BRUNEL
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STRONGER NURSING ORGANIZATION

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WORKING PAPERS
A General Note

This Working Paper was one of a series on various topics published by the Brunel Institute of Organization and Social Studies (BIOSS) between about 1970 and 1990.

The **Institute** was a self-financing constituent part of Brunel University composed of a number of separate social research units. Most of the research work was concerned with organization policy and management methods; and was developed and tested through collaborative inquiry and practical implementation. Its work covered a variety of fields including public services, governmental and industrial organization, the voluntary sector, and individual work processes and capabilities. The **Health Services Centre** was closely involved with the NHS for nearly two decades. Initially solely DHSS-funded, it was subsequently financed from a variety of sources. In due course, it became part of the SIGMA Centre which eventually moved out of the University.

The Aim of the Working Papers was to summarize the findings of various field-projects and working conferences in a form which may be most useful to those involved in the NHS. Each aimed to analyse present problems and needs in the area of concern, and to provide concepts and general organizational and procedural models that may best help to deal with them. We found that only by careful analysis and definition of basic terms and ideas can genuine progress be made in understanding organizational issues and improving management. With further experience discussion and testing, it is assumed that revision and expansion of some of the formulations will become necessary–hence the deliberate choice of title 'Working Paper'. Since 1987, aspects of nursing organization, especially in the community, have been further developed, and the context has been changed by the 1989 NHS reforms. However, the substance of the paper remains solid, having been tested in many more projects. No revisions have therefore been made.

Enquiries to The SIGMA Centre
about consultations, seminars or field projects
on the topic of this Working Paper
or on other issues of organization and management in the NHS
are welcome.

STRONGER NURSING ORGANIZATION

A Working Paper

for

General Managers and Nursing Managers

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Acknowledgements:

This Working Paper is based primarily on field work which has been carried out since 1980 at Northwick Park Hospital, Barnet General Hospital, St. Mary's Hospital, Royal Victoria Infirmary, and in the hospital and community services of Nottingham HA, Exeter HA, East Dorset HA, and York HA. Present and former HSC staff who have worked on these projects include: Stephen Cang, Warren Kinston, Ian MacDonald, Ann Melia, John Øvretveit, Ralph Rowbottom and Colin Willard. Detailed analyses of nursing work, night nursing and the night sister role have been primarily developed by Ann Melia. Much of the analysis presented in Chapter 5 has been based on *Doc. 3161B: An Emerging Model for Ward Sister Roles in General Hospitals*, prepared for the North West Thames Regional Nursing Project. Not all material from fieldwork has been included in the Working Paper for reasons of brevity and space. Important areas of nursing (e.g. the organization of nursing education) have been omitted due to an insufficiency of field experience. Helpful suggestions in the preparation of this Working Paper have been particularly provided by Ralph Rowbottom and John Øvretveit. Responsibility for propositions and conclusions rests with the author.

Note:

As a matter of convention, the personal pronoun used for nurses throughout is 'she'; while the personal pronoun used for other staff or people in general is 'he'.

Chapter 1

INTRODUCTION

Origin

This Document follows in the tradition of past Working Papers of the Brunel Health Services Centre. Its aim is to assist general managers and nursing managers design and develop nursing organization and management. Our concern throughout has been to promote, simultaneously, improved quality of care for patients, higher staff morale and more efficient working.

Few would deny that nursing organization has had its difficulties over the years. But the present time poses unique opportunities and unprecedented dangers. The radical changes in the NHS that have followed the Griffiths inquiry and report [1] provide an opportunity to bring about substantial changes in nursing organization which conservatism and inertia might have made less attractive in the past. However, it seems that in some parts of the country, nursing organization is being devalued and undermined. The deleterious results of such action will take a few years to emerge, and it is still possible to take corrective action.

Nursing is as central to health care as doctoring. Nurses are perhaps closer to patients, physically and emotionally, than any other professional group. They constitute the largest single group of health care professionals; and account for a major proportion of the health services budget. Over the past two decades we have worked repeatedly and intensively with them as part of in-depth field research, and in consultancy and workshop modes. (See Acknowledgements p. 5.)

Our 'consultancy research' has been instigated by nurses in responsible positions who have asked us to help them with their urgent problems. Solving such problems has required the development of concepts and models of organization and management processes using an analytic research method [2, 3]. This method is a process of collaborative discussion and mutual understanding, in which, together with nurses and other managers, we analyse the presenting problem, tease out the underlying issues, clarify the necessary concepts, and devise one or more appropriate arrangements. Implementing the changes which are invariably needed must, however, be led by the responsible manager. The general applicability of findings from such consultancy is examined in specially designed small workshops and large national conferences, and the ideas further refined and tested. The strongest test comes with implementation and long term follow-up. Here our view of validation is pragmatic; and the key questions are: does it work in the judgement of those involved? and if not, why not?

In the course of our field work, we have had detailed and confidential discussions with hundreds of nurses at all levels in a variety of Districts; and well over two thousand have attended seminars, workshops and conferences in the past decade. This Working Paper should therefore be seen as a form of feed-back to the NHS from nurses

themselves as a result of their collaborative work with us. To convey the sense of such discussions, the main Chapters conclude with objections which are frequently raised, and with further questions related to the ideas and arguments presented.

Perceptions of Current Problems

The problems currently perceived in nursing depend on where you stand. Some new General Managers see the very existence of nursing management above the ward as a contradiction of general management. Others are worried that a clearly defined and powerful nursing management hierarchy will inevitably weaken multi-disciplinary cooperation. Some, who accept the need for a nursing management hierarchy, are concerned to determine how this hierarchy could mesh with and strengthen general management.

Nurses at the front-line see the main problems in terms of overwork, understaffing, and interference or neglect from their own superiors. There is also concern about the lack of understanding of nursing work by non-nursing managers, which leads to anxieties amongst nurses of being unable to ensure that patients are properly cared for or protected from inappropriate demands.

In our work with nurses on their organizational arrangements, we have found that whilst they are often reasonably satisfied with those at ward level and at top level, there has been a long-standing concern with the management-work between these levels, especially with the 'role of the nursing officer'. Serious deficiencies at this middle level of the organization cannot be adequately compensated for by other levels. Attempts to compensate distort management work and inhibit effective and efficient action in the whole system. The weakness of middle management in nursing must be put into perspective: we have found from other field research that this level of management is also seriously weak in the paramedical professions, and other occupational groups, including doctors.

Patients First

In examining organization it is possible to take either a top-down approach or a bottom-up approach. In principle, the choice should be arbitrary and should not influence the results. In analyzing and presenting nursing organisation, however, we have found that a bottom-up approach is more useful as it requires immediate focus on the patient.

Many forces exist which move health services away from a patient-care focus. Some pressures are systemic: for example, the preoccupation with resource control, the pressure for upward accountability, the demands of long-term planning, requirements for in-service education, and the need for research. Lack of concern for the patient may also result from expediency or staff self-interest. Fortunately, patient-focussed care can be a value more explicitly built into the NHS structure if it is so desired.

If each patient is to get the best possible care, then health service personnel at all levels and in all occupations should have a vision that is patient-centred. One implication of this is that the numerous professional and ancillary staff who make contact with patients need their work on each individual patient to be coordinated. Both within the hospital and in the community, we believe that this role belongs uniquely to the nurse. The doctor may retain control over diagnosis and treatment, though even here specialisation seems to be fragmenting management, but *it is up to the nurse*

comprehensively to manage the wider aspects of health care— nutrition, toiletting, physical comfort, stimulation, protection, mobilization, communication, emotional care, social support. Nurses are also the natural monitors of many aspects of the physical and psychosocial environment that impinge on patients.

To restate: The organisational problem in promoting patient-focussed care is 'how can we ensure that the wards and community services are run to meet a patient's needs comprehensively and to ensure that all the required health services are brought to bear for his benefit?' The role of the nurse is central for achieving success in this endeavour. *Poorly designed or poorly manned nursing structures are therefore bound to reduce the quality of care available to patients. So are inappropriate definitions of the basic nursing work to be done.*

Structure of the Working Paper

The overall approach of a compact document such as this is to offer an orienting framework which is usable by nursing managers, and by those present and future general managers who are concerned to understand nursing. *Readers familiar with our frameworks may find it preferable to read Chapter 11 first,* because it deals with our view of the necessary relationship between general management and the management of a function such as nursing.

As in previous Working Papers, the aim is not to be comprehensive but to identify those crucial matters of principle on which all else depend. We will be as specific as possible. However, as no two Districts are the same, any attempt to offer a detailed blueprint must of necessity fail. Such a remit means that it is not possible or desirable to go into either the detailed character of nursing or the procedural technicalities of management, accounts of which are available in standard texts. In addition, we can do no more than provide hints on many other matters of immediate NHS management concern like budgetting and quality assurance, leaving more detailed report of findings on these topics for another occasion.

The Working Paper is laid out as follows:

Chapter 1 introduces the Working Paper and *orients* the reader.

Chapter 2 considers certain persistent *root problems* in the design and implementation of nursing structures, problems which have extended over decades and which are evident even in the latest Official Reports. These concern such basic matters as: exactly what is involved in nursing work, the existence of too many levels of management, confusion of grades with titles and levels, mixing line roles and staff roles, inappropriate expectations of nursing staff, and poor inter-disciplinary communication.

