THE GLOUCESTER LECTURES

Nursing into the 1990s

TREVOR CLAY

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There are moments when I feel that nothing changes. One of the recurring images of my career in the health service, and then as General Secretary of the Royal College of Nursing, has been the picture of the slightly harassed nurse pleading for time: 'I just wish they would let me get on with my job ...'

NHS REFORMS

There has been so much sound and fury over the NHS reforms that we are in danger of forgetting that nursing has been pursuing its own agenda for reforms since the mid-1980s. It has pursued them with some considerable success but we are now entering a difficult transitional phase. The preoccupation of politicians and managers is focused, perhaps understandably, on the new structures. Everyone is grappling with a new culture and new concepts in relation to purchasers, providers, contracts and trusts.

The pressure of adverse opinion polls obliged Kenneth Clarke and his team to tone down his pungnacious approach. When he spoke to the RCN Congress in 1989 he was very firm: 'No one should be in any doubt that the NHS reforms are going to happen'. Later his tone was more reassuring. Duncan Nichol has been positively emollient.

Emphasis is laid upon taking staff with you – on consensus, teamwork and a framework for quality. Nurses are not deceived by this. Fine words butter no parsnips. Practitioners at the workface know full well that the National Health Service is unlikely to throw off the habits of a lifetime and become a caring, progressive employer overnight. But nurses need to be astute and alert if we are to harvest the fruits of our own quiet revolution and not see our cherished reforms squandered or misapplied in the new structures.

Just as new parents will tell you that sleep deprivation is the ultimate torture, so I suspect, that for most nurses, time deprivation is a major area of stress and the factor which most constrains their ability to do their job – to offer skilled nursing care. None of the four major health service reorganisations

which have been unleashed on the service in the last 17 years has addressed that simple issue – time to care. The service has been tweaked, reshaped and restructured – I would say it has been tormented by politicians mesmerised by rising costs and reluctant to concede that a labour-intensive service will only flourish and deliver quality if its structures support and facilitate the contribution of individual practitioners. Successive health secretaries have found the temptation to dig the service up by the roots to check whether it is growing quite irresistible. Hence the exasperated refrain of the overstretched nurse and doctor 'just let us get on with our job'.

PROJECT 2000

I want to take the opportunity of this Gloucester Lecture to discuss how the latest relandscaping of the health service will affect nurses' ability to 'get on with their jobs' and to reflect on the changing nature of nurses' work as we move towards the next century. Project 2000 is one nursing reform which I know is very dear to your hearts as it is to mine. I am aware that you were bitterly disappointed, and rightly so, when the government failed to approve the funding for the Gloucester Project 2000 programme to start this year. Money is not the problem. It is lack of political will and failure of political imagination.

When one thinks of the millions and millions of pounds which have been found and will continue to be found in order to ensure that would-be self-governing units are seen to succeed, when you consider the budget for promoting and publicising the reforms alone, it is clear that the phased implementation of Project 2000 is not a financial necessity but a mark of Whitehall's failure to grasp the consequences of delay, or to care very much about those consequences. Yet the implications of delay are very serious indeed. It is a little more difficult to calculate the timetable for the implementation of Project 2000 in England because of the rapid pace of amalgamations of schools of nursing. However, at the current rate of implementation, it could take up to eight years to complete the process in England. I hope it will not take that long.

The profession has worked long and hard to achieve the educational consensus for reform and we need the new nurse now – not for nursing alone but for society. I have always argued that the vagaries of the annual expenditure round are a completely inappropriate mechanism for running a major service like the NHS. People's health requires sustained and assured investment. Some of you may have seen a leading article in the *Independent* newspaper which, I have to say, absolutely appalled me.

The leader stated that investment in health is not an investment in the nation. What an aberration for an otherwise excellent newspaper. We should invest in the nation's health and part of that investment must be in manpower. Manpower planning, which should underpin a major public service, also requires a firm investment timetable upon which the service can rely. The introduction of Project 2000 – as we all know but as the Department of Health appears to have forgotten – is part of planning for a service to meet the needs of the 1990s and of the next century.

Change brings tension and insecurity. The existing nursing workforce needs support and encouragement to take Project 2000 forward. Practising nurses' own support for the new concept cannot help but be undermined if the transition process is prolonged indefinitely. Delays in implementing Project 2000 also make the task of establishing a rational relationship and balance between qualified and unqualified nursing staff much more difficult. There is a danger that the skill mix within a ward team will be assessed in isolation from Project 2000, determined in fact by the availability of locally-trained health care support workers. I would not wish to hold up the progress towards establishing a coherent vocational framework for nursing auxiliaries and nursing assistants. That is long overdue. But the advent of increasing numbers of these colleagues – now to be known as health care support workers – a rather stupid generic title – was supposed to go hand in hand with the implementation of Project 2000.

