THE ROLE OF NURSES IN SERVICE PLANNING

A report of a workshop held at the King's Fund Centre 21st October 1980

CONTENTS

INTRODUCTION

A number of observers of the NHS Planning System, have expressed the view that nurses, perhaps more than any other discipline, seem to have encountered difficulties in establishing their role in the planning arena since the last re-organisation of the NHS in 1974. Most discussions and courses about planning in the NHS tend to take place in multi-disciplinary situations. However, on the 21st October 1980, a workshop was held at The King's Fund Centre, organised in conjunction with the Department of Management Studies at the Polytechnic of North London, which brought together nurses from varying backgrounds in planning to discuss and examine their contributions to the planning process and the management of change in a uni-disciplinary forum away from the pressures and prejudices of colleagues from other professions. The participants (a list of whom is attached Appendix A), came from different parts of the country and represented different management levels. They explored the type of contributions nurses should be making to planning, the difficulties and the opportunities that face them and suggested ways of improving the situation, particularly in the face of the coming NHS re-organisation.

THE STRUCTURE OF THE DAY

David Hands welcomed the participants to the King's Fund Centre, and explained the history behind the workshop. He introduced the Chairman, Audrey Emerton, who discussed why such a day was necessary, and what she hoped the workshop would achieve. The first presentation was by Marion Prince and Joy Reynolds, who gave an outsiders' view on the Role of Nurses in Service Planning. They had written a background paper for the day, based on their own researchers on the NHS planning system, and this had been circulated to all participants prior to the workshop. In their presentation they elaborated on some of the points made in the paper, and made further suggestions on areas for discussion during the workshop. The next four speakers all presented commentaries on the paper which had been circulated, from their own particular stances in the planning system. The commentators were Dorothy Blenkinsop, Regional Nursing Officer of the Northern Region· Harry Teaney, Area Nurse (Personnel/Planning) of Clwyd Health Authority: Mary Coffell, Nursing Officer (Community) of North West District, Kensington, Chelsea and Westminster AHA and Maggie Lyne, District Nursing Officer of Ealing Health District. The points they raised in their commentaries formed the basis for a general discussion afterwards. After lunch, the participants split into two groups to discuss three central questions:

1) What organisation should there be for the service planning function at unit level, District Health Authority level and Regional/National level ?

2) Who should be involved for which part of Service Planning and at which level ?

3) What preparation should be given to nurses involved in this role and by whom ?

The participants then reconvened to discuss in greater depth some of the main issues raised in answering these questions, and finally before the workshop finished, they explored ways in which the debate during the workshop could be taken further and examined in greater depth.

THE BACKGROUND TO THE WORKSHOP - DAVID HANDS

In his welcoming speech, David Hands explained how the King's Fund Centre and the Department of Management Studies at the Polytechnic of North London, had become interested in this issue of the Role of Nurses in Service Planning. In 1978 the King's Fund organised a workshop in conjunction with the DHSS and the Standing Group on Planning, on "Roles in Service Planning". Each of the main disciplines represented on management teams who make a contribution to Service Planning were present at that workshop: Clinicians, Community Physicians, Administrators, Treasurers and Nurses. The purpose at that workshop was to discuss and define the contribution which each discipline should make to the business of deciding how the future pattern of activities should differ from the present. Each discipline working on its own and also in conjunction with others, attempted to define what its own distinctive contribution should be.

Both the organisers and nurses who were present at that workshop, afterwards expressed a feeling of disappointment about the way in which the contribution that nurses could make to planning, had been articulated. It seemed very much that their role had been defined as a reactive rather than a pro-active one. Whereas the other disciplines claimed to play a crucial part in determining the way in which the service should be going, nurses seem to be basing their claim for participation upon the nursing consequences of service plans determined by others. Some of the nurses who had been present at that day,

pressed the King's Fund to organise some further work just with nurses, to explore in greater detail their role and contribution. This tied in with work being carried out by June Grun and Marion Prince at the Polytechnic of North London, who were doing research on roles in service planning. They had reached the conclusion that nurses and also GP's seem to experience particular difficulty in making their voice heard in the planning arena. It was from these discussions that the workshop which is the subject of this report, was born.

CHAIRMAN'S INTRODUCTION

In her introduction, Audrey Emerton posed some very basic questions for the workshop to address. Do nurses have a role in service planning ? If so, what is that role and who should be filling that role? And in what context in the large multi-disciplinary NHS ? She reminded participants of the basic questions which appear at the front of the NHS Planning Manual: Where are we now ? Where do we want to be ? How do we get there ? And how are we doing ? She hoped that by the end of the day, after listening to various views and after a general discussion on the various perspectives in the nursing profession, that they would come to view on the role of the nurse in service planning, and in addition, would make suggestions on ways in which the profession might take further the group's ideas.

She felt that as a profession, nurses were becoming less task-oriented and more patient-oriented, by training nurses in the concepts of the 'nursing process', and of 'total patient care plans.' This was a sort of planning process which demanded a discipline of mind and involved decision making processes after assessing needs and planned care to be carried out, and then involved programming according to the resources available and indeed being accountable for these decisions and evaluating progress. She drew a parallel with service planning, which is also a process, a discipline and involves decision making. However, instead of one patient in a ward of 28 or a case load of 15 clients, planning is concerned with a whole client/care group or a range of client/care groups: It also involves assessing needs· planning care facilities and means of delivery for that care. Planning has to take account of the resources available and possibly re-distributing resources to take account of those decisions. In the nursing profession the ward sister is a pivot, planning and managing nursing care and co-ordinating any other functions in order to deliver total care. What is the role of the nurse in the service planning function where care, be it primary or hospital care, in the main involves a high proportion of nursing care ? The role of a ward sister requires her to

be a specialist, a manager, and an educationalist. Does the service planning nurse need to be a specialist or a manager or an educationalist ? These were all fundamental questions which needed answering.