Chapter 3 briefly introduces the *principal frameworks* to be used: levels of work and authority relations. These have been substantially developed and validated with NHS staff, and found essential in resolving problems of organization. The links between levels, career progression, and types of manager are explained.

Chapter 4 focuses on the work of the *'professional' (i.e. registered) nurse*. It considers what options are available for nursing work, and implications for the use of nursing assistants or auxiliaries. The nature of nursing at night, a theme returned to in later chapters, is first explored here. Implications for training are noted.

Chapter 5 describes what is involved in strengthening the *management of wards*. The principal focus is on the role, responsibility and relationships of a 'ward leader'. The various ways in which ward management may be inadverdently undermined are explained.

Chapter 6 tackles the seemingly unresolvable *problem of the 'nursing officer' role* and provides, we trust, a definitive resolution.

Chapter 7 explains the need to create nursing entities (with a suggested label of 'Divisions') which are larger than wards but smaller than Units, and gives examples from our field work.

Chapter 8 examines the work of managing such Divisions. As this manager is *a new conception in the NHS*, responsibilities, especially in regard to workload control and quality of nursing care, are explained in detail. The need for a nurse to fill the role, what support staff are required, and the appropriate title are discussed.

Chapter 9 considers certain additional issues which are primarily pertinent to *community nursing services*.

Chapter 10 discusses the need for *top management in nursing*, given the existence of high-level general managers. Possibilities in the Unit, and in the District are examined. The nature of District Nursing Advisory Committees is briefly explored.

Chapter 11 finally places the nursing management structure in the context of the new *general management arrangements*. The need for well-developed nursing structures within the context of general management is emphasized and explained, and the way in which they interrelate is discussed. This Chapter could usefully be read twice: once after Chapter 3, and once here at the end.

References are provided referring to bracketed numbers in the text. No attempt has been made to provide a comprehensive bibliography.

The Overall Message

Nursing organization is too complex to be summarized in a few simple phrases. If there is a message, it is that substantial improvement is possible in many, probably most, Districts; and that there is no need to wait for yet another national inquiry. It is likely that change in nursing, no matter how obviously necessary, will be difficult to bring about by either nurses or general managers on their own. Working together is essential.

Chapter 2

RECURRENT ROOT PROBLEMS

When nurses have discussed their situation with us, they have presented a myriad of disturbing, disruptive and seemingly unnecessarily persistent problems—inappropriate workloads, staff constantly off sick, an inability to get a simple ward repair completed, lack of feedback on performance, confusion over clinical policies, poor telephone services, excessive paper-work, absence of trained staff, linen never provided on time, acceptance of dangerous practices, rudeness of support staff, and so on. These problems, when explored in detail and depth invariably lead to certain root problems of organization and management. Such problems have persisted in nursing despite inquiries, commissions and research reports.

These recurrent general or root problems, which will be alluded to repeatedly as we work our way up the nursing management hierarchy, include:

- •confusion about the actual kind of nursing work to be done
- •too many levels of management
- •confusing grades with titles and with levels of management
- •mixing line and staff responsibilities
- •inappropriate expectations of staff
- •insufficient integration of nursing with medical and support services.

In this Chapter we will look briefly at each of these recurrent root problems, leaving more detailed exploration and resolution for later.

The Nursing Work to be Done

Ex:1 *"I'm a newly qualified nurse. I have been here for about 5 months. I still don't really know what I'm expected to do. Of course, there have been a lot of changes, so I have tried to get on with things. But no one has given me any feedback on how I am going. When I first came they said they wanted me to implement the nursing process but we are so short of staff that it is really impossible to complete all that paperwork."*

Ex:2 *"I'm the Director of Quality Assurance because I'm also the District Nursing Adviser. But no one has explained what I should take Quality Assurance to mean. Nor do I know what the new expectations on DNAs are. The DNSs do not have time to do what I think I require of them: indeed they seem to avoid meetings I call. The DGM says I am to use my initiative."*

Management and management structures are there to see that work gets done. If the expected work is unclear or inappropriate, then not only is it unlikely to get done, but it will also be extremely difficult to devise appropriate structures. The first problem in nursing—at the top, in the middle, at the bottom—is then simply this: the expected work

is unclear. This is not only true of management work; but also applies to direct nursing care as in the first example above.

Although there have been numerous and valuable studies into the various nursing roles, and extensive statements by the nursing profession, these lack suitable precision in relation to the level of work required; and often do not place roles in the total context of nursing work to be done. In any case, the manager in the local situation must provide local guidance on exactly what is expected. Furthermore, too many studies are based on surveys. Our experience of talking to nurses in management, epitomized above, is that they are often confused about what is expected of them, and mix up what they do with what they imagine is expected, or what they would like to do. A survey in such circumstances will reveal little, except perhaps high stress levels.

Too Many Levels of Management

Depression in the ward sister's scope for action; nurse managers not knowing who their 'real boss' is; middle management jobs which do not feel real or substantial; nurse managers without appropriate authority to manage; excessive delays in decision-making; inability to exert managerial clout on consultants; disruption from support services; top nursing managers becoming swamped in detail, and so on, all can usually be traced to the existence of too many levels of management.

One level of management too many seriously inhibits organizational effectiveness; several too many is a disaster. From levels of work theory (to be explored in Chapter 3) it will be clear that no more than 3, or very rarely 4, main managerial levels are required to organize nursing.

Confusing Grades with Titles and Levels of Management

Clinical nursing and nursing management have suffered because it has often seemed essential to represent each grade with a separate post in the hierarchy, or because it has been impossible to improve the pay of somebody without changing their title or post, or because it has been difficult to change the title or type of post of a particular nurse without increasing her pay. Linking grades and titles has also meant that a manager devising a management structure can lose her focus on the level of responsibility required in the post, and instead thinks mainly about the most appropriate sounding title. *All these structural matters—posts, titles, grades, levels of management— interlink but must be considered separately by a manager.*

In the U.K., the Salmon Report [4] achieved notoriety precisely because many, probably most, top nursing managers (mis-)interpreted the Salmon **grades** as if they were **levels of management**. In most organizations (or career lines) you require many more of the former than the latter, because *grades are primarily required to provide a pay differential within the same broad range of work responsibility; whereas levels of management determine the main foci of responsibility and authority.*

Not only must grades (and pay) be kept separate from management levels, they must also be kept separate from post descriptions and from titles. For example: presumably

the head-nurse of a 20 bed cottage hospital is doing a different sort of work to the head-nurse of a 200 bed hospital; presumably therefore the two jobs should be paid for at different rates. But why cannot both be called 'head-nurse' or 'matron'? The same possibility exists with more modern titles like nursing officer and director of nursing services.

A further result of using grades as a substitute for titles descriptive of posts is that they leave the nursing managers in post unclear as to exactly what they are there for. We have found nurses who had achieved a promotion in grade terms but have then found themselves being expected to carry out work which was quite unsuitable or undesired. Job descriptions with long lists of responsibilities (typically 20 to 30!) are not substitutes for a two or three word title which encapsulates what the job is actually about (cross-infection, midwifery services, domiciliary care, outpatients, etc.) and says something about the authority carried (coordinator, advisor, manager, director).

Mixing Line & Staff Responsibilities

***Example**: A UGM constructed his line-management structure with great care. The most complex hospital division had a post for a highly-graded nurse manager (SN4) who also was expected to carry the role of hospital manager with responsibility for coordinating and controlling the hospital as a whole. The person in this post was then chosen by the DNS to be his Deputy because she knew the Unit well, was very able, and had an office down the hall. But being a Deputy DNS meant that the nurse manager now had to extend her awareness and concern to the Unit as a whole. This conflicted sharply with the time available for her own nurse management work and a full emotional investment in her own hospital. Line- management of nurses was therefore seriously weakened.*

We have found that, as in the above example, the importance of strong main line-managerial relationships has not been sufficiently appreciated. This is paradoxical in that the frequent complaint of excessive hierarchy in nursing would lead one to assume an over-emphasis on line-management. The essential positive features of main line-management have been lost amongst a welter of euphemistic terms such as supporting, enabling, coordinating, leading, reporting, supervising.

The frequent complaint of top nursing managers that their line-subordinates will not take 'the wider view' is a mistaken one. In fact, line-subordinates, who are often line-managers themselves, should **not** be taking the wider view but should be fighting for their own patch. This is the inherent tension in the manager-subordinate relation, based on accountability for different levels of work; and it cannot be avoided. *Line subordinates should not be treated or expected to act simply as assistants to their managers.* However the top manager usually does require assistants to help him take the wider view, and the relation with these staff should be felt as supportive. Such staff-officer roles (see Ch. 3) have a different focus and feel to main line-management roles. An assistant is not responsible for the main impetus to work; and he gives his attention across a range of Departments or wards rather than into one in depth.

Inappropriate Expectations of Staff

The problems of intense anxiety at work, hostility to managers and severe resistance to change, often noted in nurses, frequently stem from inappropriate expectations placed on them. We have found nurses being expected to perform inappropriate kinds of work,

inappropriate amounts of work, and work that is either well above (or sometimes well below) their personal capabilities.