As the service fragments into competing provider units, and as local managers gain greater control over the pay and conditions of service they offer to health care staff, health care assistants become an increasingly attractive option, in preference to qualified nurses, who are seen to be expensive. Early work shows that a dual nursing workforce brings down mortality rates – but not costs. Here money is a problem. It is not just politics. Nurses' pay accounts for £3 in every £100 of public expenditure. Nursing consumes 40 per cent of the £24 billion spent on the National Health Service. Nursing, therefore, cannot be immune to the direction of government economic policy (as we know only too well).

During the 1980s, thanks to our campaigning efforts, thanks to our firm stance opposing industrial action and thanks to the review body, nurses' pay made significant headway, culminating in the dramatic uplift in pay which accompanied the introduction of the clinical structure in 1988. I would still like to see higher pay for nurses – and I am concerned that already the achievements of the 1980s are being eroded by inflation and by staging. Newspapers have reported that the government will set a seven per cent pay form for the public sector and sees nurses as a major test case.

It is the price you pay for economic success. Nurses now have to justify their employment – seen as expensive – against the competing claims of an increased number of support workers. It would be foolish to deny the impact which our success has had on health service budgets. It is merely realistic to recognise that hard-pressed managers will look for savings where they can.

I am well aware that it is currently unfashionable to espouse the cause of national pay structures. The new NHS Personnel Chief, Eric Caines, refers to them dismissively as a crutch for unimaginative managers. I reject that view. I hold to the philosophy that a national service should be underpinned by a national framework for determining pay. The alternative is a merry-go-round in which shortages are simply moved from one unit to another or one region to another. By continuing to

support a national pay framework, I recognise that I am conceding that nurses' pay will remain central to the politico-economic agenda. That can be tough when, as now, the economy is in major difficulty. But I believe it is right. Nurses are important. Nursing is important. It is right that politicians should be reminded of that fact by every means at our disposal – including the bill for our services!

A NATIONAL STRATEGY

Perhaps I am wrong to describe national pay structures as unfashionable. The shift goes deeper than that. Although everyone continues to use the initials NHS as the accepted shorthand for the publicly-funded health service, references to the National Health Service, as opposed to health services, are hard to find in government literature nowadays. I remain deeply unhappy about the drift towards a structure of local services because I fear that fragmentation rather than healthy diversity may result. While I support the idea that authority and accountability should be devolved as close as possible to operational level, I would argue that national planning and central resourcing remain vital.

Without a national strategy, pockets of excellence can exist within a sea of mediocrity. We all pay for the National Health Service. Taxation is a form of national subscription, and having taken out a subscription to a national service we have a right to expect certain national standards and a comprehensive nationwide network of care. I think Kenneth Clarke knows that too. I suspect that he understands very well the place the NHS holds in the nation's affections. It may explain his sudden conversion to the concept of health targets, unveiled in October 1990 at the Consevative Party Conference.

I welcome the conversion to targets. The Royal College of Nursing argued consistently throughout the 1980s that the absence of a national strategy for health undermined efforts to reduce mortality from preventable diseases and to boost health promotion. I shall be delighted if the new emphasis on national targets signals a commitment from this government to work

seriously towards the World Health Organization's 38 objectives for health for all by the year 2000. It is just a pity that we have to endure the instability of a fourth health service reorganisation before getting on to the real agenda of promoting the nation's health. Those who long for a change of party at the next general election may be disappointed too.

THE NEW HEALTH MARKET PLACE

I want to return now to the central question nurses are asking. How will we survive in the new health market place? The future is fraught with possibilities. I have already alluded to two of nursing's own reforms – Project 2000 and the clinical career structure – which will, if we hold on to them, help us progress despite the difficulties. But I am sure that you do not need reminding that these twin reforms to education and to nurses' salaries were both directed to creating a new framework for clinical practice. Development and change were, however, proceeding apace within clinical practice while some of us pursued the higher profile lobbying needed to gain government support for Project 2000 and the new salary structure. I am thinking of the advent of nursing development units, of primary nursing and the rise of the nurse practitioner.

The 1980s also saw an explosion in the numbers and diversity of specialisms in nursing and began to see major transfers of nurses accompanying their patients out of the long-stay mental illness and mental handicap institutions and into the community. All these trends and new directions in practice will be affected by the NHS and community care reforms. It is our task to ensure that we use the possibilities open to us to reinforce the positive. Looking around the streets of our big cities I am not cheered – but we must encourage nurses to take advantage of the huge opportunities which are available. We can survive in the health market place provided we have the confidence to use the new structures to our advantage and to the advantage of patients.