AN OUTSIDE VIEW OF THE ROLE OF NURSES IN SERVICE PLANNING - MARION PRINCE AND JOY REYNOLDS

Marion Prince explained that the background paper (which had been circulated prior to the workshop), was intended as a stepping stone to an ongoing debate. It was now up to nurses, with first hand experience of the problems and opportunities to refine the issues and pursue that debate further.

She went on to outline briefly the points made in the background paper. With the ending of a past, more relaxed economic climate, there had been a shift of emphasis from capital to service planning. Although the legacy of 'capital pull' still remained, continuing economic restraint was forcing the NHS to think about needs and priorities. Staff at all levels of the Service have a contribution to make to planning the future pattern of services, by observing and analysing the problems and successes of the current service, anticipating future trends, suggesting measures to attack the problem and meet the trends, whilst at the same time considering the implications of such changes. Therefore, staff from the community team/ward level upwards, should be involved (formally or informally) in service planning.

A criticism of the NHS Planning System was the emphasis on timetabling and production of 'The Plan' rather than improving the content of planning and implementation. There was another basic ambiguity in NHS planning which was often avoided. On the one hand the system attempts to give expression to the ethos of staff democracy and public involvement, but on the other hand it assumes a rational decision making process, whereby all parties will reach the same 'logical' conclusion, provided that they receive sufficient information and there is a reasonable debate on the issue. Observations suggest that a more reasonable model of decision making in the NHS is one of negotiation, compromise and bargaining. In this arena of negotiation, compromise and bargaining, the nurse's voice does not seem, in many cases, to be loud and clear, especially in comparison with other professional groups within the NHS. Too often, nurses tend to restrict themselves to purely nurse management issues, like nurse manpower planning, while their colleagues from other disciplines are looking more broadly across all services.

In times of uncertainty, when new sorts of roles are evolving, there can

be a tendency to retreat behind professional boundaries. This problem can be compounded by a lack of confidence in developing new territories and many nurses do seem to lack such confidence. This may be caused by patterns of training: most nurse training currently focuses on individuals rather than on populations. Or it may be because nursing is a predominantly female profession with a particular historical relationship to the medical profession.

The Thwaites Report in 1977, noted that present arrangements for preparing senior nursing managers for the ' leadership of their own profession' are inadequate. While there are some nurses who are excellent in management, others seem to be at a disadvantage vis-a-vis graduate colleagues from other professions. Dorothy Blenkinsop has suggested that management education should be a continuous process from the start of nursing training and the possibilities for doing this need to be explored in greater depth.

Second in line nurse planners at Area and Region often seem to face particular problems. They may find problems in creating the necessary links with field staff, because they are regarded as part of a separate and remote organisation. They may also experience conflicting loyalties to the second-in-line consensus planning team and to their own chief officer. The question of the second-in-line nurse planning posts is immediate, since their future must be somewhat vulnerable in the coming re-organisation.

Marion Prince summarised by reiterating the basic problems which nurses seem to face in making an effective contribution to service planning:

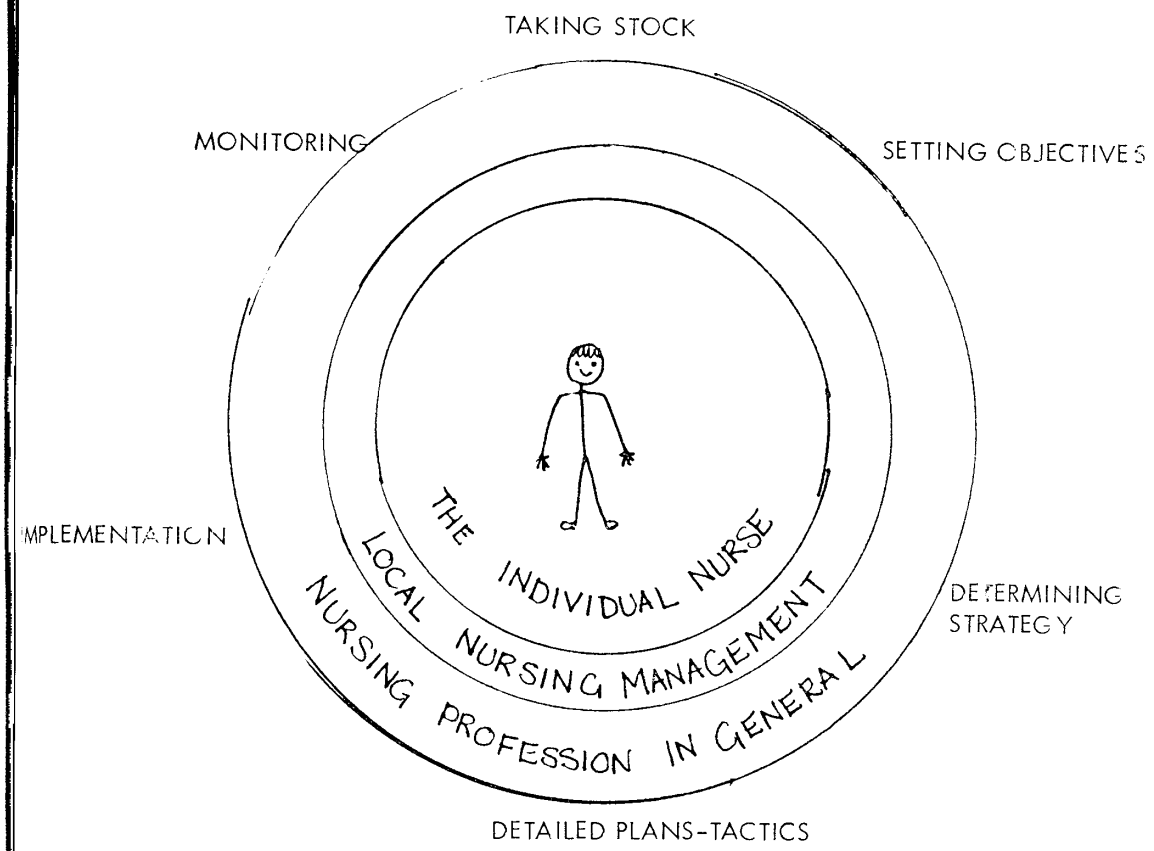
1) lack of a clear cut planning expertise