The confusion about the kind of work was the first root problem mentioned. Excessive workload points to a weakness in strong line-management described just above. So here we focus on the failure to assign individuals to posts with a degree of responsibility that matches their capability. In nursing, there are examples at all levels. Expecting unqualified staff to handle patient crises on their own is unfair and will generate enormous anxiety. Similarly, expecting an SN7 nurse, excellent at assessing situations and crises and dealing with them, to introduce budgetting or quality evaluation systems, may be unreasonable as such work is far more complex. UGMs wishing to avoid appointing a DNS have been expecting one of their Senior Nurses to propose an improved nursing structure for the Unit; but though the nurse may provide useful ideas, criticism and advice, a thorough reshaping of the Unit's nursing organization may well be beyond their abilities.

An accurate assessment of personal work capacity and its matching to an accurate assessment of work demanded in a task (or post) will be seen to lie at the core of strong main line-management, and hence strong management in general.

Insufficient Integration with Other Services

Regular 'crises', sometimes persisting over many years, are well known in nursing. For example patients due for admission are repeatedly kept waiting 8 hours, provision of fresh linen on a Friday does not arrive for as long as can be remembered, minor works problems are not attended to for weeks, ward food supplies are always late.

The final root problem endemic in nursing and responsible for the above has been lack of satisfactory integration of nursing systems with medical, paramedical and ancillary support systems. Before the Griffiths Report, the administrator's monitoring and coordinating function was regarded as the crucial mechanism for ensuring integration of the various disciplines. In the post-Griffiths era, the general manager is expected to ensure that work is integrated. However at all times nurse managers have their own responsibility to make direct contact with individual medical consultants or consultant committees and with managers in the paramedical and ancillary service departments over issues affecting nursing and patient care. Too often, these relationships have either been avoided or have been structurally impossible to set up. The result has been a network of variable informal arrangements which could not be guaranteed to see that recurrent problems were resolved or that new problem situations were speedily handled.

Questions and Objections

Q: *All the above looks like a rather serious indictment of nursing itself. Is management in nursing so much worse than that in other professions?*

A: Not at all. There are common problems. Nursing is a big important profession. When something goes wrong, it does so on a massive scale.

Chapter 3

LEVELS OF WORK & AUTHORITY RELATIONS

In discussing and dealing with the overt and root problems in nursing organization and management reviewed in the previous Chapter, it has been impossible to avoid the use of phrases like 'levels of management' (or responsibility) and 'main line-management'. However such notions cannot be applied properly unless they are clearly understood. For example, people's perceptions about levels of work, higher or lower, are usually conveyed by resort to terms like 'executive work', 'top management', 'policy-making' and so on. But these are imprecise and ultimately confusing terms often causing rather than solving problems. Thus, managers at all levels do 'executive work'. 'Top management' in a 50-bed hospital is one thing, but different from that required in a 900-bed teaching hospital. Similarly both ward sisters and Directors of Nursing should be expected to make policies, but with markedly differing scope. Much the same problem exists in relation to describing the work or authority of managers as supporting, or advising, or instructing, or commanding: different types of managers perform these functions with markedly different implications for the recipient.

As it is necessary to have a clear way of talking about such fundamental issues, we will briefly introduce here our own approach to levels of work and authority relations. The ideas will be further developed in later Chapters in relation to practical aspects of nursing management.

Levels of Work

Over the years, and from work in many organizations as well as the NHS, a useful and precise method of describing and differentiating levels of work has been developed at Brunel University. It does not rely on overt or covert references to numbers of heads or beds supervised, but attempts to capture and convey the very nature of the work itself, its output, complexity, and time-span. A summary only can be provided here and for more details the interested reader is referred elsewhere [5-8].

Recognition of levels of work is fundamental to organisational design, cost-control, information systems, recruitment and appraisal, career progression and so on. The levels of work schema is helpful in tackling some of the persistent problems in nursing management, as testified to by our field work and the response of nurses at our workshops.

The theory proposes that in all organizations, including health services, there are five basic levels of operational work to be done, each sharply different in quality. Work at any particular level shows important similarities whether undertaken by administrators, nurses, doctors, or whomever. However, as the levels are ascended, the range of objectives to be achieved on the one hand, and the range of environmental circumstances to be taken into account on the other, broaden and deepen. Giving examples of levels in

particular roles or jobs is often contentious and may be misleading, nevertheless a brief introduction is required and the framework will become clearer when the ideas are applied in the Chapters to follow.

Level 1: Prescribed Output

Here, the end-product can be specified beforehand as far as is at all significant. Clear examples are reception work, portering, typing, repairing a machine. The tasks are concrete and taken one at a time. Work is done on demand The time scale of tasks is of the order of hours, days or weeks with a probable maximum of three months. Insofar as any nursing work is completely routine—e.g. basic physical care of people, tasks exactly as prescribed by doctors, procedures learned in training—it could be performed at this level. Clearly, significant skill, judgement and knowledge may be required in carrying out Level 1 tasks, and the possession of appropriate attitudes and sensitivity is also important.

Level 2: Situational Response

Here, precise objectives have to be determined according to the 'real' needs of each particular case as it is dealt with. Tasks are still concrete, but many may be handled simultaneously, and the time scale is 3 months to 1 year. Examples are: handling breakdowns such as the loss of the drug-cupboard key; assessment of the care needs of an individual patient; dealing with anxious or distressed relatives; coping with tricky staff problems like negligence due to illness. Such tasks are required in most forms of professional practice and in first-line management. In later Chapters we will argue that full professional nursing of a patient calls for Level 2 work; and so does running a ward.

Level 3: Systematic Provision

Here, the requirement is to make and develop systematic provision of services shaped to a changing flow of needs or cases which present themselves. In other words, it is to run a service by deciding methods, procedures and quality standards. The key control task is to manage available staff and other specific facilities or resources so as to handle the demand of the workload, taking into account inevitable fluctuations both in workload and staffing. Examples of typical Level 3 tasks include providing rotas for continuous cover through the year, developing a new complex procedure for dealing with a group of conditions, producing a new teaching curriculum, and implementing changes generated by long-term plans or higher-level policies. Analysing such situations, developing a new system, negotiating its introduction and ironing out problems lead to a typical time scale of 1-2 years.

Level 4: Comprehensive Provision

Here, the requirement is to make and develop comprehensive provision of services of some conventional or agreed kind in response to the needs of some social territory. This work therefore calls for a response to needs that are not currently being met as well as those that are, and the time scale for planning, implementing and evaluating extends to 2 to 5 years. Such development in the NHS is always associated with changes in many associated disciplines i.e. it is *general* in nature. As new services are added, older ones must often be reduced. The key control task is to match long term plans for service change to budget, and to implement these changes within the budget. Developing and maintaining a comprehensive nursing service for a large general hospital would be an example of typical Level 4 work.

Level 5: Field Coverage

Here, the requirement is to provide services in some specified field of need, like 'health care' in some given social territory (*viz.* the District) by responding in the most fundamental way possible within given definitions of the nature of these needs and services. The exact ranges of service to be provided have to be defined, and negotiated with other agencies, which in the NHS might include other Districts, the private sector, and voluntary and local authority agencies. This fundamental response is essentially one of shaping and structuring services and it has an extended time scale of 5 to 10 years. The nursing control task here concerns managing the boundaries of nursing with other disciplines, and defining the changing nature of nursing problems, services, education and needs. Financial constraints and possibilities must be managed, but detailed budgeting is not required for such work.

Higher Levels of Work

Levels of work above Level 5 do exist. Level 6 work involves producing a coordinated output in a range of separate but linked fields, as arises in industrial conglomerates, large local authorities, or the Regional organisation of District health services in England. Level 7 work involves covering a 'total field', providing the definitions of needs, services and methods to be used at lower levels, and creating or dissolving Level 6 or Level 5 agencies as required. Nursing is a relevant concern at both these levels, but as the work does not connect immediately to operational service provision, higher level issues will not be further discussed.

Calibre & Career Progression

It appears to be the case that the capacity to do useful and effective work at any particular work level, whatever the discipline or domain, varies markedly from person to person. Work capacity develops at different rates throughout the careers of different people: some people, for example, show no obvious ability to move beyond Level 1 work at any stage of their life; others become able, at successive points in their careers, to tackle work at Level 2, or 3, or 4, or 5, or even beyond.

At any point in a working lifetime, it is desirable that the work expectation on a person and his work capacity are in equilibrium. Within complex organizations, this equilibrium is not automatically achieved as both the work to be done and the people doing it are changing. Matching of staff to work is therefore a continuous and difficult management task. Managers must realize that if people are not properly matched to their job both people and the organization suffer. Attempting work at a level beyond a person's capacity leads to failure and possibly ill-health. The reverse, underemployment, is intensely frustrating and wasteful.

The times in his or her career at which the individual moves from posts at one work-level to posts at another, as opposed to periods of progression through grades within the same work-level, appear to be particularly testing. This is because each work-level demands a different outlook on the world, different patterns of relationships, different styles of operating, different modes of thinking and so on. It is likely that management education can develop a person *within* a work level, or prepare him for his natural

progression to the next work level; but training cannot move an individual *across* work-levels at will.