Our ability to promote positive developments in clinical practice will hinge on our ability to get nursing structures and

culture right. Within provider units, whether they are grouped into clinical directorates or use other organisational models, we must assert the need for nursing leadership as a resource to the practitioner and, very importantly, as a resource to the community. If there is not a senior nurse involved in the corporate, executive level decisions about care, then there is no one with direct experience of hands on care and no clear advocate for the patient who can prevent the slide into poor practice and the circumstances that led to the scandals in the mental hospitals.

I am aware that senior NHS figures are keen to encourage more nurses to move into general management. I hope this will happen too, because I know that nurses make an excellent contribution. But I believe that even if all the general managers were nurses, I would still want to see an input from nurses, as nurses, with a brief to talk about the politico-economics of care.

In some areas of the country, the clinical directorate model is providing new opportunities for nursing. Nurses are assuming responsibility for the total delivery of patient services, controlling resources, determining workload, recruiting and deploying staff and setting standards of care in partnership with their medical colleagues who occupy the bulk of the clinical directorships. When the model works well, the senior nursing team is valued and is able to promote excellence at ward level.

When it is misapplied, senior nurses are eliminated from the structure. When this happens under the guise of devolving responsibility to the ward sister or charge nurse, the results can be disastrous as ward sisters are left to struggle with a mountain of administrative duties, the introduction of new technology and new patient information systems, inadequate staffing complements and the constant pressure to increase throughput. Paradox now is the fact that too many nursing leaders have left demoralised and unwanted and there are too few development programmes to produce new ones in time. Quality cannot thrive without peer support and management commitment.

If time and nursing leadership are squeezed out of the system, innovative nursing and care cannot be expected. But if we can ensure that nurses in the provider units – that is, the vast majority of practising nurses – do have clinical leaders on hand

to support them, then the new system of clinical contracts opens up some interesting possibilities for nursing care. The contracts will be fairly rudimentary initially, but as nurses and others learn to manipulate them, the opportunity to make quality an enforceable element of the contract mechanism undoubtedly exists.

If we have confidence, for example, in the care effectiveness of primary nursing, and I do, then it should be possible to write standards of care which build on the primary nursing ethos and which translate across into the quality specifications for the relevant clinical contract. If we have confidence in the care offered in nursing development units or nursing beds, then nurses should tender for the contract to provide those services.

It is a major cultural change for nurses to have to market their skills and I remain unhappy about the competitive nature of the contracting process. I am absolutely confident that nursing has the skills to provide a quality service and a cost-effective service. We just need to be a bit more street-wise and assertive. But let us also remember whose interests we serve.

PATIENT AUTONOMY

I have always been an exponent of the value of nursing as a discipline separate from but closely linked and complementary to medicine. I have sometimes felt uneasy when nursing specialisms have simply followed the emergence of new medical specialties. I have welcomed the emergence of nurse practitioners at senior levels whether in the hospital or community setting. I understand the desire for independence but I have some problems with the notion of autonomy. The only autonomy I could wholeheartedly support is patient autonomy. The concept is starting to crop up in nursing literature. It marries well with the consumerist thrust of the NHS reforms and the genuinely growing desire of patients to take charge of their own destiny wherever possible. Full autonomy for the patient is probably an impossible dream since patients will always need to rely on professional advice and judgment to a greater or lesser extent.

We could do a lot better though and we should go a lot

further in assisting people to make their own judgments about methods of treatment, choice of practitioner, styles of care and whether they will receive care in hospital or at home. It is a fundamental element of the nursing philosophy that nurses should promote the independence of the patient as part of the process of assisting recovery and promoting health. But nurses become institutionalised too and need reminding of this.

In our search for new models of clinical practice, and in our approach to setting standards of nursing care, we need to give renewed weight to patients' own perceptions of their condition and treatment and embrace the idea of fostering patient autonomy. To do so, we need to give full weight to the vulnerability of patients at every point of contact with the health system.

Ken Jarrold, Regional General Manager of Wessex Regional Health Authority, and not unknown here, gave a public lecture in January 1990 at the University of Southampton in which he highlighted both the vulnerability which is associated with being elderly or having a mental or physical disability and the special vulnerability which derives from anxiety and concern at the time of contact with health services. I think that we can tend to pay lip-service to that vulnerability. We only feel its full force when we become inpatients ourselves or when someone close does. It is then that we experience very directly what powerfully coercive institutions hospitals are. Most patients spend most of their time as inpatients trying not to be any trouble, fearful of authority and unduly grateful for the care they receive.

That observation is, I think, true, both in acute wards where patients are highly dependent and in, for example, maternity wards where the clients are basically well women. It is also true in primary health care. People find it difficult to communicate with their general practitioners, may perceive their health visitors as authoritarian and, by the time they need district nursing services, feel wholly dependent on the goodwill of the visiting nurse. Breaking through the gratitude barrier is still incredibly difficult; but we must strive to do it.

So how do we overcome this vulnerability and restore power to the patient? Part of the answer, but only a small part, lies in

the front-of-house, customer services which hospitals and health centres should offer.