2) failure to prepare many nurse managers properly for their jobs

3) a certain passivity in the profession as a whole

4) specific problems of second-in-line nurse planner posts

Joy Reynolds continued the exploration of the thinking behind the workshop. The day was intended very much as a forum for nurses from different authorities and different management levels to share their experiences and ideas on the role of nurses in service planning. However, it was important first of all, to clarify the levels at which action on this issue might be pursued:



Using the basic planning model of TAKING STOCK, SETTING OBJECTIVES, DETERMINING STRATEGY, DEVELOPING DETAILED PLANS, IMPLEMENTATION AND MONITORING, the same steps can be pursued but for different levels of aggregation. Each individual nurse needs to examine his/her own role by looking at his/her own circumstances, goals, resources required, strategy, etc., although the answers will depend on management level, seniority and local issues, etc.

At the next level, nurses also need to examine the part their local organisation plays in planning - the demands of their managers and the roles played by their own staff and the sort of support they require.

At the broadest level, nurses need to examine, in this way, the role of the nursing profession, in general and the way in which planning responsibilities are being developed and supported.

As Joy Reynolds pointed out, the focus of the workshop would necessarily be at this last, broadest level. Some of the assertions in the background paper

needed to be questioned in the workshop.

- Are there common problems to be tackled ?
  If so, what are they ? What is their timescale ?

- What should the nurses' roles and responsibilities in planning be ?
  What skills and resources do they need to carry these out ?

- Is it useful to produce guidance for:

  - nurses in service planning ?
  - the nursing profession as a whole ?
  - those determining management structures ?

- What are the constraints ? What is the timescale ?

- What are the best ways of consolidating views ?
  of communicating the message ?

- What supports are required for nurses pursuing changing roles
  and responsibilities ?

- What are, appropriate criteria for monitoring nurses' performance ?
  Who should do it ?

She thought that it was worthwhile going through this process, because she believed that nurses did have a contribution to make to planning.

As managers or advisors to managers of nursing service, they:

- need to know what is going on in nursing service

- inform colleagues in NHS how this is likely to affect services
  to patients/resource

- be ready to guide patterns of change

As managers/advisors to managers of nursing service, they:

- need to know of external changes - demographic and
  technological, and about resource availability and the effect
  this is going to have on nursing

As individual members of multidisciplinary teams they:

- should have information/expert knowledge about changes and the likely effects of plans which help those responsible for planning understand existing situation

- should explore implications of goals and strategies

THE VIEW OF A REGIONAL NURSING OFFICER - DOROTHY BLENKINSOP

Dorothy Blenkinsop felt that the paper was a sad commentary on the role of nurses in service planning thus far, but that the criticisms expressed were not new. However, she wondered if nurses had really been less successful than other disciplines in making their mark. She felt, for instance, that specialists in Community Medicine had also experienced problems establishing their position, not only in multidisciplinary groups, but also amongst clinicians. She also felt that the paper did not acknowledge the successes that some nurses had achieved, despite the ethos of basic nurse training and the lack of training for planning and management.

However, there was a fundamental question which needed to be answered: Is there, in fact, a role for nurses in service planning ? She felt that the paper had not given a justification for involving nurses directly in service planning. Although she believed that 'planning was part of every managers' responsibility, Dorothy Blenkinsop questioned what distinctive contribution nurses could make to the development of the service. There was little value in having a nurse on a multidisciplinary planning team, simply because they represented the largest group of employees in the NHS or because they needed to know the implications of service developments for nursing.

She quoted Raymond Moss from the Medical Architectural Research Unit, who said of the capital planning nurse:

> '... it is the planning nurse who frequently occupies the centre of the stage. The reason for this is twofold. Firstly, she spends more time than any other class of hospital user in contact with the patient and secondly, she is deeply involved in and often responsible for 'behind the scenes organisation and preparation'.

