NURSING IN A POST GRIFFITHS WORLD

A STUDY IN FIVE ENGLISH HEALTH DISTRICTS

by

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CHAPTER I

INTRODUCTION

1.1 BACKGROUND & RATIONALE

In 1983, the Government published the NHS Management Inquiry, led by Sir Roy Griffiths and colloquially known as the 'Griffiths Report'. The remit of the Inquiry Committee was to give advice on the effective use and management of manpower and related resources.

Amongst its conclusions, the inquiry commented on, "the lack of a clearly defined general management function throughout the NHS". It was this particular observation which resulted in the recommendation of a new general management ethos within the service: namely the identification at Regional, District and Unit level of a General Manager, regardless of discipline. This individual would be charged with the general management function and overall responsibility for management's performance in achieving the objectives set by the Authority. For the first time, the service would be explicitly managed rather than administered through consensus.

Much has since been written elsewhere about the Griffiths Report and its ramifications. Suffice to say that it is having an enormous impact on the NHS. This is manifest in such general terms as management culture and climate, and in specific ways, such as District and Unit structures, role changes, the establishment of a Management Board, individual performance review, and performance-related pay.

The report has been described as the stealthy revolution, producing initially unappreciated, yet fundamental, changes in the organisation of what is the largest employer in Western Europe.

As the biggest workforce, and most costly component of the NHS budget, nursing would clearly be affected by Griffiths. Indeed, the circular which instructed Regions and Districts on the implementation of general management, referred to *"determining optimum nurse manpower levels in various types of unit, having regard to the needs of the local situation and the maintenance of professional standards, so that Regional and District chairmen can re-examine fundamentally each Unit's nursing levels"*.

Yet, although the Report was clear on principles, it was far more circumspect about the specifics. The Secretary of State himself wrote of his anxiety *"to avoid an over-centralised implementation ... We are resisting the temptation of prescribing in detail what Authorities must do"*.

As a result, the effects of Griffiths, particularly on nurses and nursing, are far from consistent. It was in order to explore some of the issues being raised, that the King's Fund College convened a nursing management seminar. This led to the King's Fund College and the Royal College of Nursing commissioning a study of the implications of general management for the nursing profession, and of the constraints placed on general management by perceived professional concerns. The project was overseen by a Steering Committee, whose composition is given in Appendix A, and was

carried out by a member of the NHS Training Authority's Change Management Consultancy Scheme.

1.2 THE STUDY

The aim of the study was :

"To explore practical operational issues concerning the current general management - nursing interface".

The objective overall was :

"To add to the body of knowledge about professional management in a general management context, with particular reference to nursing".

Specifically, the objectives were :

a) To describe some of the implications for nursing of recent changes in the NHS, following the introduction of general management, and

b) to disseminate such information in the form of a joint King's Fund / RCN report, describing the issues to be addressed by both general management and professions such as nursing, in a "Post-Griffiths NHS".

1.3 THE METHOD OF THE STUDY

The project involved five English Health Districts. These were selected by the Steering Committee so as to include, as far as possible, a geographical spread, teaching and non-teaching Districts, urban and rural, some of which had retained most of their pre-Griffiths structure and others which had made more substantive structural changes and/or had introduced new roles.

Within each District, the following key people were interviewed :

- The DGM
- A UGM
- The Senior Nurse in the District
- The DNE
- A Director of Nursing Services or equivalent
- The Chairman of the Medical Executive Committee or equiv.
- One group of Clinical staff at the level of Ward Sister.
- One group of Senior Student Nurses
- The Community Health Council Secretary.

In addition, several nursing officers were interviewed in one of the Districts.

The precise profile of Districts and interviewees are given in Appendix C.

The interviews, which were semi-structured, covered the following broad issues :

- The Nursing Advisory Structure
  (including Representation, Management, Advice)
- Nurse Education
- Nursing Specialties
- Nursing Morale
- Standards of Care / Quality of Service
- Accountability / Responsibility
- Involvement in the consultative process during implementation of Griffiths.
- Levels of decision-making
- Clinical career structures
- Nurse Personnel
- Nursing Input to policy information and planning
- Essential job of Nursing post-Griffiths.

All interviewees were offered anonymity, and no District or individual is identified by name. However, general descriptions, analyses and tentative interpretations have been made on the basis of information obtained.

1.4 THE SCOPE OF THE STUDY

The project was designed to take 30 days in total, to include preparation, travel, visits, report-writing, etc. It commenced in October 1986 and was completed in February 1987. Each on-site visit took two days, and each interview approximately one hour.

Given such timescales, there are clearly some methodological constraints to be borne in mind. Firstly, this particular research, unlike some others currently being undertaken, is an 'historical snapshot' rather than a longitudinal or in-depth analysis. It is descriptive rather than prescriptive. Because of the timing of the fieldwork (Oct-Dec 1986) it should be viewed against the wider timetable of Griffiths-related changes in the NHS. Secondly, it derives its data from a small, selected sample of Districts and must, therefore, be considered for its qualitative rather than quantitative value. Thirdly, as will be seen from the report, views about Griffiths are inevitably coloured by the positive or negative benefits experienced by respondents.

Fourthly, the anonymity offered to interviewees has influenced the presentation of the findings. Short of verbatim reports, it is impossible to repeat every comment in every interview. The findings are, therefore, a faithful "distillation" of views. Any misrepresentations are entirely the author's.

The remainder of this report briefly considers the state of nursing prior to Griffiths, before examining each of the major

issues identified earlier. Finally, some tentative conclusions are drawn.

CHAPTER II

NURSING IN A PRE-GRIFFITHS WORLD

2.1 INTRODUCTION

The NHS is a large and complex organisation which, at the time of the publication of the Griffiths Report, had a budget of around £17,000m and a workforce of over one million, of whom around half were nurses.

While in its history the NHS has experienced three major changes (1974, 1982 and 1983), nursing has undergone further changes as the result of such reports as the Salmon Report (1966) and the Mayston Report (1969).