Authority Relations

The term 'manager', often as opposed to 'administrator', is more and more frequently used in the NHS. However this assumes that there is only one type of manager, or that all people called managers operate in the same way. Nothing could be further from the truth. There are many types of manager and they must be carefully distinguished, whatever the title eventually used. At least five main types must be recognized: main line-manager, staff officer, coordinator, supervisor, and monitor. Their principal features and their link to levels of work are described below.

Main Line-Managers have 'total' responsibility for results, and so they are dependent on the work-output of their subordinates. They must therefore be able to set general policies and standards, judge the abilities and potentialities of each of their staff, assess the training and development needs of each accordingly, and assign general responsibilities and specific tasks for each accordingly. For the same reason, they also require the authority to join in selection of their own staff with the power of veto, to initiate de-selection (e.g. by promotion, transfer or dismissal), and to zoom into any detail of any work of a subordinate at any time. Each work-level requires its own line-manager. The strongest and most straightforward organizational structure provides for one, and only one, main line-manager in each work level. The system of line-managers is the back-bone of an organization.

Coordinators are essential to integrate within and across hierarchies, or even across Agencies. In a multiple hierarchy service like the NHS, they are of particular importance. Their main responsibilities usually involve convening and chairing meetings of those to be coordinated; preparing and issuing detailed plans to forward agreed objectives; keeping informed of actual progress; attempting to overcome obstacles. This requires and involves giving instructions, but does *not* imply authority to set new directions, to override sustained disagreements, or to appraise personal performance. Coordinators typically operate with others working at the same work level, or at one or even two work-levels below. Although it is often convenient for the coordinator to be of equal or greater seniority to those he is coordinating, this is not a requirement, and they may work with staff at higher levels.

Supervisors take charge for the period in question; see that all necessary work is handled; and deal with immediate problems. Sometimes they are described as 'acting up' or deputizing. They are typically line-subordinates rather than assistants, and are usually required at Work Levels 1 and 2 (e.g. among junior doctors, in nursing, paramedical work, portering, domestic work &c) where they assist by: inducting, giving technical instruction, assigning tasks, checking performance, and helping with difficulties which present. Supervisors usually are at the *same work level* as those they are supervising, but in a more senior grade.

Staff Officers are assistants to line-managers, helping him by dealing with problems and implementing policies in particular fields like personnel, planning, information, and budgeting or on aspects of management which cross the responsibilities of several or all

subordinates. To do this they monitor and coordinate the activities of others. They may also 'act up' or deputize for a period. Main line-managers at Work Levels 5, 4 and 3 often require staff officers. Staff officers always work at least one level below their line-manager and may require their own direct subordinates.

Monitors may operate at any Level. Like coordinators they can cross occupational boundaries in pre-specified areas of concern; and they may monitor staff in both higher and lower work levels. They are used to ensure that activities of staff conform to satisfactory standards in one or more particular respects and where line-managerial, supervisory and staff officer relationships need supplementing. The monitor must be able to check or otherwise keep informed of activity in the given area, warn of deficiencies and advise corrective action, discuss possible improvements with the person concerned or his superiors, and recommend new polices or standards. They do not have the authority to judge the appropriateness of breaches, to set policies or standards, to give instructions or to appraise performance. Nurses are the natural monitors in many areas of health service work.

Questions & Objections

Q: *Does not this system of work levels represent the sort of rigid hierarchical thinking that has already done irreparable damage to nursing?*

A: A hierarchy of work is intrinsic to complex systems and simply cannot be avoided. The same can be said of authority. The question is how the work and authority is divided and allocated to posts, and whether the hierarchy is well-designed or poorly designed. Nursing has indeed been damaged by inappropriate hierarchical arrangements. Of course, we do not defend rigidities of thought, obsession with status, or authoritarian styles of management.

Q: *But surely work cannot be organized so rigidly and with such sharp divisions?*

A: The hierarchy is required to clarify the work expected in a post, not to promote rigidity. The necessary sharp divisions between kinds and levels of work can cause problems, and these must be dealt with by working relationships across the levels, by team development, and by suitable styles of working. Each level should be seen as a framework which permits maximum autonomy at the levels below; and all staff positively need frameworks within which to operate.

Q: *Is it possible to work at more than one level?*

A: Ideally jobs should be arranged to operate at one level. This is what people prefer. It also minimizes confusions of responsibility. Very occasionally it may be necessary for a post-holder to do two jobs: one at Level X and another Level X-1. However posts should never be so described that it is unclear which work level the post-holder is expected to operate at. There are grades within levels, but there is no such thing as a Level X-and-a-half post. This is a recipe for muddle.

Q: *But surely staff at higher levels (L-4, L-3) deal with situations (L-2) and may take notes of meetings (L-1)?*

A: Yes, those at higher work levels do some work at lower levels, but if this becomes excessive they seek assistants or resolve the problem in some other way. They also

regularly 'zoom' down into the problems at lower levels in the organization. However if they are truly able to work at the higher level assigned to them, they then 'zoom' up again, carrying the broader implications of the low level problems into successively higher levels of response.

Q: *Is it possible to work at higher levels, say, during planning meetings?*

A: Any notion of 'zooming up' beyond one's true level-of-work capacity at any point of time is a self-contradictory one within this approach. The work levels relate to the ability to carry *full and sole* responsibility for making decisions and seeing them through, and so to being able to be held accountable for results. This does not mean however that those at lower work levels should not be involved in work at higher levels either individually by contributing to working discussions (like planning meetings) or putting up ideas or proposals spontaneously, or collectively by setting up and using arrangements for sanctioning higher level policies.

Q: *How do Levels of Work relate to General Managers and District-Unit Organization?*

A: In the U.K., some small Districts and hence their District General Managers may operate at Level 4, but the large majority of Districts require the DGM to operate at Level 5. In the latter case, the Unit General Managers, responsible for the prime subdivision of the District, should work at Level 4.

Q: *Can a person be more than one* ***type*** *of manager?*

A: Yes, in fact this is common. For example, a main line-manager is often a natural site coordinator; and all line managers and coordinators are monitors for areas within their sphere of concern. There is a common combination which must be avoided, however, and that is expecting a main line-manager to be a staff officer as well (see Ch. 2).

Q: *Surely the* ***style*** *of the manager is what really counts in getting things done?*

A: Work style **is** important: it does affect decision-making and successful achievement; and asserting formal authority rarely solves problems generated by unsuitable work styles. (Work-styles is a topic that we have discussed elsewhere [9].) Nevertheless, clarity about legitimated authority is necessary if work is to get done efficiently and effectively.

Chapter 4

ENSURING PROFESSIONAL NURSING

In this Chapter, we need to consider exactly what is involved in 'basic nursing work' and what the nursing needs of patients are. This will enable us to clarify the level of work expected of a registered nurse, and to examine different possibilities for organizing the nursing of an individual patient. We will briefly examine the implications of our analysis for nurse staffing, nurse education and for nursing at night.

Kind of Work

The task of describing nursing work in general is properly left to the literature of nursing [e.g. 10]; and the task of defining the nursing work to be done in a specific situation is properly decided by the nurse or nurse manager. Additionally, nursing work is defined by statute [e.g. 11]. However we must concern ourselves, at least briefly, with this issue, because *so much, from quality of care to methods of evaluation, depends on an understanding of exactly what nursing work is.* We have found confusions amongst managers and nurses in our workshop and field experience and these demand clarification.

The form of work that is recurrently emphasized by non-nursing managers is the responsibility to carry out medical presciptions, as if nurses were no more than assistants to Consultants. However there is much more to nursing than this. The ill individual is unable to care for himself in a myriad ways by virtue of the illness and/or its treatment. If admitted to hospital, the patient is deprived of family members who would wish to minister to his personal needs, and of his household comforts and facilities. Only nurses are placed to meet the need for comprehensive personal care and attention that is an inevitable consequence of serious illness. In other words, the nurse needs to pay attention to **all** physical, psychological, spiritual and social concerns of the patient contingent on his illness; and one must not see her job as no more than performing specialized medical or nursing technical procedures.

For example, of particular importance to the patient's well-being is provision of appetizing food, warmth, quiet and personal cleanliness. All patients require physical and mental occupation; and they need to be helped to make sense of their illness and its treatment by providing sympathetic listening and information or explanations. Mediating between the patient and relatives is also frequently required.

Such a characterization of nursing highlights aspects of patient-care which are missed by many assessment systems. For example the coordination of all elements of care, perceptive surveillance and inquiry, and the provision of a continual comforting presence are typically by-passed. As most nursing-needs continue 24 hours a day, the conception of night-nursing as somehow subsidiary to day-nursing requires re-thinking.

Nursing at Night

Later we will be dealing in more detail with the arrangements for managing nursing at night in hospitals. Here it is necessary to clarify the way that the kind of nursing required at night differs from that required during the day. In particular we would wish to argue against the conception that nursing at night is primarily technical or no more than surveillance.

In many ways the work of nursing at night is identical to the work during the day. For example, many technical procedures, such as drug administration and dressing changes, are required round the clock. More importantly, the increased tendency to shorter length-of-stay has meant that wards contain sicker individuals who may develop medical crises and require assessments or action as much during the night as during the day. Nursing education also must be provided at night.