Dorothy Blenkinsop believed that it was this daily contact with patients

which gave nurses an understanding of their health care needs. There is a fund of such knowledge among nurses which could be used in service planning, but it needs to be channelled into the policy making process by those with the skills to use it. The distinctive contribution of nurses is one of extensive knowledge and expertise of service developments.

Unfortunately, however, the nursing profession is bedevilled by arguments about status. Dorothy Blenkinsop felt that when specific services were being planned, the expert in that service was required rather than the generic service planning nurse - even if they were of a lower grade. This was not to negate the importance of the generic service planning nurse, who had a vital role to play as interpretor. Such a person had to be expert not only in service planning technology and jargon, but also in all aspects of nursing development. He/she had to know where to get special advice and knowledge and even more important, when to ask for it.

Highly skilled nurses were required to fill this role. If every specialist nurse manager was trained to develop their analytical skills, verbal reasoning, a wide-rangingknowledge of their specialist subject and a spirit of enquiry, we would have potential generic service planning nurses of the future. Those staff who achieved major service developments were those who followed the dictum: "there are no problems only opportunities."

Generic nurse planners needed the same basic training as other service planners, without these special planning skills they can only make a nursing contribution which specialist nurse managers should be able to do. At present many nurse planners fulfil neither a functional nor generic role. We should be profoundly grateful to the service planning nurses who have survived in their role and ashamed that their training needs have not been recognised before now.

THE VIEW OF AN AREA NURSE (PLANNING) - HARRY TEANEY

Harry Teaney commented on the assertion in the paper that nurses had failed to adapt to the challenge of becoming skilled in planning, and were lacking in clout to adequately represent the nursing interest and perspectives in the planning arena. Although this was undoubtedly true in some cases, he could also point to many successes which had been initiated by nurses, for instance in Health Care Planning Teams for the elderly or mentally handicapped. He also felt that the same criticism could be levelled at members of other disciplines involved in planning. Moreover, attitudes to planning varied enormously from one authority to another throughout the country, and the extent to which nurses were interested and accepted into planning often depended

not only on their own skills and attitudes, but also those of their senior officers and indeed the authority as a whole.

He agreed that the basic training of nurses could lead to a routinization of attitudes of work. However, he felt that basic ward experience and especially experience in the community, also bred attitudes of self-reliance, so that nurses often tried to solve problems within their own resources rather than seeking help or pressing for change at more senior level.

Another difficulty was that the various aspects of planning were often disintegrated. For instance, operational planning was often separated from strategic planning: capital planning separated from manpower planning, which again were separated from local authority liaison. Even worse, in many cases posts had not been established to cover some of these aspects. This was becoming a particularly difficult problem in the face of the economic squeeze, with vacancies not being filled.

Historically, the nurses had often played a major part in both health and social planning and it was easy to point to particular nurses who had initiated major changes in service. However, he felt that when planning had become specialism in itself, it had acquired a certain mystique. It used the language of social science and economics and new techniques such as OR methods. Nurses who are usually very practical people often found difficulty getting to grips with this new jargon, and were often frightened off by the sophistication of the new techniques.

Harry Teaney made some comments on the basis, not only of his present job as an Area Nurse, but also of his experience as a Div. N.O responsible for mental illness and mental handicap services. He said that as a Div.N.C. with many day to day management responsibilities, he had often found difficulty finding time to organise the right forums in order for staff to express their views on necessary changes. He had also seen the difficulties experienced by junior nurse managers sitting on Health Care Planning Teams, about their authority to commit nursing resources without referring questions further up the line. Nonetheless, he was quite sure that particularly in the long-stay and community services where the caring role of nurses is vital, nurses had an enormous role to play in planning, and could often have a central co-ordinating function. As an Area Nurse, he felt that his introduction to the job had been very 'hit and miss'. In his particular case, he had been lucky because his predecessor had been very good, but there was no formal system for training nurse planners. He referred back to the point about the importance of communication, but felt that often the existing communication channels were overloaded and a great deal more thought had been given to providing the right forums for nurses, and indeed other staff, to make their view heard and to make their input into planning. It was also very important that generic nurse planners

should be able to understand planning jargon and be able to interpret it to colleagues at grass roots level.

In conclusion, he believed that any nurse going for a senior management post was going to need higher education or they would find difficulty working alongside highly qualified colleagues from other disciplines. Nonetheless, most nurses had good skills at personnel interaction, and the ability to humanise the planning process. Nurses also had an important role to play in ensuring in times of economic hardship, that essential services to patients were not eroded. He also believed that more than any other discipline, nurses already had the basic building blocks of planning ability. The nursing process was a very systematic way of approaching the nursing task, and also a number of nurses at junior level had had experience of developing very detailed ward policies, and the skill required to do this was also of great importance in service planning.

THE VIEW OF A NURSE WITH SPECIALIST SKILLS IN SERVICE PLANNING - MARY COFFELL

Mary Coffell is the Nursing Officer (Health Visiting) on a District Planning Team for the care of the children. She illustrated her various comments on the paper with examples from her early and current experiences in a local planning situation. She highlighted some of the problems and opportunities which she had faced at this level, and suggested the necessary skills a Nursing Officer required to bring to a team.