It was the first of those, the Salmon Report of 1966, which produced the most significant effects on the profession. It delineated three principle levels of management :

- Top Management, who decided on policy
- Middle Management, who programmed the policy
- First Line Management, who controlled the execution of the policy

The intention was to involve nursing in policy and planning decisions at the top of the organisation, and to give nurses line management responsibility, culminating in a Chief Nursing Officer, for nursing at each level within the service, while relieving them of such tasks as the co-ordination of domestic and catering support staff.

The report also differentiated several routes for advancement within the profession, namely:

- Specialised Nursing
- Nursing Administration
- Teaching.

The tasks which nurses could be required to undertake were specified as: Professional, Administrative or Personnel related. Ironically, however, in the light of Griffiths, the report spoke of *"the most senior posts where managerial ability and not nursing is the important criterion"*.

The key effects of Salmon were thus twofold. Firstly, it defined a career structure for the profession. Secondly, it combined in the top post of CNO the three responsibilities of professional advice, professional representation, and managerial control. Nurses were ultimately managerially and professionally responsible to another nurse.

Although Salmon has been commended for recognising the enabling nature of the nurse in a managerial position (Rowden, personal communication), it was not without its critics. Even the RCN has referred to its *"mechanistic system based on a hierarchy of decison-making, derived from industry"* (RCN 1981). There were too many organisational levels in the line relationship and, ultimately, too much differentiation between the management, clinical and teaching roles.

By emphasising professional functional management, it led to the strengthening and developing of nursing management but failed to develop a clinical nursing career structure. Indeed, some writers

have commented that, by introducing a management hierarchy, nursing created a split between practitioners and managers, since the latter presumably have a knowledge-base distinct from that of nursing (North West Thames 1987).

In the early 1980s, nurses, to progress up the promotional ladder, continued to be faced with the choice of nurse education or nurse management. They were still firmly managed by nurses and given professional leadership by a CNO who was accountable to the Authority and whose responsibility encompassed the following :

- Management of Health Services within a District, together with other members of the District Management Team;
- Formulating, allocating and managing the nursing budget;
- Advising the Authority on all matters pertaining to nursing in the District;
- Management of all nursing staff within the employing Authority;
- Education and training of all nursing staff.

(RCN 1983)

Hence nurses were still led by the CNO to whom they were both managerially and professionally accountable. Moreover, the CNO as a member of the DMT, had <u>executive</u> power and her management remit therefore extended to the provision of health services per se across a District.

2.2 THE GRIFFITHS REPORT

It was against this background of recent structural changes and professional functional management within the NHS, including personnel, manpower planning and general consensus management, that the Griffiths Report emerged.

The aim of the Report was to achieve a more efficient and effective delivery of service. It made several recommendations, the effects of which are still filtering through the NHS. As mentioned earlier, it is the concept of general management which is having most impact, particularly given the lack of identifiable environmental, organisational and management strategies in the service (cf. Best 1984).

As advocated by Griffiths, general management was expected to provide leadership, facilitate change, motivate staff, involve the local community and enhance professional functions. Of these, it is this last aspect, namely the relationship with the professions, which has caused so much consternation.

While the General Manager was, *"not intended to weaken the professional responsibilities of the other chief officers"*, Districts were to:

> *"Review and reduce the need for functional management structures, at all levels ... and ensure that the primary reporting relationship of functional managers is to the General Manager"* (para 6.6)

Most tellingly, Griffiths observed:

> *"Any apparent advantages of functional specialisms are nowadays more than offset by the need to establish the general management process effectively"* (para 9(d)

The notion of general management applies to all District resources, and cuts across the tradition of professionalism in the NHS - nursing could be no exception. The interpretations of Griffiths could be considered to affect such issues as :

i. the CNO role as previously understood;
ii. the CNO having line management responsibility;
iii. the CNO having an executive place on the management board;
iv. the DNE being accountable to the CNO;
v. DNSs and NOs being retained;
vi. specialist nurse planning, personnel and manpower functions remaining distinct;
vii. nurses being managerially and professionally accountable to another nurse.

The likely result, as perceived by nurses, could be to devalue the profession, separate management of nursing from provision of nursing advice, reduce career opportunities above the level of Sister/Charge Nurse, and worringly, to separate managerial and professional accountability.

The RCN, in particular, was concerned at the possible effects of Griffiths. While debate raged, the College undertook an advertising campaign designed to draw to the attention of the

public (and General Managers) the possible drawbacks inherent in nurses no longer managing patient services by right.

Predictably, some General Managers perceived this as threatening, and hardened their resolve to continue with the general management process.

By mid-1986, of 750 General Managers appointed, 9% were former nurses. Two out of fourteen Regions had not retained a Regional Nursing Officer. The July 1986 edition of the NHS Management Bulletin carried a feature on professional aspects of management, designed to promote the value of nursing advice.

Most nurses remained sceptical about Griffiths. As the organisational culture and climate of the NHS became increasingly management-oriented, several issues were emerging of particular relevance to nurses. There was a view that, just as nursing had to accommodate to general management, such accommodation should be reciprocated.

What follows is an exploration of a by no means exhaustive list of some of these issues, namely :

1. Role of CNO.
2. Management of nursing.
3. Provision of professional nursing advice.
4. Nursing representation.
5. Nursing input to policy formation and planning.
6. Accountability/responsibility.

7. Nursing personnel.

8. Nurse education.

9. Standards of care/QA

10 Nursing specialities.

11. Levels of decision-making.

12. Involvement of nursing in the consultative process.

13. Nurse morale

14 Clincial careers structure.

15. Essential job of nursing.

16. Development of the profession.

Each of the above will be taken in turn and discussed on the basis of the research interviews.

CHAPTER III

FINDINGS

3.1 ROLE OF THE CNO

3.1.1 Role Title & Function

All of the five Districts in the study have made changes to the original role of the CNO. The title of 'the most senior nurse in the District', even where it remains CNO as before, is thus no longer an indicator of the duties of the role, nor of the nursing structure.

Of the five Districts : (see Appendix D for a more detailed description of roles)

- One CNO had retained much of the previous post (District A)
- One had retired prematurely, the post abolished, and a Nursing Adviser appointed at DNS level who combined this with an Assistant General Manager post (District B)
- Two were CNOs/UGMs (Districts C & D)
- One was a CNO but with management responsibilities for nurse education and training (District E).

