59. Not all sick people require the skill of a nurse and not all care given to sick people is nursing. We suggest that the severity of the illness decides the amount of nursing skill required. For the critically ill patient, all care requires the skill of a nurse, while at the other end of the scale the patient with a minor ailment can look after himself as the doctor recommends. In between these two are the patients who require one or more skills of a nurse but for the rest require only board and lodging.

60. Since trained nurses came into being they have taken the responsibility for the general welfare of patients in hospital wards and departments. At no time would we recommend that this responsibility should be passed to another service although much of it can be delegated at ward or departmental level. This means allowing for trained nursing supervision in all patient areas. Observing the patients and assessing their requirements being two of the most important for skills of a nurse, it is necessary to ensure that whenever there are patients in hospital there is a trained nurse responsible for their well-being.

61. The nursing authority in the hospital, knowing the nursing required, has to decide on the content of each nursing team within each ward and department. It is one thing always to know the standard of care required and the amount of nursing care to recommend, but the availability of the right category of staff will not always match the recommendations, and the best standard of care has then to be given according to the standard of staffing.

62. It is not within our subject to suggest ways in which the nursing service and the school of nursing should be administered, but this is an essential part of nursing policy which has to be decided before the nursing establishment can be completed. We would just like to emphasise the importance of examining the need to the same degree as is required at ward and department level.

63. In assessing the average amount of nursing care required in each ward and department, there are bound to be times during each 24 hours when the amount of nursing required varies. We have suggested previously that the times at which nurses are available for work in the hospital also varies and that given a graph of both, one is in a better position to match the demands one with another (para. 21). How the hours of duty are arranged to cover the work and suit the staff will be the ultimate deciding factor on the number of nurses or, more correctly, the number of nursing hours required and lead to plans for shift systems, internal night duty, five-day weeks, and many other problems of organisation so essential to the smooth running of a hospital.

RECRUITMENT

64. As with the allocation of money and planning the nursing establishment, so recruitment of nursing staff for hospitals is a shifting responsibility with no agreed right way to set about it.

65. At the national level the Ministry of Health would claim responsibility for overall national plans of campaign and occasional definite drives. The Nursing Recruitment Service of the King's Fund gives valuable service to the candidates and to the hospitals through its very careful nurturing and selection of suitable trainees for individual hospitals.

66. Careers teachers and youth employment officers seek to explain nursing among other careers for young people. Local Labour Exchanges tell young people about work available in hospitals and occasionally place enrolled or auxiliary (particularly male) nurses. The

Regional Hospital Boards usually have a nursing officer responsible for nursing recruitment and directing interested young people to their local school of nursing. Recently, one or two Hospital Management Committees and a Board of Governors have appointed a nursing recruitment officer: one hospital committee has given the responsibility to a personnel officer, and another is considering handing over the task to a public relations firm.

67. It is a mistake to underestimate the appeal that a nurse from a hospital has for the girl considering nursing as a career. For the trained nurse also, first-hand knowledge of the hospital of her choice from a member of the staff is what will most quickly reassure her when looking for work in a certain vicinity.