She was nominated to the Health Care Planning Team in 1976, when planning teams were just being introduced. She had only been in post for six months, but was enthusiastic about the challenge. Her Div. N.O. discussed with her the role within the team and she gathered that she was to act as an individual, not necessarily giving the views of the nursing organisation. Those individual skills were a knowledge of their Health District and an awareness of many of the paediatric problems there. The Div. N.O.explained to her the concept of planning in the Re-organised Health Service, but Mary Coffell felt upon reflection, that she received very little information about the managerial and negotiating skills which were necessary in the Health Care Planning Team context.

As a nurse working in the community, she had had various opportunities of being involved with multi-disciplinary teams, for instance the non-accidental injury case conferences and the primary care team meeting.

She had anticipated that this would be good preparation for the skills required in the multi-disciplinary planning team arena. However, in practice she soon found that she was involved in a completely different situation and she had to learn very quickly how to cope with this very strong committee. She learnt that she had to make a very clear and positive contribution to draw any reaction at all. She was amazed at first, that other members of the team, noticeably doctors, had so much to say on behalf of nurses. A lot of the time, especially at first, was spent informing the hospital-based workers of the role of the health visitor within the health district, for many of them had very little understanding of this role. In retrospect, she felt that being so provoked into selling herself to the team certainly put her on the right road from the word go.

She illustrated some of the difficulties that she had encountered by the way in which the Court Report had been discussed at the planning team. This report involved the health visiting profession very much and it obviously needed to be discussed with the planning team. However, a number of problems arose, She had not been able to obtain a copy of the report before the meeting. The Area Nurse (Child Health) had circulated a very brief summary of the report, but this ill prepared her for the discussion at the planning team. She faced a particular difficulty because (a) she was the only health visitor present and (b) one of the medical members of the planning team had actually sat on the Court Committee. She felt that she was being attacked from all corners and although the Chairman realised her dilema and agreed to defer the items until the next meeting, she had found the experience very draining.

A further frustration on the team was having to compete with the strong medical influence. There were five doctors and only two nurses, a dentist, a very vocal member of the CHC, an ILEA representative, two social services managers, a district planning service administrator and a remedial therapist. She soon realised that the medical input was stronger by the mere fact of their number, and also because each monthly meeting is held in a hospital setting. Mary Coffell felt that, as a nurse working in the community, she often had a broader picture of the need for paediatric care, and also of the need for better communication between hospitals and community. However, she was often faced with the same old arguments that communication was expensive and time consuming.

On some occasions she felt that she had to provide a really graphic illustration of problems arising in the community, in order to force the attentions of the team on to communication problems. One example she gave was the case of a suspected non-accidental injury were neighbours had reported to the health visitor that a four year old child was quite often heard crying. The outcome of this investigation was that the little boy

was partially sighted and cried because he was always walking into things and falling over. The surprising thing she found out was that the child was currently attending the local ophthalmic department and had been treated for his visual problems only. The ophthalmologist had not thought to even involve a paediatrician let alone the health visitor, or social worker and the education authority. As a result of her raising this particular case at the planning team, the child was assessed and soon attending school for partially sighted children. However, he could have been attending school much earlier. The family would have felt better supported and the suspician of non-accidental injury would never had occurred. This illustration certainly aroused much discussion and support from other members of the team, but it had been necessary to present it in very positive and graphic terms.

Mary Coffell was conscious that nursing input in the team was weak at times. She felt that she could have better preparation and made time for discussion with the other nurse members of the team. However, this good intention was made very difficult because the hospital representative has changed three times within the four years that the team was going, thus breaking down the continuity of the relationship between them. She was also worried by assumptions that between them, the two nurses knew all about paediatric nursing care within the District. Sometimes, for instance, she would be faced with questions that she did not know the answer to. In this type of situation she felt that she was at a disadvantage.

She summarised the skills which she thought that nursing officers needed to bring to the health care planning team:

1) The obvious skills and the reason for her nomination are her knowledge of the local situation and her expertise within the discipline of nursing.

2) She needs to develop committee room skills and this includes having a good working relationship with her colleagues and senior managers.

3) She needs to be confident and caring with her approach

4) She needs to have an enthusiastic imaginative personality, but at the same time a realistic attitude.

5) She needs to take a positive lead on behalf of her nurse colleagues, to be determined to put their points of view over clearly by being sure of her facts.

6) She needs to be interested in the development of the nursing

profession to understand the input that she should be making to planning.

7) She needs to be strong enough to cope with difficult opposition and she needs confidence to put new ideas forward and to discuss the need for change and better use of resources.

8) Finally, she must be committed to the concept of health care planning, as a means of improving a very complex health service.

The opportunities which Mary Coffell felt she had gained as a result of being a member of the Health Care Planning Team, were:

1) She felt more self-confident and after the initial trauma, finds the whole experience very stimulating and enjoyable.

2) It has given her a very strong sense of the importance of nurses being involved in planning health services.

3) She has taken the opportunity to humanise aspects of the paediatric service.

4) She has found it easier to follow up deficiences in her own particular sphere of the service.

5) She has learnt more about the service up-take and the problems that exist by listening to her own staff and colleagues more acutely than before.

6) She has easier access to information and the relevant documents now and in particular, she has used the School of Nursing library facilities more often.

7) She has had experience of making comments on many documents produced by the DNT and the AHA.

8) She can now appreciate the feelings of colleagues of other disciplines and what they are trying to achieve.

9) It has given her many opportunities to meet members of senior management.