In other ways, however, the work of nursing at night is sharply different to that required during the day. The patients and nurses are freed from many of the demands and distractions produced by the variety of professional and ancillary staff on the ward, by the needs of medical education and research, and by routine ward administration. More attention can therefore be provided for the patient: how is he eating, is he getting adequate rest and sleep, how is he feeling, does he understand what is happening, are new symptoms emerging, how are the relatives managing and so on. It sometimes looks as if *only at night can the real work of nursing be done*.

There is a further dimension which perhaps deserves mention given the current emphasis on quality of care. Most physically ill patients have some lesser or greater degree of emotional disturbance. Studies indicate that at least 25% of patients who are acutely physically ill and hospitalized have a diagnosable psychiatric illness. Although anxiety and depression have negative effects on physical recovery, very few patients suffering from emotional disturbances are ever seen by a psychiatrist or managed by their doctor. Such disturbance typically leads either to difficulties in falling asleep or early waking; and distressing pre-occupations tend to surface at night. The emotional and spiritual care of these patients is either carried out by nurses or their suffering is, in effect, ignored. If quality of care means anything at all, it surely means nurses paying attention to a patient's distress and making a sensitive response. Sometimes recognition of the emotional state and simply being there is enough.

Level of Work Desirable in Nursing Patients

Having briefly clarified the kind of work required in the nursing of patients, we must now turn to a most important issue in determining how it is to be organized: namely, the level of work in nursing. Nursing work may organized on the basis of either a 'prescriptive' (or 'quasi-industrial') model which places nursing work at the top of Level-1, or a 'responsive' (or 'truly professional'*) model which latter places it in Level-2.

The 'prescriptive model' (Level 1) sees the nurse's job solely as carrying out tasks either as prescribed by a doctor or nurse manager, or as required by hospital routines, or

* The terms 'profession' and 'professional' are contentious. We argue that 'nursing' should be considered a profession because (a) the appropriate level of work should be Level 2 as in the standard professions; (b) the work should centre on a relationship with an individual with whom a personal relationship must be forged; (c) national nursing organizations decide on matters of ethics, minimal standards and education requirements which cannot be overruled locally.

as specified by her training. Such a model implies the possibility of a precise prescription of work. This is most easily accomplished when the work is predominantly routine and most contingencies can be anticipated and prepared for. When work is of this sort there are usually readily available 'clock measures' of activity and standardization of work may be aimed for. At Level 1, tasks are typically carried out sequentially, but some simple planning and prioritizing of tasks may be required. It should be noted that prescribed output work may also demand a high degree of skill, the use of complex technical procedures, judgement and sensitivity; and of course it needs to be carried out 'professionally' in the colloquial sense of 'doing a first-rate job'.

The 'responsive model' (Level-2) implies that an important element of unpredictability exists in nursing such that no two situations are exactly the same, each situation needing to be assessed separately and a response tailored to it. This will be required if many nursing situations are complex and require repeated re-assessment as they are dealt with; or if multiple tasks must be simultaneously dealt with.

It seems that the expectation of nurses from patients and medical staff is usually Level 2 work, however precisely specified some tasks may be. Patients and their relatives need rapid access to nurses who are not task- or ritual-bound but able to make and action their own assessments. And regularly-arising nursing work such as the handling of a difficult patient, responding to a medical crisis, prescribing, rescheduling procedures, dealing with complex problems of relatives, or urgently handling a breakdown in some nursing-related system all place nursing squarely in the 'responsive' category. It is this work of making important judgements in complex situations which pitches the registered* nurse role at Level 2.

Having said this, much nursing work does, however, also involve carrying out routine or fully prescribable techniques in stable circumstances: e.g. bathing or walking a patient; taking a temperature; keeping a patient company; feeding a patient. And a qualified nurse should be expected to be **responsible** for ensuring that patients receive such basic care. *But there is an important and too often ignored difference between being responsible for deciding that something needs to be done to a required standard, and doing it oneself.* Delegation of tasks to another is not equivalent to abdication of all responsibility for those tasks.

In short, we would argue that while a 'prescriptive model' of organization is wholly inappropriate, a pure 'responsive model' will not serve either; and that this applies as much during the night as during the day. Registered nurses should all be expected to work at Level 2 in their handling of individual patients, and in seeing that Level 1 tasks are performed well. However they should not *always* be expected to do *all* the Level 1 work. An organizational consequence of this conclusion is the need to examine alternative ways of getting the L-1 work done. Some of the L-1 work may indeed need to be done by the registered nurse, but it will often be appropriate for her to arrange delegation to a person with more or less training and with a title like 'nursing aide' or 'nursing auxiliary' or 'care assistant' or 'helper' or 'basic carer' or 'patient's aide'.

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* We refer here and throughout to 'registered' nurses rather than using the confusing terms 'qualified' or 'professional'. State Enrolled Nurses (SENs) are qualified and can be expected to operate 'professionally'; and even nursing aides may require some qualifications. The SEN role appears to be pitched at Level 1, but sometimes Level 2 work is expected. Some SENs are clearly capable of Level 2 work.

Organizing the Nursing of a Patient

In any nursing situation (hospital or community) therefore, we can identify three distinct options for the organization of professional nursing work on individual patients:

Option #1:

*The registered nurse not only does the L-2 work, but **all** L-1 work on the patient as well:*

e.g. in an intensive care unit where the physical state of a patient is highly unstable, crisis is usual, and the nurse needs to draw flexibly on past experience, registered nurses should handle all aspects of the nursing of a patient.

Option #2:

*The registered nurse handles most of the patient's care, but has an assistant to help her do **some** of the L-1 work:*

e.g. on many wards and in many community situations, it may be necessary for a registered nurse to assess (L-2) the patient repeatedly during a day and carry out some of the L-1 work either as part of the assessment or because the situation is complex; however a certain portion of the L-1 tasks may be assigned to an assistant at once or over the day.

Option #3:

*The registered nurse has several assistants who perform **almost all** of the basic care work (L-1) and she manages them:*

e.g. for a stable patient receiving domiciliary psychogeriatric care, the registered nurse may make an initial assessment and regular re-assessments (L-2), but provide only a very limited amount of basic patient care, assigning most of this L-1 work to nursing aides and supervising them periodically.

Each of the above arrangements requires specific tailoring to the particular circumstances. They should not be seen as formulae but as frameworks for thinking about the work that is emergent or desired on the basis of the needs and situations of the patients.

It has been argued that unless the registered nurse does L-1 work she will not get to know the patient. It must be emphasized therefore that no suggestion is made that registered nurses should completely avoid L-1 work. Indeed all professionals regularly do substantial amounts of L-1 work with their patients or clients. There have been arguments which go further and favour the total abolition of auxiliaries i.e. in effect of all L-1 nursing roles. However all professionals (unless their income depends on it) use assistants and attempt to delegate portions of L-1 work that are routine. Perhaps as an example we may consider the taking of a temperature: when this was new, only doctors performed it; later only nurses; now brief training but no extensive education is regarded as necessary for use of a thermometer.

As well as protecting nursing morale, a further cogent argument for the use of L-1 staff are the cost implications. Using L-1 staff may mean that larger numbers of patients can be cared for. *Standards can be maintained or even improved as long as the nursing needs are sensibly assessed, divided up and managed by registered nurses.* Such management work is unfortunately not stressed in nurse training.

The use of L-1 staff may, however, be overdone. Their effectiveness and efficiency depends on adequate L-2 staff. Where L-2 responses are required, by patients, the registered nurse is the only sensible solution by criteria of quality of care, efficiency and economy.

As we shall see in later Chapters, where many qualified nurses at L-2 work as a team, there is almost always a need for a strong L-2 coordinator or leader: the 'ward leader' in a hospital; the 'team leader' in the community. Unlike higher level managers, the leader keeps a focus on specific patients. This team arrangement is common in professional work e.g. among social workers, paramedicals, teachers.

Implications for Nurse Education

We must now consider the implications of this analysis for nurse education. Naturally the approach to educating staff for work at L-2 is different to that for educating staff to work at L-1. The general desire for the practice of nursing to be pitched at L-2 has not always been matched by clarity of aim in the field of nurse education. Educating for the task of making decisions in complex situations on the basis of a body of knowledge is a different job entirely to educating for precise compliance to task prescriptions.

The 'nursing process' is a paradigmatic approach to developing L-2 skills. A checklist form may be useful during training, but its continuing use post-qualification has a danger of reducing nursing assessment to L-1. The nursing process in practice means an ability to size up a patient rapidly and automatically considering all categories of patient need and so come to a confident conclusion as to the effects of previous nursing decisions, the nature of the total situation at present and what needs to be done now. Records are then primarily useful for periodic communication.

Until recently perhaps, the NHS could choose to some degree whether to keep nursing at L-1 or raise it to L-2. However the current trend to more complex education for nurses, and higher entry levels for training will do away with any possibility of keeping nurses performing L-1 work.

Most of the previous nurse training programs which successfully qualified nurses for L-1 work have been or are being converted to programs for producing nurses capable of L-2 work. However as indicated above the need for L-1 nursing assistants is not going to disappear. Depending on where they are working and what is expected of them, the assistants will need to be trained to carry out the L-1 tasks. Some training schemes will be most appropriately provided within the NHS using the service staff. However, the numbers involved are likely to be so great that it is to be expected that training schools for certain varieties of assistants, revamped L-1 practical nurses, will be required. Probably they will be given many different titles. Attempts to remove or ban the label 'nurse' from all L-1 posts which provide basic nursing care, though understandable, are potentially misleading, and perhaps positively to be discouraged because patients will experience themselves as being 'nursed'. Doctors and patients will be concerned, however, to distinguish the 'registered' nurse from the others.