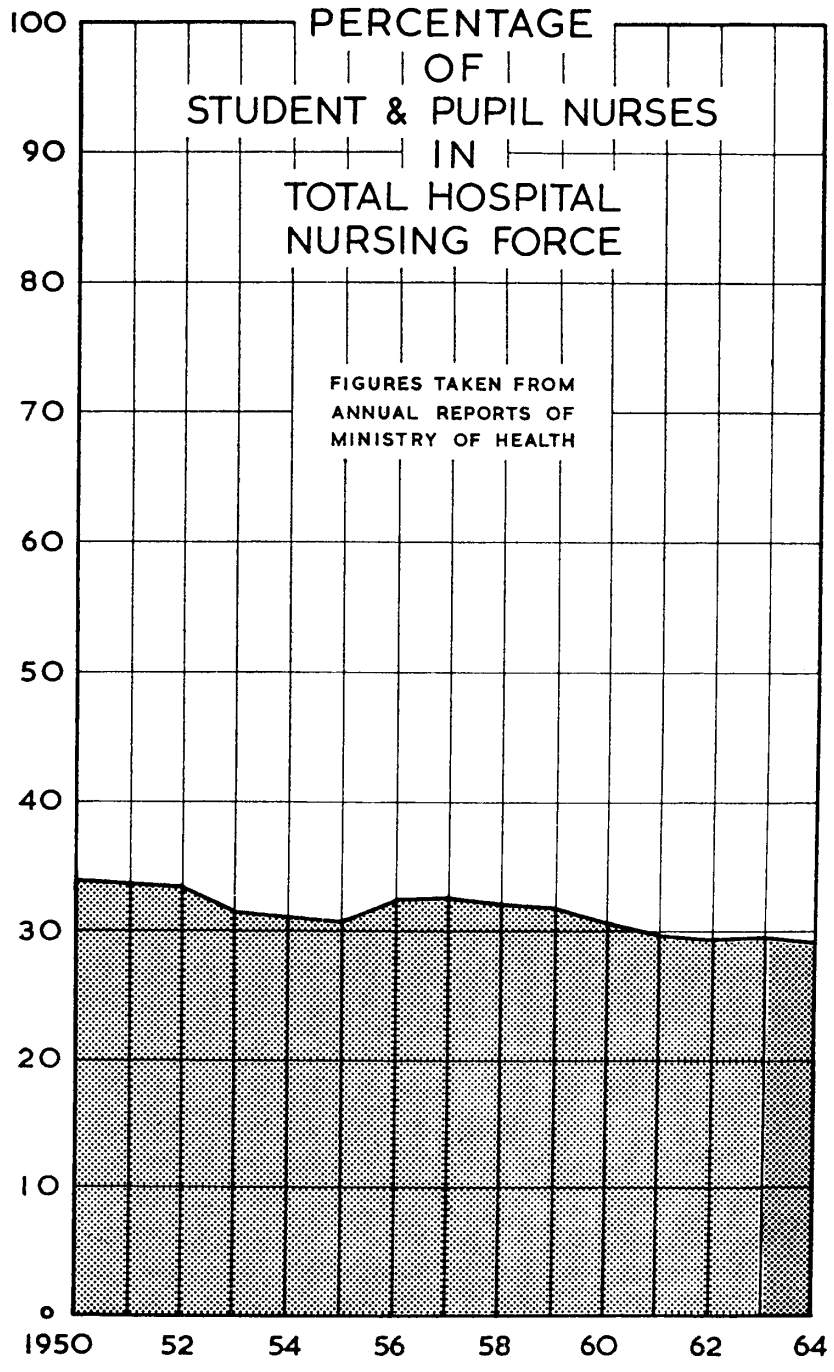
68. We would recommend therefore that the matron and the head of the nursing school, whatever assistance they may have from other bodies, should have the main responsibility for finding trained staff and candidates for training. We would expect the matron to play her part also in selecting other staff who may be employed to share in the direct care of the patients.

69. When thinking of recruitment of nursing staff, it is the candidate for training who comes first to mind. During the past ten years, the percentage of student and pupil nurses in the whole nursing staff employed in hospitals shows a slow decline from 34% in 1954 to 29% in 1964 (See Graph 4 and Table C). The increase in the numbers of "other" nursing staff may be one of the causes of this.

70. A more systematic attempt to attract **all** grades of staff likely to be involved in patient-care is badly needed. A careful plan of the type of staff required has to be combined and with a knowledge of where to look for recruits and what the facilities are in the way of transport or resident accommodation, and so forth.

71. If married women, including trained nurses with families, are to be attracted into hospital work they need help with their children. Some hospitals are providing creches, supervised by nursery nurses but this does not cater for the school children in holiday time. Work in hospitals is not confined to term time and if mothers are needed in hospitals, they are required all the year round. Perhaps further exploration into ways of providing for the supervision of school children would enable married women to give a greater contribution to the hospital service.

GRAPH 4


PERCENTAGE
OF
STUDENT & PUPIL NURSES
IN
TOTAL HOSPITAL
NURSING FORCE
FIGURES TAKEN FROM
ANNUAL REPORTS OF
MINISTRY OF HEALTH
100
90
80
70
60
50
40
30
20
10
0
1950
52
54
56
58
60
62
64

SUMMARY

It is necessary:—

1. To know the financial situation in the hospital, and the amount of money allowed for nursing staff. This is of primary importance. We must emphasise that all efforts will be rendered useless so long as it is possible for the supply of money to pay for nursing staff to be reduced or frozen at short notice. This, in our opinion, is the vital matter which overrides anything that individual hospitals can achieve. (paras. 6-8)

2. To assess the patient care required in each ward and department. (para. 16)

3. To plan to use every hour of nursing available as economically as possible by employing nurses at times when the work is to be done. (para. 21)

4. To remember that student nurses do not give full-time nursing service to the patients. (para. 24)

5. To allow sufficient nurses to cover sickness, holidays and incidental shortages of staff. (paras. 26-28)

6. To take into account the work of all other hospital staff who can affect the load of the nurses' work and responsibility. (para. 29)

7. To separate the nursing duties from non-nursing duties and divide the patient care into nursing and non-nursing care. (paras. 36-40)