All five Districts had in common the transfer of some or all of the line management functions, usually to the DGM or UGMs. Only one post (District A) had any corporate executive authority at Board level not derived from a general management role.

3.1.2 Management Considerations

There were two routes whereby DGMs arrived at their decisions about the CNO post. Some decided to start with a clean sheet of paper, define the tasks to be done and then select the most appropriate personnel. Others approached it from the opposite direction by looking at the individuals they had and then arranging posts to make maximum use of their human resources.

3.1.3 Reasons for Abolishing or Altering CNO Post

The rationales given for the changes were essentially managerial or professional :

a) the old CNO role entailed a conflict of interest and was, therefore, unhealthy for the individual post-holder and for the service;

b) the whole thrust of general management was contrary to professional functional management;

c) initially, some DGMs felt less secure or that they had to make a major impact to demonstrate that general management was different;

d) growing unit autonomy and devolution of budgets inevitably challenged the old arrangement of a chief nurse with authority to vire budgets;

e) with the loss of line management responsibilities, it was difficult to justify a full time chief nurse (except possibly in a large teaching district);

f) the size of the nursing workforce paradoxically militated against having a single head of service for over half the personnel in a generally managed

District. (With smaller professions, such as chiropody or speech therapy, the span of control was more 'manageable').

3.1.4 Reasons for Retaining the CNO Post

Opinions given here were :

a) To provide leadership for the profession. Because of its size, nursing justified an identifiable professional leader who can :

   i. act as the central focus;

   ii. be the obvious channel for communication;

   iii. be an advocate for nursing (DGMs would not be credible champions of the profession).

b) A need for high level input on :

   i. policy development;

   ii. training;

   iii. a holistic view of District needs, etc.

3.1.5 Hybrid Roles

These appeared to have emerged either because :

a) a CNO wished to have additional QA duties, or

b) DGMs found it convenient to combine the reduced CNO role with something such as QA or general management.

The impression was that, since full-time CNO posts would now be hard to justify, it made sense to set up a combined role. Those CNOs who were UGMs thought most of their time (60-80%) would be on the management aspects of their new hybrid posts.

3.1.6 Role of DNA

All five Districts had nominated an individual as their channel for professional advice. In District B, where the CNO post was not retained, a Nurse Adviser was selected from among the remaining nurses at Director level. There was a feeling that ex-CNOs were at an advantage as DNAs, because they would be more credible and have better networks. Where DNAs were appointed below this, the Health Authority might need to reassure other nurses that it valued them. Alternatively, there was an interesting view that the new DNA role could be more independent than the old CNO post and was thus potentially more powerful.

3.1.7 Opinions

While General Managers, including some nurses who had become subunit general managers, understood the rationale for the CNO changes, some (but not all) nurses believed this eroded the power, status and ease of access to and from nursing.

3.2 MANAGEMENT OF NURSING

3.2.1 Definitions

Bowman (1986) has defined the role of nurse managers as follows :

> "to maintain and to improve the care provided for patients/clients by optimising human resources - the skills, knowledge and expertise of nurses - and by providing a suitable environment for the practice of care".

With the advent of Griffiths, this tradional view of management of nurses and nursing by nurses has changed.

3.2.2 Management by Nurses *(as* Nurses)

As with all other professions, except medicine, nurses are now managerially accountable to a General Manager at either District or Unit level. In that respect, they are no longer managed by nurses. In practice, the situation is rather different. There was common agreement that (up to the grade of Ward Sister at Clinical level) nurses should be accountable to a more senior nurse. Beyond this, at subunit level, there was a view that 'you don't have to be one to manage one', that is, general managerial skills become more relevant further up the structure than a professional knowledge base. This view was held across all categories of interviewees, from the CHC to nurses themselves. Those dissenters from this opinion were mostly nurses.

The advantages of management by nurses were twofold :

a) it permits informed decision-making;

b) as a professional, a nurse might take things into account which a non-nurse manager would not.

3.2.3 Management by Nurses *(as* General Managers)

In addition to management by nurses at the operational level, there was considerable evidence of nurses above this at sub-Unit level as general managers. The possibility that others would manage nursing almost seemed to be the opposite.

For instance, in District B, the two assistant GMs in the Community Unit were nurses, as were 7 out of 11 Subunit Managers in District D, and 6 out of 9 in District C. Nurses were professionally pleased that nursing had penetrated general management at this level, and personally pleased when they were managerially accountable to a Subunit Manager who happened to have been a nurse.

3.2.4 Management by Non-nurses as General Managers

Typically, nurses were accountable to GMs for the general management component of their roles, eg. *"for not overspending, for hiring and firing, etc"*. (All nurses had a professional line of acountability to a nurse somewhere in the structure - though see the later section on Accountability/Responsibility.)

From the non-nurse GMs' standpoint, GMs could never know everything about everything:

> *"It's a general management function to manage nurses".*

Some saw the hierarchical tradition of nursing as 'psychologicaly' inhibiting nurses from adopting a broader management ethos.

Nurses saw several disadvantages in this arrangement :

a) Priorities of clinical nurses and General Managers need not coincide;

b) It is sometimes difficult to explain professional problems, eg. staffing levels or skill mix, to a non-nurse.

c) It is easy to save money but it requires a skilled professional to know how to cut back without patients suffering.

d) How would nurses obtain management experience if they could rarely advance beyond say, sister level?

3.2.5 Management of Nursing versus Nurses

There was a school of thought among GMs that the management of *nursing* should be differentiated from the management of *nurses*. The former could be carried out by nurses but the latter by a General Manager.

3.3 PROFESSIONAL ADVICE

3.3.1 Arrangements

The provision of nursing advice is one of the three professional responsibilities of the nursing role as set out in the RCN/King's Fund Working Party paper. (The other two are statutory obligations and nursing standards.)