Student nurses differ from auxiliaries or assistants in that, although needing to carry out L-1 tasks, they should be helped continually to see the L-2 assessment associated with the task and encouraged under supervision to make such assessments. Nurses, just after qualification, may occupy an intermediary role. In many professions, an initial period is provided in which most of the L-2 work done is supervised. However, the expectation should be a rapid assumption of L-2 duties. This analysis therefore opposes the use of students as a cheap labour force simply to perform L-1 work.

QUESTIONS & OBJECTIONS

Q: *Project 2000* [12] *describes its proposals as 'nothing less than a revolution in the usage of manpower in the NHS'. How do they differ from what is suggested in this Chapter?*

A: Very little. The Chapter starts from the position of what is required by the *patient*. Project 2000, which also claims to do this, is a nurse training document which might appear primarily to be advancing *nursing* aspirations. Project 2000 makes no mention of the needs of nurses for even the most basic management education, and yet their proposals mean that management of aides by professional nurses may well be a demanding responsibility.

Q: *If an aide only responds to assessments carried out by the qualified nurse, how will the changing needs of a patient be met when the aide is alone with the patient, say, at home?*

A: The aide must have some limited flexibility. However, if needs are truly changing, then either only L-2 registered nurses should be allowed contact with the patient, or L-2 staff must be able to anticipate possible developments and instruct aides accordingly. The latter seems realistic in certain situations, but it will only work in practice if an aide can get rapid assistance if the patient's state changes unpredictably. In other words, where regular L-2 assessments are necessary, a regular L-2 presence is essential.

Q: *Could training make the aide more flexible without pushing her up into a higher level of work?*

A: Yes. This would be the basis of an argument (which we predict will emerge in the NHS) for lengthy courses of a year or more for aides, probably organized on an in-service basis. Project 2000 which attempts to maximize the distinction between aides and nurses suggests that training courses for aides should be very much shorter.

Q: *How does this analysis aid in clarifying the role of keyworkers?*

A: The keyworker approach appears to be part of a desirable attempt to increase the individualization adn continuity of patient care. However it must be noted that a keyworker role can be provided either at L-1 or at L-2, with different consequences for costs and for patient care.

Q: *What is the role of specialist nurse practitioners?*

A: 'Specialist', as applied in nursing and the paramedical professions, strictly indicates no more than a focussed area of work requiring extensive expertise and knowledge in that area. It does not necessarily imply a higher level of work, although certain practitioners may be capable of such work. Sometimes we have found that it implies a lower level of

work—to the frustration of those involved! Usually it implies increased responsibility and expertise but still within Level 2. The place of clinical specialists will be discussed further in a later Chapter.

Q: *Could the ideas in this Chapter be used by unscrupulous general managers to cut costs, exploit aides, and reduce standards of care to patients?*

A: Anything can be misused! We also object to reliance on student labour and to excessive dependence on untrained staff. But the aim of giving as many people as possible satisfactory nursing care at a minimum cost is not unreasonable, and a variety of approaches to achieving this may be required. Sensible innovation in nursing care organization is to be encouraged. Our main point is that if nursing is to be effective, its practice needs to be set at L-2. Proper use of nursing aides (working at L-1) can help registered nurses meet patient needs, improve nurse morale and reduce management costs.

Q: *When the workload is high and staff shortages are persistent, is it possible for nursing to continue operating at Level 2 rather than falling back to Level 1?*

A: In such a situation, assessments of what should be done for any particular patient will need to take into account the exceedingly large amount of work expected of the nurse. In other words, quality standards usually fall if the quantity of work increases, but *the level of work required rises rather than falls*. Excessive workload may encourage or force nurses to adopt a task-oriented assembly line approach to patients rather than an individualized approach, but even then a Level 2 perspective should be maintained.

Chapter 5

DEVELOPING A WARD LEADER

In the previous Chapter we examined the practice of nursing itself but said little about managing it. Nursing takes place in many contexts including wards, outpatients, primary care settings and in the home. The sickest patients are cared for in the ward, and it is to nursing work in this context that we now turn.*

Ward Work and the Need for a Leader

If nursing organisation in the ward is to be matched to the needs of the patient, then our research indicates that the main features of the work which constrains any model of ward management are:

- The patient is in the ward 24 hours a day and requires *continuity of nursing care* through this period.
- The patient requires ready access *at all times* to a registered nurse with appropriate authority and should be monitored at appropriate intervals by such a nurse.
- The patient's needs require consideration in the light of the needs of other patients.
- The ward is within a hospital and dependent on the larger system for a reliable supply of crucial services such as heat, repairs, materials, food and so on.

The idea of a ward sister arose from *the need to manage patients in groups by groups of nurses* and to give that management some coherence and unity. The key requirement in regard to managing the quality of individual patient care is to balance the priority of any one patient at any particular moment against the needs of all other patients in the ward. Priority decisions of this type need to be taken by a single individual in charge.

Our research has therefore concluded, as have other investigators, that the preferred model is for a single post, the *ward leader*: the person given this job should be in charge of the ward 24 hours per day, 7 days per week; and she should be known by name and sight to the patients and other NHS staff and be identified with that ward. The term 'leader' rather than 'sister' is used because sister has come to mean a grade, not a role or title. Although it is quite possible to have more than one sister on a ward, it is essential to designate one of them as leader. Group leadership or alternating leadership of the ward does not meet the criteria spelled out above e.g. for a focus of authority and for continuity of care.

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* This and most subsequent Chapters tend to focus on hospital nursing but most of the principles and analyses are applicable with only minor modification to nursing in the community. Special issues in community nursing are examined in Chapter 9.

Such a ward leader is actually 'on duty' for only one shift, typically during the day. At this time, she is also the *shift-leader*. Other *shift-leaders* are therefore required at other times as the 'supervisors' or persons 'in charge' (as defined on p.17). If the ward leader is to be responsible for the work of the ward as a whole, then these shift-leaders, whatever their grade, must be seen as her deputies or assistants. Before moving on to discuss the work of the ward leader in detail, it is therefore necessary once again to examine nursing at night.

The Night Sister Role and its Problems

A particular issue in ward management concerns control of night nursing and night staff on the ward. As indicated in the last Chapter, our researches do not bear out the common assumption that nursing responsibilities at night are significantly lower than during the day. However it is true that night time responsibilities vary considerably amongst wards. In many wards the continuous presence of a registered (L-2) nurse in the shift-leader role is essential; but in some a 'Night Sister' role (L-2) shared with several other wards may be adequate.

The frequent practice, dating from the last century, of assigning night nurses (and Night Sisters) a different manager to nurses working on the day shift makes 24-hour responsibility and coordination of care by the ward leader impossible; and implies the need for some higher line-manager embracing days and nights.

If activity on wards at night is very low, and it is decided to staff wards with unregistered nurses, then it is necessary to be clear exactly what the Night Sister's responsibilities in relation to such nurses are. L-1 ward nurses are authorized solely to carry out prescribed tasks. The Night Sister does not need to witness these, but must periodically check that they have actually been carried out. If an assessment is required, or if skilled technical nursing work is involved (e.g. setting up an intravenous infusion, checking wound drainage), then this must be performed by the Night Sister. Similarly only the Night Sister should be permitted to summon the on-call doctor. This implies some familiarity of the Night Sister with the patients and the course of their illnesses in general and through the night. Furthermore, the Night Sister must be fully responsible for collecting information not only on the clinical state of individual patients, but also on their psychological state and on issues concerning relatives or social arrangements. There are usually matters concerning staffing (e.g. redeployment), and teaching responsibilities for her as well. This now places them in a typical confused role, partly line-manager immediately responsible for a large group of patients, partly assistant to some higher manager. *Clearly, in many situations, if reasonable standards are to be maintained, the point is quickly reached where the constant presence of an L-2 nurse ('shift-leader') for* ***each*** *ward is desirable to provide a primary and immediate focus on patient-care.*

Responsibilities and Level of Work

The ward leader, as described above, is first and foremost responsible for the nursing care of all the patients on her ward. This involves, above all, knowing the clinical state and course of all patients on the ward and seeing them as 'her' patients—even if she uses a system in which individual patients or groups of patients are assigned to professional