10) She feels that she has developed as spokes-person for the community services in mixed hospital/community settings.

11) She has felt the need to participate in in-service training programmes to keep herslef up-to-date with trends and developments.

12) She has met members of staff from agencies outside the NHS.

13) She has become the community nurse representative on a hospital based working group which is producing a paediatric nursing policy.

14) She has set up a multi-disciplinary working group looking into the needs of teenage mothers.

Nonetheless, she has experienced many problems working in the planning team situation. These included:

1) A sense of isolation.

2) Confusion as to what her role was at first.

3) Not always feeling able to cope with searching questions, positive answers and silences.

4) A sense of personal anxiety. She was often very anxious before and during early meetings.

5) She wondered whether her contribution was strong enough.

These are problems that she has learnt to cope with. Nonetheless, she still has problems. She feels that her current problems are:

1) Accepting that developments and improvements take so much time to achieve.

2) Having difficulty in actually seeing what the team is achieving.

3) Anger. She feels angry when other members cannot see why changes are necessary.

4) Frustration with financial limitations.

Nonetheless, she would not want to give the impression that these problems outweigh the opportunities that exist.

THE VIEW OF A DISTRICT NURSING OFFICER - MAGGIE LYNE

Maggie Lyne said that she was in harmony with much of the content of the background paper. She had had many discussions with colleagues on the planning role of nurses, and on her perspective of the future role of specialist nurses in service planning. She personally felt that re-organisation '82, was one of the most exciting opportunities for nurses to introduce flexible phased changes and experimentation. She urged nurses to grasp the opportunity with both hands. The background paper has listed a number of criticisms of the past role of nurses in service planning. However, she felt these criticisms were mild in comparison with many that she had heard. Hopefully however, this would bring a positive response from nurses and it was up to them now to make things happen.

Maggie Lyne felt that the planning model, promoted in 1976, was still valid. The trouble was however, that the new planning system had been heralded as a brave new world and the answer to all problems. There was little realisation that systems are only as good as the people who use them. 1976 had been the year of the magic pen. If you wrote it down in the plan you could have it. Heightened expectations in a cumbersome planning cycle where all the attention was given to the time-scale, blinded people to many other issues.

She listed the factors which had led to the disillusion with planning. There had been a great deal of naivety about the political influences of members who would toe the party line and damn an NHS strategy. There is now a much greater consciousness of political influences, but a great deal of energy and guile has to be used in the pursuit of members allegiance, brain washing, courting and education. It was also extemely difficult to plan a health service without adequate budgetary information, and on the whole budget information was provided much too late. Economic decline had also increased the sense of disillusionment. The jargon of planning had also discouraged many practical managers from getting involved in planning, and they tended to say " you plan (if you must), while I get on with the job". Nonetheless, she believed that one of the key sentences in the background paper was:

> "The planning approach should be a feature of management at all levels in the Service. Planning should not become the perserve of those who produce the final documents".

She believed that there planning must be part of every nurse managers work. She talked about her particular responsibility as

a District Nursing Officer in service planning. She was convinced that it was the duty of the nurse to be involved in planning. The nurse is the one person who has the longest and most continuous contact with patients and their families. She therefore, must have more information for a comparison of care v cure models than anyone else in the caring team. However, she wondered whether nurses really used the information that was available to them. She felt that they could increase their credibility by producing the comments of the front line troups. "I was there, I am there, I know." If information is power, then nurses have a powerhouse in their hand. Sharing information is sharing power.

She questioned the assumption in the background paper that nurses had greater difficulty than members of other disciplines in asserting their contributions to service planning. She could point to many examples where Finance Officers were no more than book-keepers, and where Community Physicians lacked the necessary epidemiology skills for planning. The important thing was that a team should contain complementary skills. Nurses are not 'also - rans' or ' simply running in the field next door'. Nurses must take a leading role, if only from an informational point of view, but the nurse must channel the information selectively and influencially. She has to learn how to critically analyse her own contribution and those of her staff and move on in the safety of being her own evaluator and reviewer. Nurses look, but do they see ? They should do, as they are trained as observers. She personally had never found any conflict between her role as a manager of the nursing profession and her responsibilities to the District Management team.

Maggie Lyne went on to discuss the problems which have to be overcome. The District Nursing Officer should be a manager, a catalyst, a change agent, and an enabler. Nurses need to refine their training in order to prepare them for their role. Planning and financial management are indivisable. Training is required in numeracy, research techniques, committment,accounting and budget control. She cited, as a good example of management training, the courses run by Police Service. On the question of basic or post-basic training, she felt that a critical approach to this work and the desire to search for knowledge, and self help must be instilled at the basic nurse training level. However, there should be a continuum of training from basic to post-basic levels offering the opportunity for personal and professional growth.

On the question of second-in-line planners, Maggie Lyne agreed that the creation of specialist posts could enable an organisation to perform its planning functions better, but there was a very real danger that it could stultify the planning input of people at the grass roots. In other words, they would be tempted to abrogate their planning responsibilities because one person was appointed to carry out the planning function. She did not see planning as the responsibility

of a single nurse, but as a natural part and a vital part, of every nurse managers function. Nurse managers must grasp the mettle and not hive off to a single nursethe responsibility of planning, thereby highlighting and reinforcing their incompetence and giving a field day to the critics. Planning must be a direct responsibility of the new Directors of Nursing come Re-organisation.