The Secretary of State's letter to the General Secretary of the RCN is quoted in the King's Fund document as stressing the importance of such advice:

> *"In practice, so far as nursing is concerned, we would expect Authorities will need a Nursing Adviser at a senior management level, whose main responsibility is the provision and quality of nursing advice to the Authority".*

Every District will, therefore, have someone designated as the District Nurse Adviser, such as the CNO, or else a DNA from among the senior nurses in the District. In theory, the range of areas on which a DNA might advise include :

- nurse manpower planning
- training and education
- development of new nursing specialities
- responses to national regional or local proposals, or consultation documents
- reviews of service.

3.3.2 Practical Issues

In practice, several issues arose :

a) Is such advice given 'as required', or routinely by custom and practice? Clearly if advice is only offered when sought, then the nursing view will be heard less readily.

b) Professional doubts may be ironed out before advice reaches management level.

c) There is no guarantee that advice will be acted upon; whereas, when the CNO was an officer of the Authority, in an executive role, nursing advice was more powerful. The onus is now on the DNA to ensure advice is both listened to and acted upon.

d) Where DNAs are CNOs, or have a strong network, they have more credibility than 'junior' DNAs. These latter may be combining the advisory function with demanding operational responsibilities, which may limit their time and availability to provide a District-wide view.

e) There is a perception that DGMs are receiving narrow parallel sets of advice from the different professions, such advice often not being influenced by inter-professional discussion. This limites the degree to which a nursing viewpoint can informatively 'enrich' general management.

f) Although UGMs are increasingly appointing Unit Advisers, as evidence of the value they place on local advice, there was a view that the District advisory role might become redundant, and the co-

ordinated District response lost.

3.3.3 Prospects for the Advisory Functions

One DGM stated that no manager would be foolish enough not to take the professional dimension into account. One Health Authority had even prevailed upon a District to ensure the nursing advisory function was adequately arranged. In another District, where both nursing and dentistry advice were relegated to an 'as required' status, a substantive post of adviser was appointed for nursing - but not for dentistry.

Clearly the role of DNA is, like those of DGM and UGM, very new. There is, therefore, an opportunity for nursing to be proactive in deciding :

- what the DNA's key functions should be
- what support is required
- how it should be perceived
- what are the career implications
- how it can operate most effectively.

3.4 NURSING REPRESENTATION

3.4.1 Advisory Machinery

The ways in which nurses were represented within the professional advisory machinery varied across Districts. One District had the same system as pre-Griffiths, but others had reconstituted their advisory committees. These were now known by any one of several titles, eg. NPAC, DNAC, NMPAC.

Irrespective of title, functions were similar, eg:

- to share information
- to maintain contact
- to discuss policy and practice
- to co-ordinate District practices and standards
- to consider nurse training.

Membership was either elected or selected and varied from 7 to 24. Some committees were more 'democratic', having representatives from SEN upwards. The Chairman was ususally the DNA, though not necessarily.

Nurses had other commitees, such as Senior Manager Meetings, Senior Nurse Management Group or Nursing Personnel Group, all of which usually fed into the key Advisory Committee.

Most DGMs acknowledged that nurses felt a need to meet professionally, but tended not to attach much importance

to the meetings, preferring to deal with one individual. One DGM remarked that the groups could be more proactive, in which case managers would take more note of their actions.

3.5 INPUT TO POLICY AND PLANNING

While the absence of the CNO might have reduced one line of policy advice, the existence of professional nursing advisory machinery and of DNAs did provide the means for nurses to contribute to policy and planning debates. There was also a view that, by virtue of their strong presence at sub-unit level as General Managers, nurses would also ensure nursing involvement in unit decisions.

With respect to DGMs, most preferred to work through one identified nurse, typically their DNA, with nursing contributions being fed through this individual. Some DNAs remarked on a willingness among DGMs to listen to them before moving forward.

3.6 RESPONSIBILITY & ACCOUNTABILITY

3.6.1 Definitions

The notions of responsibiity and accountability are frequently used interchangeably in everyday speech, and even in the literature. Strictly speaking, responsibility is :

> *"A charge for which one is answerable. The focus is on the charge, not on how or to whom the answering would or should occur".*
>
> (Batey & Lewis, 1982)

It denotes having an obligation to perform a specified task, or see that others perform it in a way that satisfies specific criteria.

Accountability, on the other hand, is :

> *"the fulfilment of a formal obligation to disclose to others the purposes, principles, procedures, results .. for which one has authority".*
>
> (Batey & Lewis, 1982)

Being accountable means being liable to be asked to report on and justify actions in relation to specific matters.

These distinctions are important in the context of professionalism within a general management process. Being a 'professional' means, among other things, acting responsibly in accordance with one's code of professional

practice and one's conscience. It is primarily a matter for the individual and the profession.

Accountability, as suggested above, is a requirement of members of an organisation to be answerable for their work. It is more a matter for that organisation.

The effect of Griffiths has been to expose these two concepts to scrutiny, and in a sense to separate them. As one UGM remarked:

> *"Accountability versus responsibility is a necessary distinction to make general management work".*

3.6.2 Dual Accountability

On paper every nurse interviewed had a professional line of accountability to another nurse, but was ultimately managerially accountable to a general manager (who may or may not have had a nursing background). In practice, nurses at the operational level, ie from learners to sisters, saw themselves as both professionally and managerially accountable to another nurse.

This raises the issue of dual accountability, on which there were a range of opinions:

> *"The whole ethos of general management is against a code of conduct".* (CHC secretary)
>
> *"It is difficult, in the context of nursing, to compartmentalise managerial and professional accountability and attempt to divorce the two"* (RCN)

"Dual accountability does cause a problem because you don't always know the dividing line". (DNS)

"Accountability is thrust upon nursing as a muzzler". (a doctor)

DGMs, UGMs and some nurses took a different stance:

"This question of accountability/responsibility was an issue two years ago. Now it's just theoretical". (DGM)

"There was an initial concern about this but now it seems to work in practice". (DGM)

"The GM is also a professional in his own right". (DGM)

On balance, the majority opinion was that while dual accountability was an issue, it had not yet seemed to cause major problems. (This is an interesting finding given the recent NWTRHA study, where dual accountability did appear to be more problematic.)