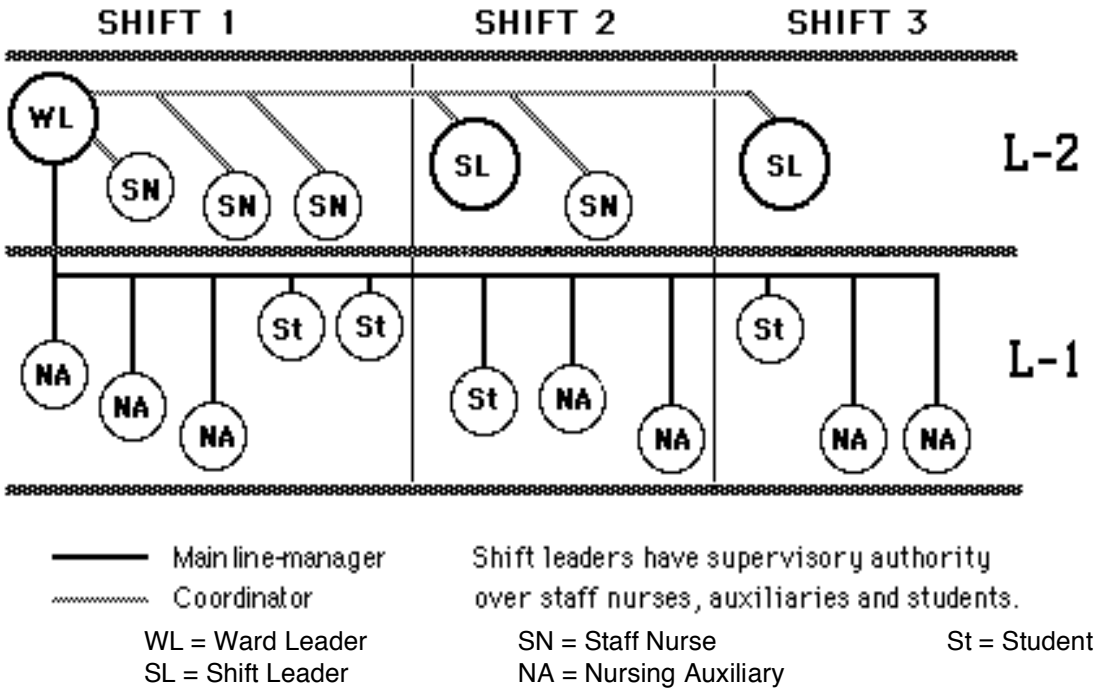
nurses or to mini-teams of nurses on the ward. The leader must be responsible for ensuring that patients receive proper feeding and are made physically, psychologically and socially comfortable; and must ensure that the special procedures required for individual patients are carried out. The provision of general care of patients is mentioned before the carrying out of medical prescriptions, because this is what patients are primarily affected by; and yet, being the first casualty when the demands on the ward increase, the former may sometimes fail to be properly reinstated when the tension eases. Both general care and specific prescriptions are carried out largely by the team of registered nurses, auxiliaries and students assigned to the ward.

Second, the ward leader must be responsible for managing the ward environment, that is to say developing and using relationships with the rest of the hospital and the external world. This means a concern with the catering, cleaning, clerical, supplies and other services needed for smooth and aesthetic ward operation. Third, the ward leader must provide for nurse education on the ward, both for nurse students and for newly registered or inexperienced nurses.

The ward, not unlike the patient or the shift, may be subjected to marked fluctuations in state or sudden urgent demands. These cannot be fully anticipated or ruled on beforehand but must be assessed and dealt with authoritatively and confidently on the spot. Hence the level of work required is Level 2: it consists essentially of making situational responses that is to say, of assessing the needs of particular cases or situations, deciding whether anything needs to be done, and then doing it or delegating one or more specific tasks. The similarity in level of work required for the patient, the shift and the ward is the basis of the common practice of moving nurses about between roles to deal with holidays, illness, absences, emergencies and so on.

The image of nursing on a ward that we are suggesting is schematised in Figure l. It consists of a team of registered nurses divided into shifts, each with a shift leader and with one of these designated as the ward leader. The ward leader is the main line-manager of auxiliaries and students, but may assign these to assist other qualified nurses. To gain maximum benefit from strong 24 hour ward management and to avoid the common difficulties between shifts, professional nurses assigned to a ward should be expected to work on a more than one shift, including nights, and the system of cadres of nurses who work days only or nights only should be phased out. Problems of pay and union resistance, where present, must be faced directly for the good of patients.

Figure 1: Schema for Ward Organization*



*We have not provided a model in which the Ward Leader is the only nurse working at L-2 over the whole 24 hours and is the main line-manager of all nurses on her ward. (In the light of the previous Chapter, this would be tantamount to arguing that nursing practice was L-1, and could be exclusively provided by aides.) There may be occasional circumstances, however, where this is suitable.

Qualities and Skills

As an on-site first-line manager, the ward leader must be comfortable in the performance of managerial work. She must have the character and interpersonal skills to lead: to act as a figurehead, to develop a strong team spirit amongst students and staff on her ward, and to liaise effectively with a wide variety of hospital personnel and outsiders. She must be able to take decisions which affect her own and other staff and patients so as to handle disturbances rapidly, to allocate her own staff, and to negotiate new arrangements within the ward. She must comfortably handle information, so as to be effective in monitoring the ward, planning its activities daily, disseminating news, recording relevant data and speaking clearly on important issues. As we have emphasized, if she is to create a patient-focussed ethos on the ward, the ward leader should have a measure of direct contact with each patient. This is requisite because on the one hand, the patient needs (as do his relatives) to be in touch with the person responsible for his care; and on the other, it is essential if the ward leader is to make judgements about individual and total ward priorities. It is this requirement for personal contact with patients which limits the size of wards.

Exactly how the contact between ward leader and patients is to be made cannot be specified, but it is essential that all concerned do not see the ward leader role as simply administrative. The ward leader must feel personally responsible for the *standards of nursing care* in her ward, given the resources provided for her and given higher level policies. Minimum and maximum standards may be set by higher levels, but the exact standard at any moment must be determined on the ward. Because of the fluctuations in

the ward workload generated by doctors and patients, and fluctuations in resources generated by higher level decisions, the quality of care which it is possible to provide will inevitably fluctuate. These largely unpredictable fluctuations require the ward leader to be flexible, perhaps stopping certain optional activities, or modifying the way others are done, or rapidly negotiating changes with consultants.

Authority Relations With Nurses and Others

It is simplistic and positively misleading to describe the ward leader as the 'ward general manager' with overall responsibility for all ward activities. The argument so far implies that the ward leader is the *main line-manager* of all Level 1 nursing staff on the ward, *coordinator* of all registered nurses on the ward, including the other shift leaders, as well as *monitor* and possibly *coordinator* of staff from other disciplines that enter or use the ward (*v*. definitions provided in Chapter 2). We will now examine in detail the ward leader's authority in relation to the various groups of nursing and non-nursing staff, including medical consultants, paramedical professionals and support services staff.

Relationship with L-1 Nurses on the Ward

The ward leader can be the unequivocal main line-manager of nursing auxiliaries and of nurse learners (while on the ward). In the latter case, a dual influence situation exists and there will be joint responsibility on some matters with tutors in the school of nursing.

Relationship with L-2 Nurses on the Ward

Some managers are disturbed to think that the ward leader, though the undisputed manager of the ward, is not the line-manager of all the nurses. It would be simpler on paper if line-management was possible within the one level, or if registered nurses worked at Level 1. However that is just not the case. (Our conclusions from field work here are further buttressed by finding similar team arrangements required at Level 2 in neighbouring professions like social work and physiotherapy.)

If the ward leader is to have adequate authority to run the ward as schematised above, but must do so with other nurses working at a similar level of work to herself, and possibly capable of substituting for her, then careful articulation of the extent and limits of her authority is essential. The dangers to be avoided include undesirable suppression of the level of work of registered nurses by the ward leader and inappropriate challenges to the ward leader's way of running the ward by the registered staff on her team, in particular the shift leaders.

Responsibility for the quality of nursing on the ward means that the ward leader must do more than judge the work to be done on the ward, she must also appraise to some degree the various qualities and abilities of the nurses assigned to her. Such appraisal will lead her to assign work in a particular way and possibly cause her to request the removal of a nurse because of 'unsuitability'. However, we suggest that it is essential to distinguish such appraisal and designation from that performed by a line-manager, who works at the next higher level of work. The ward leader does not appraise the overall performance of an L-2 nurse. Although she will influence the L-3 manager's appraisal, she should not unduly affect her colleague's promotion or future employment. If a particular registered nurse does not fit into a ward leader's team or if the nurse is

dissatisfied with the assignments given to her, then the responsible person to whom the ward leader or the nurse should appeal is the level 3 nurse manager.

Relationship with Medical Consultants

The responsible Consultant (often through junior medical staff) prescribes work to be done for particular patients. The ward leader must integrate this work with the total work-load for the ward with an eye to maintaining standards and morale. She should be able to negotiate with consultants over patient-related issues or conflicting requirements by different consultants, but should the issue concern medical policies rather than particular decisions or cases, then negotiation becomes a matter for a higher level nurse manager. It appears quite appropriate for Consultants using the ward to be involved in the appointment of ward leaders though they neither manage nor assess her nursing work. But they are not the manager of the nursing staff. If consistently dissatisfied with the care provided on a ward, doctors should turn to the ward leader's own manager.

Relationship with Other Health Professionals

Other health professionals with whom the ward leader must work include physiotherapists, pharmacists, and other doctors giving specialist opinions or carrying out special procedures. The ward leader requires *monitoring and coordinating authority* in relation to all such staff who wish to make contact with patients or wish to be on the ward for other purposes, such as research or education. The growing tendency for paramedical staff to provide direct assessments and treatments for patients, i.e. work not prescribed by a doctor, means that the ward leader must be recognized as the person generally responsible for ensuring that diagnostic and treatment services for a patient do not clash or overwhelm the patient. The ward leader requires the authority to request some services or to refuse to allow them. The natural arbiter for disagreements would probably be the medical consultant.