8. To study the most satisfactory method of grouping patients. (paras. 42-50)

9. To take into consideration the building and the architectural features which make for extravagance or economy in staffing. (paras. 51-55)

10. To put all the separate requirements into perspective to enable the nursing service to fit into the function of the hospital as a whole (paras. 56-63)

11. To know the availability of nursing staff, from where they are to be sought and the hours of work they will be able to spare the hospital, be they trained, untrained or in training. (paras. 64-71)

This memorandum provides no magic formula for determining the numbers of nurses needed in a hospital. It does, however, point to the complexity of the problem—the necessity of not looking at nursing numbers in isolation, but for the needs of patients in both wards and departments to be considered in every hospital.

Just as patients are people, so are nurses. The quality of care that they give to the patients will depend largely upon two factors—their own personal standards and integrity, and upon the tradition, atmosphere and morale that exists within the complex human organism that is a hospital.

TABLE A

BED OCCUPANCY

(Taken from M.O.H. Annual Reports)

Year	Bed Complement	Average Daily No. of Beds Available	Average Daily Occupancy	Discharges and Deaths
1950	504,321	453,466	402,601	3,085,491
1951	507,005	461,892	406,844	3,259,214
1952	507,368	468,255	416,123	3,414,373
1953	509,028	473,559	424,126	3,543,544
1954	509,828	476,887	427,628	3,630,269
1955	481,710	476,912	426,048	3,651,978
1956	482,553	476,945	423,818	3,739,248
1957	482,930	477,138	420,170	3,793,605
1958	483,083	477,460	417,575	3,889,000
1959	482,495	476,119	412,619	4,000,000
1960	479,454	474,597	410,290	4,136,000
1961	478,360	469,493	404,401	4,269,000
1962	473,965	467,580	403,028	4,391,000
1963	472,102	466,640	404,019	4,576,000
1964	472,039	465,860	400,277	4,725,000

TABLE B

NATIONAL HEALTH SERVICE EXPENDITURE

(From Ministry of Health Annual Reports)

Year	Total Revenue Expenditure £	Total Expenditure on Salaries and Wages £	Nursing Salaries £
1950/51	227,160,200	132,863,607	49,111,273
1951/52	246,344,880	141,804,850	51,131,513
1952/53	268,381,183	154,513,675	56,242,019
1953/54	281,671,606	162,121,499	59,152,069
1954/55	293,444,431	172,686,603	62,603,192
1955/56	318,291,632	186,153,729	68,725,857
1956/57	346,818,262	203,393,400	76,492,682
1957/58	370,695,765	217,819,293	81,921,687
1958/59	391,797,301	232,419,847	87,544,389
1959/60	421,313,738	255,300,613	101,856,845
1960/61	464,654,383	287,874,589	107,716,658
1961/62	487,342,483	299,581,922	114,732,304
1962/63	515,648,899	324,264,201	128,090,974
1963/64	550,169,767	351,414,918	137,620,023

TABLE C

NURSING STAFF

(Taken from Ministry of Health Annual Reports)

YEAR	REGISTER			ROLL			OTHER	
	W/T	P/T	Stud'ts	W/T	P/T	Pupils	W/T	P/T
* 1950	44,666	7,526	49,417	12,179	5,298	2,248	18,925	11,416
* 1951	46,366	7,964	49,937	11,746	5,237	2,582	20,216	11,822
* 1952	47,673	8,381	50,475	11,501	5,300	3,222	22,436	12,113
* 1953	50,969	9,400	48,953	11,206	5,641	3,557	24,357	12,894
* 1954	51,822	10,177	48,817	10,863	5,763	3,742	23,818	13,725
* 1955	50,878	11,037	48,834	10,140	5,853	3,820	20,595	14,705
1956	50,715	11,732	51,498	9,916	5,918	3,986	20,804	16,591
1957	50,525	12,407	52,832	9,614	5,983	4,443	21,264	18,393
1958	51,188	13,172	53,899	9,580	6,175	5,103	23,561	20,427
1959	53,311	13,271	54,960	9,960	6,175	5,799	26,583	20,887
1960	54,392	14,349	54,075	10,146	6,174	5,777	27,331	22,192
1961	54,374	15,834	53,696	10,129	6,599	6,085	28,037	25,704
1962	54,902	18,470	56,066	10,154	7,265	7,187	29,982	30,112
1963	55,320	18,978	55,661	10,502	7,482	8,418	29,247	29,611
1964	55,993	19,858	55,039	10,924	7,897	9,169	30,515	30,920

* at 31st. December.
rest at 30th September.

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hospitals and
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