"So far nurses are coping with it". (CNO/UGM)

"It's not a problem - it depends on the degree of autonomous relationship". (DNE)

"It's a hazy split in practice but I'm not bothered about having a non-nurse as a manager". (Divisional Manager/ex-DNS)

"The split is something everyone will have to live with but it's not a problem - possibly only midwives and the community are likely to find it confusing". (DNE)

Some interviewees even pointed out that nurses have always had this kind of split to contend with, eg sisters used to be professionally accountable to nurses but 'managerially' to consultants or administrators.

Perhaps the most appropriate modus operandi is to accept that:

> *"Nurses must be responsible and accountable for their own [professional] actions. It follows logically, if nurses are to be held responsible and accountable for nursing practice, that they must be given the necessary authority and autonomy if they are to act effectively".* (Bowman, 1986)

Thus the dispute seems to be between professional accountability for one's responsibilities as a professional, and managerial accountability for management issues to a General Manager.

3.7 NURSING PERSONNEL

Pre-Griffiths most Districts maintained a separate nursing personnel department. The trend now seems to be to integrate this into the District or unit personnel service.

DGMs doubted whether professional support staff at District were necessary:

> *"In personnel we need personnel people first and nurses second".*

All five Districts had assimilated any personnel nurses into the integrated service; these individuals now tended to be more generalist than specialist.

Possible drawbacks from this were, for instance, that valuable nurse databases might be lost, or that unitised services might limit a District view of manpower levels.

Overall nursing personnel was no longer considered a special case but had to amalgamate with the rest of the service. However, at the clinical level, notably because of the numbers involved, nurses seemed to be involved in much of the actual 'hiring and firing' of nursing staff.

3.8 NURSE EDUCATION

Nurse education presented a complex picture. Part of the reason is the diffuse role of the DNE who is accountable at district, regional and national levels for a range of educational, professional and financial responsibilities. Some Districts have idiosyncratic arrangements, with Schools of Nursing providing basic and/or post-basic courses, often to more than one District.

In four of the five Districts visited, the DNE was accountable to the CNO/CN. In one (B) s/he was administratively accountable to the Director of Manpower Resources and Organisation (a non-nurse). The ENB has recommended that the person who monitors and is accountable for teaching must be a teacher, which was not always the case.

On a day to day basis this may not be problematic. Of more concern was the prospect that increasing unitisation would mean decisions being taken which might fragment the District education service. This could cause credibility problems within the profession and a possible knock-on effect on recruitment.

Financially, nurses were concerned that, if unit budgets became overspent, a UGM might stop training, eg district nurses, ie "we can't retain so why train?" In addition, where a nurse education budget was underspent, the surplus might not be returned to nursing but be 'lost' at District.

The final issue arising in nurse education was the plea from students and qualified staff alike for better management training. Senior nurses reported feeling at a disadvantage compared to other disciplines with respect to quality and quantity of management education.

3.9 STANDARDS/QUALITY ASSURANCE

In its 1981 discussion document 'Towards Standards' the RCN named eight necessary constituents of the professional control of standards, namely:

- a philosophy of nursing
- relevant knowledge and skills
- the nurse's authority to act
- accountability
- the control of resources
- organisational structure and management style
- doctor/nurse relationship
- the management of change

Griffiths has led to further focus on standards, notably with the establishment of posts in QA, (as distinct from Consumerism). Sceptics may view this, as did one UGM, as ' a device to find a job for someone'. The more common view was that standards were everyone's concern, and should stem from a bottom-up approach. Some groups were identified as especially responsible for standards (interviewees in brackets):

- CNO (CNO)
- Sisters (sisters)
- UGMs (DGMs)
- DNA (DGM)
- Senior sisters (NOs)

Districts were approaching QA in different ways. One Health Authority was producing a set of guidelines on areas such as

'Care of the Dying'. In another, the Senior Nurse Clinical Practice chaired a Standards of Care Committee, and in others 'Monitor' or quality circles were in operation.

Sisters in particular did feel standards were dropping, eg because of:

- Closures of beds, wards
- Unfunded pay awards
- RAWP
- Untrained staff in charge of wards
- Employment of agency staff

However, CHCs did not report evidence of deterioration in nursing standards. One CHC Secretary commented that complaints about nursing care (as opposed to medical care) were rare. Of the total complaints he received, 50% were not about incompetence but about lack of communication; if anything, nurses were praised.

3.10 NURSING SPECIALTIES

By and large nursing specialties were aligned with functional medical divisions. There was evidence of specialist nursing roles developing, eg District Stomatherapist; or 'clinical nurse specialist in cancer care'; or 'senior nurse clinical practice' who was responsible for standards, procedure and policy guidelines.

In one or two Districts, Health Visitors and District Nurses were managed separately. In one District there was some confusion because gynaecological surgery came within surgical services and not women and children's. In another case, the care of elderly mentally ill people was split across units. The overall picture, however, was reported as satisfactory by nurses.

3.11 LEVELS OF DECISION-MAKING

The consensus opinion was that meaningful decision-making was most appropriately equated with budget-holding. All general managers supported the move to push decisions further down the system, aiming ultimately at ward level and encouraging innovation. At present, most budgets were still held at unit, though in District E, for instance, sub-unit budgets had been devolved for some time.

Nurses felt that, where they were budget-holders, it was often in name only. For example, they might be responsible on paper for catering or ODAs, yet had no corresponding budget and hence little authority:

> *"They've made us more responsible but haven't given us the power or resources".*

Those sisters who received a budget statement need not have been involved in allocating it:

> *"I put it straight in the waste basket".*

There was no incentive to save because subsequent budgets would be cut accordingly:

> *"I make sure I overspend".*

One charge nurse reported that for minor items he had to go via a ward clerk to his DNS for countersigning - yet had the authority to order heroin by himself!

Clearly, most budgets have yet to match sub-unit management arrangements, so nurses at the direct care level rarely have the opportunity to contribute to debates about allocation of resources, let alone being responsible for spending them. Moreover, once budgets are pushed down the structures, managers must ensure the balance between involving and overloading.