Finally, Maggie Lyne listed the opportunities which exist for improvements and suggested some ways forward:

1) The line-management structure in nursing.

2) The role of nurse as a change agent.

3) Manpower planning, for without adequate manpower planning, service planning is nonsense.

4) The opportunities to involve nurses of all levels in planning.

5) Involvement in primary care and also the links with local authority services.

6) The training possibilities.

Finally, in thinking about the way forward, she stressed the importance of improving information on all counts, although it was not always easy to know how this should be done. The nurse could also be, indeed must be, a path finder in health work. She must play the roles of advisor, team member, a resource person, researcher, educationalist and public relations officer. However, each individual in planning had to recognise the part that they had to contribute, and not attempt to play everybody's part. It was important that nurses at different levels and in different roles should recognise the contribution that they had to put forward, and the value of the membership in the teams as complementary to those of other team members.

THE MAIN ISSUES WHICH EMERGED IN GENERAL DISCUSSION

The Unique Contributions of Nurses to Service Planning

One message which emerged very clearly from the discussion during the day was that despite the doubts which had been expressed in a number of quarters, nurses did have a unique contribution to give to service planning and they needed to define it and express it in all quarters. That contribution was

very much rooted in the structure of the nursing profession, and the information network it provided. However, nurse planners should not just represent nurses in their thinking, they should be involved in health care issues as a whole. Nurses had the longest and most continuous contact with patients and their family and they therefore, had the broadest view of the patient's needs, both in community and in the hospital. It was very important therefore, that nurses, at every level, had an opportunity to participate in the policy-making process. This was particularly important in the light of the growing needs for caring services for Cinderalla groups such as the Elderly and the Mentally ill.

The basic building blocks were already there, and every grade of nurse manager had been involved in developing the nursing process and developing individual ward policies. The skills required to carry out this kind of activity were also required at a broader level. The most important thing therefore, for nurse planners was to ensure that the communication channels were kept open, that nurses with specialist practical experience had the opportunity to contribute to the planning process, and the support to do so. Nonetheless, difficulties of keeping those communication channels open were not to be underestimated and needed considerable thought and definition.

Nurses also had an important role to play in humanising the planning process. By contributing concrete examples about the effect of plans and about the need for change, nurses could bring a more personal and more vital attitude to planning.. It was also agreed that most nurses had developed a good inter-personal skill, which they can bring to bear in a team setting, although it is perhaps dangerous to attribute such personal skills to one discipline alone. In addition, it was pointed out that nurses have to learn to cope with many concurrent activities and often unexpected events, and that this might be a valuable background for planning.

Which Nurses should be involved in Service Planning

It was agreed by all that planning responsibilities should start from the point of delivery, from the ward sister upwards, and it was necessary to think hard about ways of involving nurses. There was considerable discussion about the role of the service planning nurse. The majority agreed that there was a need to explore much further the precise role of this person. Certainly, it was important that there was someone with the time to plan, who could act as advisor, co-ordinator of the planning efforts of other nurses. However, it was pointed out that one person alone could not control all the communication channels. There was a need to link planning activities with the monitoring and appraisal systems, and everyone recognised the dangers of developing isolated planning units.

One area which aroused considerable debate, was how far Directors of Nurse Education should be involved in planning. Audrey Emerton argued that it was vital to involve the Director of Nurse Education in all aspects of planning and criticised the complete absence of any manpower philosophy in current nurse education thinking. Not only did the policies adopted by Directors of Nurse Education affect the provision of service in the district (and indeed should be affected by decisions about that provision of service), but also the Director of Nurse Education should be well aware of service developments within the district when assessing the educational needs of nurses working in the district.

Preparation for Planning Responsibilities

It was generally agreed that nursing should be taught about monitoring and reporting systems and about the philosophy of planning from basic training levels. All nurses needed to be taught to question what they are doing, and also how to find and use information. It was recognised that this would involve considerable changes in the current educational system. There was considerable discussion about the existing inate soft skills of nursing, and the contributions that these could bring to planning. However, there were also doubts expressed about pinning the case for a greater involvement of nurses into planning on this type of very personalised argument. It was certainly agreed that generic nurse planners needed to develop specialist skills such as numeracy, ability to analyse research, awareness of social sciences, etc. However, they should not be frightened off by the fears that they have to be experts in these fields. Their task was to recognise where this type of skill would be obtained. At a more general level, there was a need to train nurses at all management levels from staff nurse upwards, on how to retrieve information, how to sift information and how to report information.

And certainly when nurses became involved in the multi-disciplinary planning teams, they needed the skills of negotiation and the ability to present their case very clearly and positively: skills which had been well illustrated by Mary Coffell's contribution.

The Organisation of Nurses Contributions to Planning in the Re-organised Service

It was agreed that within districts the DHA and the DMT would be responsible for setting the broad service development objectives. What happened below that level depended very much on how the units were developed. Many nurses felt that it was very important that units should be based on client groups rather than geographical

units. Providing they were based on client groups it would be quite easy to take the unit officers i.e. the doctor, the nurse and the administrator, as the core of planning groups, adding in other participants as necessary. The sort of participants suggested were finance officer, member of the CHC, representative of the cogwheel division etc. etc. These planning groups would be responsible for planning services to the particular client group served by that unit.