It is easy to be cynical about efforts to smarten up outpatient and casualty departments. It is easy to make smart debating points about managers who think that quality assurance is about flowers in reception and Laura Ashley curtains. But these things matter as well. I sometimes feel that when you enter health care institutions you get the impression that patients are the last ones to be considered. If a hospital or clinic is short of space, it is the patients who end up queuing in the corridor – not the managers, nurses or doctors!

Patients need to have confidence that their needs are considered paramount. A clean, warm, cheerful environment with good food and clear and relevant information is very important in reassuring patients and their relatives that they are in competent hands. If patients perceive that the hospital is geared towards making their stay comfortable and as pleasant as possible, they may have more confidence to ask the more difficult questions about their care and treatment.

It is also easier to have confidence in one nurse than in many. If we accept that the essential prerequisite for patient autonomy is self-confidence, then I think it follows that self-confidence can only be built upon a continuous relationship with the caring team. That is the strength of primary nursing. I would like to quote from an address given by my dear friend, Colin Ralph, Registrar of the UKCC, to a conference held in September 1990. I think Colin captured the essence of what primary nursing, and indeed all good nursing care, is striving to achieve. He said: 'The essence of primary nursing ... is similar to the essence of individualised nursing care, and the essence of the special relationship between midwife and mother and health visitor and client.

'It is also the essence of the UKCC code of professional conduct. This can be captured by one simple word and that is "personal" ...

'Care must have a personal quality. It matters deeply to patients and their families that "their" nurse knows them and that they know their nurse ...

'It is through the "personal" relationship and trust between nurse and patient that the true humanitarian quality, compassion and the concern of nursing finds expression. It is through this that the bewildering and frightening worlds of health care institutions and services are translated by "personal" nursing into sources of support, comfort, soothing and skill.'

A similar concept has been offered by Alastair Campbell in his book *Moderated love: a theology of professional care*. Alastair Campbell recognises that to offer this personal relationship involves what he calls a 'costly mutuality' for the nurse. He says 'nursing is a companionship which helps the person onward whether the destination is recovery or death, a companion helps the hardness of the journey ... the skill and knowledge of nurses make them able to see, sometimes better than the patient, how the journey can be accomplished ... the closeness of contact between nurse and patient means a costly mutuality for the nurse. It involves "being with" not just "doing to" ... thus in the skilled care which the professional nurse offers there may be discerned a form of love.'

THE CHALLENGE TO NURSING IN THE 1990s

I think the challenge for us all, as we move nursing into the 1990s is to bring that spiritual dimension into the debate about consumerism. As Margaretta Styles once said: 'I love nursing, but not the conditions in which I practise it.'

The difficult conditions in which so many nurses practise are very apparent to the patients we care for. That must be the root of Kenneth Clarke's abysmal poll rating in *The Guardian* in October 1990. For a health minister to come bottom of a poll of ministers with a stunning array of controversial policies reflects deep public unease about this government's commitment to the health service. Our commitment is not in doubt. We are secure in the knowledge that the public at large is committed to the ideals of public service which we hold dear. It is old fashioned but it is true. So we must go forward with confidence.

Nursing is the most wonderful occupation, which has enriched my life. It has to do with all the finer and most

beautiful things of life. Nurses are very privileged, because human beings, generally, react well to adversity and illness. It brings out their courage, tenacity, generosity and bravery. If we can harness those qualities in the people we serve, and match them with our own, costly, love, then we will continue to offer a service of which we can all be proud.

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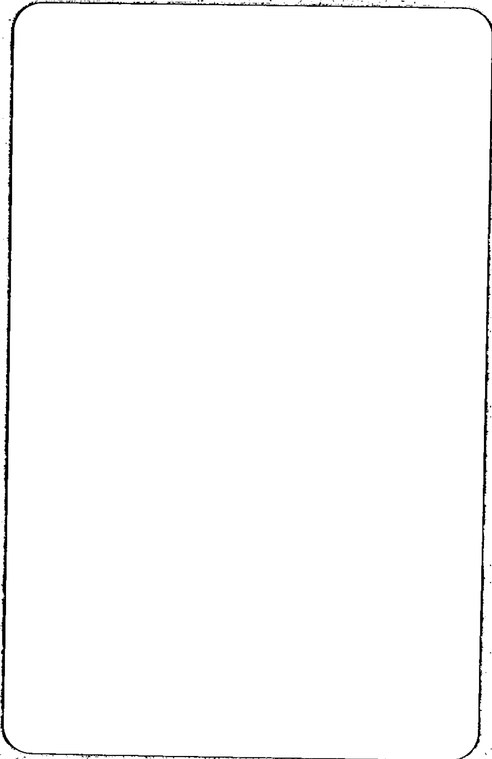

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