3.12 INVOLVEMENT IN CONSULTATIVE PROCESS

Such involvement seemed to span two time-periods: that of initial District structures and then subsequent unit arrangements. In 4 of the 5 Districts visited, there had been full consultation with such bodies as the Nursing Management Committee, the Hospital Management Team, JSCC, Nalgo, RCN and the CHC. One DGM specified 'for comment' as opposed to consultation; the difference being that the first was *"less negotiable"*. In the fifth District, the DGM consciously chose not to consult with any disciplines about the District structure, in order to signal a break with the past. His UGMs have, however, now consulted widely about unit proposals. One nurse observed that, at unit level, the nursing staff are the last to be informed:

> *"It's a standing joke that we usually hear it from the cleaners"*.

Clearly, individual management style and circumstances have varied, but the overall picture was one of nursing involvement.

3.13 MORALE

This was an emotive issue. Consensus was that staff morale was 'pretty poor' for a variety of reasons listed below :

3.13.1 Drop in Standards of Care

"Unless you've worked at the bottom level, how can you understand what it's like to give a service you know isn't as high as you'd like?"

Nurses quoted such examples as reductions in the shaving or barber service. Privatisation meant the demarcation of tasks which were previously done by a 'team'.

3.13.2 Increased Pressure

This was due to :

a) increased throughputs.

b) more dependent patients being discharged to the community.

c) lack of resources.

d) lack of staff.

"There are fewer nurses on the ward"

"There are fewer nurses to do the actual work"

"It's all crisis intervention".

3.13.3 Increased Responsibility

These resulted from, eg.

a) Having to manage budgets without appropriate training (or the co-operation of other disciplines)

b) Being responsible for other staff or services, such as domestics, ODAs, or Ward Clerks.

"The responsibility is phenomenal"

"You have so many things coming at you, that I don't feel I'm doing my job properly any more"

"This is not what I trained for".

3.13.4 Perceived Lack of Support

Nurses felt they had little physical or managerial backup: 'each nurse is on his or her own'. Sisters did single out the support of NOs as valuable, which raises the question of how nurses, without such higher professional support, cope.

3.13.5 Lack of Concern about Staff Welfare

There was a perception that nurses are not cared about :

"They're cutting back on wardens and security guards while more nurses get assaulted"

"They're closing down our accommodation"

"Management gives care to patients but leaves nurses to get on with it"

"Nurses are seen as copers"

"They pay lip-service to counselling"

"I'm appalled at the way we have treated the odd one or two nurses".

3.13.6 Poor Education & Training

This concern varied according to the level of nurse. Some students, for instance, felt they were caught between two systems. At school they were taught new practices, eg. about dressings or salt baths, but were unable to implement them because qualified nurses seemed threatened. Others commented that much of the teaching was done by third year students because they were approachable.

For qualified staff the issues were either that fewer courses were available and/or staff could not be released; or that current provision of management training was poor. This last comment was made time and again.

3.13.7 Poorer Career Prospects

Some nurses felt they had less chance of promotion in nurse management because of general management, and were generally uncertain about their prospects:

"I don't want a career with a cut-off point"

At the other end of the spectrum, enrolled nurses were simply wondering whether they had a viable future at all.

3.13.8 Management Changes

a) Structures

There seemed to be 'too many administrators':

"I don't know what these GMs do"

Some arrangements for slotting in or internal competition seemed unfair and disadvantageous.

b) Operationally

Nurses appeared sceptical about some aspects of general management :

"General management is about different uniforms and titles, but the same job"

"Pre- and post-Griffiths it's the same, only now you do more work with fewer people".

c) Management style

There was an impression among many nurses that :

i. Decisions were often taken by people not in touch with the patient;

ii. There was less dialogue between staff and managers;

iii. Management offered little support;

iv. Staff were not consulted about changes as much as they would wish :

"Everyone wracked their brains about how to save money, but it had already been decided"

"All the little ideas that everyone thought of were swept aside"

"If you want to innovate, you get blocked".

d) Financial implications

Nurses were disappointed that some of the savings made were not coming to nursing. There was a sense that some financial decisions impinged on patient care :

"Our main contact with management is about switching to less effective needles and cheaper catheters".

e) The nature of change

Change by its very nature was uncomfortable - "It's like musical chairs", and the long time taken in some districts to implement Griffiths had made nurses unsettled.

The overwhelming sense among nurses was that their goodwill was being squandered:

"My health suffers and I go home stressed"

One nurse spoke for many when she stated:

"We're bad-tempered, crotchety and disillusioned"

3.13.9 Timing & Perspective

Despite the discontent among nurses, many interviewees, especially managers, thought that *"the tide is turning"* and *"the real danger signs have subsided"*. Whereas, initially, general management had led to upset, *"as time passes and management arrangements improve, morale is lifting"*.

The process appeared to be :

Apprehension -- (Mental) Resignation -- Adjustment

For many nurses the outcomes were better in practice than they had expected. Griffiths provided the justification for them to start challenging doctors, eg. about the respective merits and costs of dressings.

3.13.10 Correlation versus Causation

Interviewees in every District, including nurses, pointed out that many of the difficulties associated with Griffiths may well have happened anyway, given certain political or economic climates. Griffiths was simply a convenient peg on which to hang some issues, which could well have emerged in any case.

This distinction between correlation and causation is critical: Griffiths in general and general management in particular may well have compounded matters but that is distinct from being the prime cause.

3.14 CLINICAL CAREER STRUCTURES

Pre-Griffiths, promotional prospects for nurses beyond Sister level usually meant management or education. Those nurses who enjoyed direct clinical contact were obliged to leave it for enhanced pay or status. Those who chose to remain were considered unambitious. Nurses reported feeling forced into management and thought the profession was losing out because many young, able nurses inevitably moved away from the bedside.

Among the sample interviewed, there was common agreement on a need to provide ways for nurses to stay at the client level. Proponents of Griffiths argued that this is precisely what general management has facilitated.

As well as the career options in general management (and doubtless because of the commensurate reduction in nursing management posts), GMs believe clinical career roles are opening up. GMs believed there were more career possibilities post-Griffiths than before, and a genuine attempt to make Sister posts more attractive.