There was considerable discussion about Health Care Planning Teams and a number of damning comments passed. However, the biggest problem that people had experienced with Health Care Planning Team to date, probably stemmed from the fact that they were standing groups which met, whether or not there was a policy issue to be discussed. If the planning groups in the new Re-organised Service were called together as and when it was necessary to consider changes in the patterns of service, then it was felt these would be much more successful. Clearly, however, this sort of arrangement would be only suitable where units were based on client groups. If the units were based on geographical divisions or even worse, on community and separate hospital divisions, then clearly this type of arrangement for planning services would not be suitable.

The need a staff post in planning at district level was also discussed. It was generally agreed that such a post would be necessary in order to co-ordinate the contribution of nurses at the planning team level, planning for separate groups. Clearly, at this level, there would have to be co-ordination across the client groups. The possibility of a staff post at unit level was also discussed. People could see that there might be a necessity for such a post, albeit at a relatively junior level, but this would depend on the size and nature of the unit. It was pointed out that one of the advantages of the terms and conditions of the coming re-organisation was the opportunity for flexibility and for trying out a number of different models of planning. On the other hand, the dangers of this flexibility were also pointed out and a warning sounded that one could end up with nothing.

At Regional level, it was agreed that the Regions were likely to strengthen their planning and monitoring functions in the absence of multi-district areas. It was felt that they should strengthen their role as an information resource. Again the example of Regions providing epidemiological services was quoted. Insofar as the nurses role in planning was to facilitate the communication of information throughout the nursing network, there would be a need for a staff post in planning at Regional level as well.

THE WAYS FORWARD

There was a very strong feeling at the end of the workshop that the dialogue that had been begun should not stop there. It was agreed that a good many questions had been raised and certainly more time was required to discuss the possible answers. Indeed, the questions themselves had to be refined and defined more narrowly. Various options for continuing the debate were discussed. It was suggested that a report could be produced on the basis of the workshop. However, a number of people present felt that there were too many questions to produce a report yet which would receive a wide circulation. It was therefore, necessary, either to reconvene the group who had met at the workshop, or perhaps to reconvene a smaller working group to work on the production of a report. After discussing these possibilities, it was agreed that the best course of action was to circulate a factual report of the day's event to all the people who had been present at the workshop, and to ask each participant to return their comments to Joy Reynolds at the King's Fund Centre on ways in which they would like to pursue the issues further. However, time was at the essence since the date for Re-organisation plans is set at March 1981. It was therefore, agreed that in the meantime, it would be a good idea to informally let information about and from the workshop reach as many people as possible.

APPENDIX A

THE ROLE OF NURSES IN SERVICE PLANNING

List of Participants

Miss J BEAK	Divisional Nursing Officer (Midwifery)	Tunbridge Wells HD
Ms J BLAKE	Job and Organizational Design Consultant	
Miss D BLENKINSOP	Regional Nursing Officer	Northern RHA
Miss P BLIGHT	Senior Nursing Officer (Geriatrics)	Southwood Hospital, Islington H.D
Miss J BRYANT	District Nursing Officer	Enfield Health District
Mr A N CARR	Area Nursing Officer	Newcastle AHA (T)
Mrs A CLEEVE	Area Nurse (Service & Capital Planning)	Camden & Islington AHA
Ms M COFFELL	Nursing Officer	North West District
		Kensington, Chelsea & Westminster AHA (T)
Miss J M DAY	Regional Nurse (Service Planning)	Trent Regional Health Authority
Miss E DAVIES	Regional Nurse (Planning)	Wessex Regional Health Authority
Miss A C EMERTON	Regional Nursing Officer	South East Thames RHA
Miss E ENSING	Area Nursing Officer (Retired)	(formerly) Brent & Harrow AHA
Miss M FITZGIBBON	Divisional Nursing Officer	Central H.D. Manchester
Ms J GRUN	Senior Lecturer	Polytechnic of North London
Mr J HALL	SNO (Planning)	Cuckfield & Crawley H.D.
Ms C HANCOCK	Area Nursing Officer	Camden & Islington AHA
Mr D HANDS	Assistant Director	King's Fund Centre
Ms J INGASOL	Professional Officer	Association of Nursing Management, RcN.
Mr JALIL	Area Nurse (Service Planning)	Norfolk AHA
Ms C LEVER		King's Fund Centre
Miss N M LYNE	District Nursing Officer	Ealing Health District
Mr W G MACLEOD	District Nursing Officer	Kirklees AHA
Mr H McCREE	District Nursing Officer	Winchester & Hampshire Health District
Mrs B MOORE	Area Nurse (Service Planning and Capital Projects)	Nottinghamshire AHA (T)
Ms M PRINCE	Researcher	Polytechnic of North London
Ms J REYNOLDS	Project Officer (Planning)	King's Fund Centre
Ms B RIVETT	Principal Nursing Officer	DHSS
Mr G ROOKS	Divisional Nursing Officer	Havering Health District
Mr H TEANEY	Area Nurse (Planning & Personnel)	Clwyd Health Authority
Miss D TONGE	Area Nurse (Planning)	Oxfordshire AHA (T)
Mr P WATKINS	Divisional Nursing Officer	North District, Warwickshire
Miss A WEST	Senior Nursing Officer	Atkinson Morley's Hospital
Miss F WOOLSTON	Divisional Nursing Officer	Medway Health District

[redacted]