As mentioned elsewhere in this report, some of the five districts studied had expanded various clinical posts above Sister level, varying from Clinical Nurse Specialists to Senior Nurse Clinical Practice to Senior Sisters. GMs presented this as an opportunity to reprofessionalise nursing and hoped that it would encourage a re-evaluation of clinical nursing.

3.15 THE ESSENTIAL JOB OF NURSING POST-GRIFFITHS

There was universal agreement that the key aspects of nursing had not changed because of Griffiths.

Virtually everyone interviewed believed that the fundamental hallmarks of the profession were unaltered. The essence of nursing was still to provide good comprehensive 24-hour care to patients.

3.16 THE DEVELOPMENT OF THE PROFESSION

The three career routes open to nurses, namely clinical, educational or managerial have not been changed, except that there is now an opportunity to branch into general management. This was seen by many to 'empower' the profession. The movement of nurses into management was considered good for the organisation, if unfortunate for the profession.

Many nurses admitted that they had not thought themselves as able as the competiton for general management and so had not applied. Having seen the standards of successful applicants, they were now more confident of being able to compete successfully when contracts were up for renewal: *"Just wait till next time!"*.

GMs were already thinking about where the following generation of managers would come from. Nurses as 'natural' people managers were obvious candidates.

CHAPTER IV

CONCLUSIONS

4.1 OVERVIEW OF FINDINGS

4.1.1 The line management functions of the nursing profession have been eroded as a result of general management. (3.1.1), (3.2.2)

4.1.2 Hybrid nursing roles are emerging by way of compensation. (3.1.5)

4.1.3 There is growing unit autonomy. (3.1.3)

4.1.4 All five districts and some units have designated Nurse Advisors. (3.3.1)

4.1.5 Nursing advice must be perceived as credible to be acted upon. (3.3.2)

4.1.6 Professional advice is often restricted to advice about the particular profession rather than about general issues. (3.3.2)

4.1.7 GMs acknowledge the value of the professional dimension. (3.3.3)

4.1.8 DNA roles present an opportunity for nursing to demonstrate a proactive approach to service delivery. (3.4.1)

4.1.9 There is continued nursing input to policy and planning via the DNA and NACs. (3.5)

4.1.10 General management has sharpened the theoretical and practical distinctions of professional responsibility and managerial accountability. (3.6)

4.1.11 All nurses have professional lines of accountability to another nurse, but are ultimately managerially accountable to a UGM or DGM. (3.6.2)

4.1.12 Many subunit general manager posts have been filled by nurses. (3.2.3)

4.1.13 Nursing personnel is increasingly integrated into a District or Unit service. (3.7)

4.1.14 The role of the DNE is diffuse and complex. (3.8)

4.1.15 Nurses desire improved management training at all levels. (3.8)

4.1.16 QA is of topical interest but seen as a common concern. (3.9)

4.1.17 Meaningful decision-making is equated with budget holding. (3.11)

4.1.18 Most budgets have yet to match subunit arrangements. (3.11)

4.1.19 Budget responsibiities should strive for a balance between involvement and overloading. (3.11)

4.1.20 Nursing has typically been consulted in the implementation of Griffiths. (3.12)

4.1.21 Morale has been very low for a range of reasons, some personal, some professional and some managerial. (3.13)

4.1.22 Much of the climate currently in the NHS is correlated with, rather than primarily caused by, Griffiths. (3.13.10)

4.1.23 Griffiths has provided qualitatively different career opportunities for nurses, either as professional managers, General Managers of nursing, or General Managers per se. (3.16)

4.1.24 Clinical career opportunities for nurses appear to be opening up. (3.14)

4.1.25 The essential job of nurses as comprehensive holistic carers of patients remains the same. (3.15)

4.1.26 Nurses are now more confident of their suitability as prospective general managers, because of their managerially relevant professional experience. (3.16)

4.2 RETROSPECT & PROSPECT

Griffiths may be viewed with hindsight as part of a radical change of approach which required a critical review of existing roles and practice. It is the differing interpretations of it which have led to the emergence of 194 'mini' NHSs.

By extension, the differing experiences of individuals at the personal or professional level have tended to polarise views for and against it. The enforced upheaval of yet another oganisational change may have inhibited senior professionals from demonstrating the leadership and assertiveness needed in a period of transition when professions perceived themselves as being eroded and disenfranchised.

Once initial apprehensions subside and are replaced with acceptance, nurses frequently acknowledge the possibilities available for more real power and clinical expertise.

When the understandable concern about structures dies down, it is likely that the outcomes of service delivery will be essentially the same. Some tasks will be done better, eg. the specification of objectives, swifter decision-making, financial accountability. Some may not, eg. skill mix, manpower planning. Some structures facilitate the new general management process, others have yet to orchestrate this.

General management looks here to stay, at least for the foreseeable future. To use an evolutionary analogy, the

professional species which cannot readily adapt to the inevitable, will only face more difficulty if not extinction. However, the essential role of nursing guarantees its survival. The question is, therefore, survival in what form?

Griffiths has facilitated a permanent revolution: the only thing certain is that change is now constant. Given this, nurses and nursing should embrace general management opportunities. The three options of professional management, general management (of nurses) and general management (qua general management) are now available to the professions.

The accommodation which the professions felt they had to make to general management can then be turned around so that general managers will reciprocally accommodate the professions.

The resultant combination of complementary knowledge bases and skills heralds a powerful synergy for the NHS.

* * *

APPENDICES

APPENDIX A

COMPOSITION OF THE STEERING COMMITTEE

Gordon Best	:	Director, King's Fund College
Judith Bryant	:	Regional Nursing Officer North West Thames RHA
Derek Dean	:	Director of Nursing Policy and Practice, RCN
Catherine McLoughlan	:	DGM, Harringey Health District
Kate Newson	:	Director of Midwifery Services, Tower Hamlets Health Authority
Ray Rowden	:	UGM, M.H. Services, West Lambeth Health Authority
David Rye	:	Fellow, King's Fund College (Chairman of Steering Committee)

APPENDIX B

COMPOSITION OF ORIGINAL SEMINAR GROUP

Miss P.J. Hibbs
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David Rye
Fellow in Organisation
Nursing Management
King's Fund College.

APPENDIX C

INTERVIEW TABLE

Interviewees Districts	Total	DGM	UGM	Senior Nurse in District	DNS or Equivalent	Chairman of Medical Exec Committee	DNE	Sisters/ Charge Nurses	Students	CHC Sec	Others
A	18	1	1	*CNO/Director of Quality Assurance	1	1	1	8	5	1	-
B	29	1	2	Nurse Adviser	3 : Asst Gen Man " " " Inpatient Svs Manager	1	1	6	7	1	Director of Manpower Resources & Organisat'n
C	15	1	2	*CNO/UGM	2 : Div. Man. Surgical Svs Man. of Women & Children's Services	1	District Training & Nurse Education Officer	7	-	1	-
D	12	1	3	CN/UGM	Child Health Manager	1	1	1	-	1	INO HA Chairman 1 Admin.
E	4	-	1	CNO	2 Patient Svs Managers	-	-	-	-	-	-

* Member of Executive Board

NB Totals differ within Districts because some individuals occupy more than one role.

APPENDIX D

DISTRICT PROFILES & MANAGEMENT STRUCTURES

District A is an inner-city teaching district, with district, regional and national obligations and reputation. It has 3 units: two Acute, each centred on a major hospital, and one Priority Care unit.

The concept of Clinical budgeting has been introduced (though not necessarily as a result of Griffiths) in the two acute units. Across both these are twenty-two (medical) Directors of Clinical Services. Within each Directorate are a number of clinical teams, each consisting of 4-5 consultants. These clinical teams agree a level of expected annual work and likely associated resources. The emphasis is on prospective activity workloads and budgets for whole services, such as medicine or surgery, rather than functional parts, such as domestic staff or nursing. Consultants are, therefore, very closely involved in planning and managing budgets.

The CNO has been retained and is also the Director of QA. There are six DNSs and a DNE. DNSs are deemed 'staff managers', responsible for staff deployment, hiring and firing, training and development, etc. UGMs and Directors of Clinical Services are 'resource managers'. The DNSs act as service providers of nursing services to the twenty-two clinical directors, and agree with them the quantity and quality of nursing services required for a

given area. It is up to the CNO, together with the DNSs and DNE to ensure that the resource levels agreed are compatible with high standards of care and training.

Each Director of Clinical Service is allocated a senior nurse (NO or above) as appropriate and, together with an administrator, these three form the Directorate's management team. The senior nurses are still accountable to the DNS but work on a day-to-day basis to the medical directors.

For the general management component of their role, DNSs are responsible to the UGMs. On professional matters, all nurses are responsible to the CNO, who is a member of the Specialist Directors Group and the District Management Board.

District B is a non-teaching, urban district with two units, Acute and Priority. The DGM has retained the DMO post but not the CNO one. The former CNO took early retirement. All operational and functional activities, wherever possible, are accountable at unit level.

There is a recently appointed Nurse Adviser, drawn by interview from the senior nurses in the District, ie. the DNE and the DNSs. Of the DNSs, one is now the In-patient Manager at the DGH, the other two are Assistant General Managers in the community, of which one is the hybrid Nurse Adviser role.

This NA role is held in addition to any other post, but receives support and remuneration accordingly. The NA chairs the Nursing & Midwifery Advisory Committee, but his/her primary function is to give nursing advice. S/he, although a member of the District Policy Group, has no executive function.

In the Acute Unit, the ex-DNS/In-patient Manager sits on the UMB. Below him/her are nine nurse managers, who are general managers of the areas in their charge. Eight are professionally and managerially accountable to him/her, and one is managerially accountable to a non-nurse but professionally accountable to the ex-DNS/In-patient Manager.

All other nurses operate at ward/departmental level. There is no nursing management tier between the nine nurse managers and ward level, although 18 posts have been designated Senior Sister posts. Ward Sisters are in overall charge of their ward and of

all staff, including domestics (except doctors).

In the Priority Unit, apart from the two ex-DNS/Assistant General Managers, several other subunit level management posts are held by nurses. The DNE is accountable to the Director of Manpower Resources and Organisation.

District C is a non-teaching district, centred on a coastal town. There are four different local authorities within the catchment area, and numerous parish councils. There is a large voluntary and private sector vying for recruitment.

There are two units, Acute and Priority, with most services on a functional split-site basis.

The CNO post has been retained and combined with one of the two UGM posts. The CNO manages the nurses in his/her own unit, plus the nurse education department, and provides professional advice to the authority. However, s/he is not the manager of the nurss in the other unit. Thus, although there is a CNO in name, some of the executive line management responsibilities have been removed. In effect then, the title of CNO remains but, in practice, the role is primarily advisory.

District D is a non-teaching district with four units derived from seven care groups, as follows :

- Acute, elderly and physically handicapped
- Maternal and child health
- Mental health
- Mental handicap

The management structure is discipline-based, with district HQ retaining only those functions and responsibilities which cannot be managed better at unit level.

There is a District Management Board which has no corporate management authority but is the means of ensuring that District policies and tasks are implemented. The 'Brunel' levels of work have been applied to define posts within the district.

All Board members, except the Consultant and GP representatives, report to the DGM. There is a Chief Nurse who is also a UGM, but whose only management role as Chief Nurse is the Departmnet of Nurse Education.

District E is a non-teaching district with a large population and a high proportion of elderly residents. It has four units: two Acute, one for Mental Illness/Mental Handicap, and one for Community/Elderly.

Among the district's principles are accountability to the UGMs wherever possible, and the retention of a CNO. So, for instance, in both Acute units, the nursing services are managed by a Patient Services Manager, who is professional head of nursing, and is directly accountable to the UGM. Most Chief Officers were matched into revised posts at District level. The CNO advises on all nursing matters and is directly responsible for nurse education and training. All other nursing staff are managed at unit level, as are all nursing budgets, except for nurse education.

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