Relationship with Support Services Staff

Under the heading of support services staff, we include such groups as domestics, porters, catering staff, clerical staff, laundry and linen staff, supplies staff, and works staff. Domestics and perhaps catering staff might appear to be in a different category to works or supplies staff in that the former may involve direct patient contact. However for practical as much as for organisational reasons, patients cannot deal with these staff, and *it seems appropriate to see all services as provided to the ward leader who is acting on behalf of the patient*. The ward leader should be able to ask for the services required for her staff or for the patients (within given policies) and indicate the urgency of the requests. She should then expect the requests to be complied with without complicated arguments or extensive paperwork. This will not occur in the absence of explicit and clear arrangements developed and maintained by the next level up in the organization.

The service-giving departments should be set up so as to respond to such requests in addition to any other routine responsibilities which they may have. Service-givers are typically expected to set priorities amongst requests. Problems inevitably arise where such priorities have not been set, or where the volume of requests far exceeds the staff and other resources available to meet them. In such a situation, both the ward sister and/or the first-line service department manager need to refer upwards so that priorities can be set. Prompt decisions resolving such problems with full feedback is essential for nursing morale on the wards. How this may be facilitated is discussed later.

In addition, the ward leader is in a position to monitor activities by a wide variety of staff and disciplines with respect to their impact on patients. In certain matters this monitoring responsibility may require to be formalized if it is to be effective.

Inappropriate Work for the Ward Leader

It is fitting to conclude this Chapter with a mention of *inappropriate* arrangements and demands on ward leaders. Paradoxically, the widespread awareness that the role of the ward sister required strengthening led to arrangements which all too often have weakened the ward leadership role. *The easiest way to undermine ward nursing is to give the ward leader responsibilities which take her time and attention away from her own ward.* So-called special coordinative roles for ward sisters covering several wards are in danger of doing this. (This is not to say that ward leaders may not regularly need to coordinate each other in various ways.) Doubling up wards to 40-50 beds radically alters the work, makes patient contact impossible, and produces new L-2 sub-ward entities requiring a leader. Increasing the responsibility for monitoring or controlling the effects of changes in support services (organisation, procedures, staff training, etc.) has similar results. (Other mechanisms are required to deal with this.) The current urge to give ward sisters budgets and reams of information on patient flows is also seriously misconceived: first-line managers should not be given such responsibilities. (Though someone else should.) Ward leaders do have a part to play in recent initiatives e.g. they should have information on the cost of various items, and assist others in interpreting variations in workload figures and patient costs. However we conclude by emphasizing the obvious: the ward leader's attention must be focussed on her own patients and how they are faring; anything which detracts from this lowers the quality of care and weakens the morale of nurses.

QUESTIONS & OBJECTIONS

Q: *The model does enhance the Ward Leader role, but does it do so at the expense of the other registered nurses on the ward whose level of work will be depressed?*

A: No. The ward leader does not herself care directly for all patients and usually cannot carry the workload without other professional staff working at L-2. It is assumed that the **other registered nurses will be applying their ability fully in the direct care of patients.** The ward leader's appreciation of a patient's state will be primarily focussed on ensuring consistent 24 hour care, handling care priorities within the ward, or dealing with conflicts involving other disciplines or departments. Note we argue that the ward leader should **not** have full line-managerial authority over registered nurses; and it should be clear to all registered nurses who their line-manager is.

Q: *Should all registered nurses aspire to become Ward Leaders?*

A: Ward leaders need to operate at the top of L-2. Not all nurses will have this potential or be willing to shoulder the responsibility involved. Even for those that do, there should be alternative promotion to top L-2 grades in clinical nursing specialist roles. However, nurses who have aspirations to become senior managers in the health service should expect to work for a while as a ward leader.

Q: *Taking the ideas in this Chapter with that in the last, there is a financial and manpower resource problem emerging in trying to run all our wards with so many highly graded ward leaders, shift leaders and registered nurses. What is to be done?*

A: As usual, the shortage of resources brings out the need for setting priorities. It is not possible for us to give guidance on the requisite skill mix for any particular ward, department or sector, because **the issue is essentially that of deciding where the available L-2 staff should be deployed in the light of given priorities**. We do believe that each ward leader needs to work within an explicit policy for staffing numbers and levels which should be real not fictional (as in: 'our complement is 5 staff, but whenever we do have 5 staff on duty one is taken away').

Q: *There are a variety of ward leader posts of different degrees of responsibility. How is this to be taken account of in your scheme?*

A: The complexity of work, and hence the burden of responsibility, on different wards will indeed vary. Ward leader posts should therefore carry a variety of grades to reflect this, probably as high as SN7. Complexity may be reflected by the need for more staff, more registered nurses or more high-graded nurses—but not necessarily. Hence the responsibility in the post is primarily a matter of judgement for the higher level manager.

Q: *Many General Managers are saying that Ward Leaders must now be expected to work at a level corresponding to your Level 3. Is this possible?*

A: This is a typical NHS response: swinging from one extreme to another. Extensive fieldwork with many charge nurses and ward sisters confirms our assignment of the role to Level 2. Indeed one of the few things on which most nurses, official reports, ourselves and standard textbooks agree is that the ward leader is a first-line management post—and not higher. It is essential in the model presented that the ward leader know each patient in the ward as an individual: this ideal is gravely weakened if the ward leader is burdened with statistics, cost-flow projections and other matters that are not directly related to the needs of individual patients. The ward is in any case too small an entity to have its own staff systems and manage its own flow of work, an issue which we will discuss further in the next Chapter. We have, however, occasionally found nurses of Level 3 capability who prefer to remain in a L-2 role in charge of a ward so as to keep close to patients.

Having argued as above, we accept that there is possibly scope for ward leaders working at L-3 in certain very specialized areas in teaching hospitals. Then the ward leader role allows for patient contact, strong management, close collaboration with medical consultants, and for educative and research work to be undertaken.

Chapter 6

RESOLVING THE NURSING OFFICER PROBLEM

The Problem

The 'nursing officer' problem is widely recognized in the NHS, and indeed in nursing textbooks. To bring it alive we provide below some typical findings from recent field work in a large teaching hospital:

Ex: *The ward sisters were dissatisfied with their NOs who were often felt to be a burden rather than a support. The sisters usually had to work under two or three NOs and complained of being unable to get help from them in dealing with supporting services like catering, domestics and supplies. For example, one sister described a three month saga to get a disturbingly squeaky wheel oiled culminating in her breaking regulations by buying the oil and doing it herself. The NOs were themselves not clear as to what they were supposed to do. Some felt they should be doing more practical or teaching work on the wards. Some thought their role should be in counselling or staff development. Others were more concerned about cross-ward integration. Many felt over-occupied with clerical drudgeries and resented being just message-passers. NOs varied greatly in what they actually could do and did do.*

Sometimes nursing officers have been exhorted to be more concerned with clinical care and at other times pressed to see their role as primarily in management. A quite proper concern to support and encourage developments in clinical nursing and to provide a career path for top clinical nurses has exacerbated the confusion. Some solutions have actually worsened the plight of able nurses. For example, attempts at compartmentalizing and specializing nursing work to produce clinical specialist or so-called consultant nurse roles sometimes appear to have resulted in the development of no more than super-efficient Level 1 technician roles.

Analysis

Perhaps the most serious consequence of the defective middle management structures which followed the Salmon Report [4] was the promotion of skilled practice nurses to quasi-administrative roles, and subsequent lowering of the level of work of the ward sister. Sometimes the promoted nurses crowded or intruded on the ward sister's sphere of authority further depressing the level of work provided at ward level. Equally serious was the proliferation of roles whose position in the line-management hierarchy was exceedingly unclear or untenable and so generated confusion about accountability. The Salmon Report was not to blame for the way the Salmon *grades* of Nursing Officer

(NO), Senior Nursing Officer (SNO), Principal Nursing Officer (PNO), and Chief Nursing Officer (CNO) were interpreted as *posts*. All too often these grades were seen as progressively higher levels in the managerial hierarchy above the ward sister. Although the grades have now been replaced by those of Senior Nurse with a variety of numbers attached (SN8 to SN1) and the DNS grades, the profession is still dogged by 'the problem of the nursing officer'.

Resolution of this problem is urgent for nurses as individuals, for the nursing profession, for District organization of services—and hence for patients.

The Resolution

The first point to establish is that there is no such thing as 'the proper role of the Nursing Officer', or 'the correct image of the Nursing Officer' because the label Nursing Officer (or now Senior Nurse) is a *grade*. Grades exist to determine payment attached to posts and for career progression purposes—not as descriptions of jobs. One might as well ask what is the proper role of a Scale 14 administrator. Any post requires more than just its grading to explain it, and any post must be accompanied by a *simple descriptive title or name* which makes it clear what the person is supposed to be doing (see Ch.2 and examples below). *The job description is never a substitute for such a title*. If an unambiguous and satisfactory title is difficult to determine, serious doubt is cast on whether a coherent job really exists.

With these insights, the argument for whether the NO should be a clinical, management, or mixed clinical-management role simply evaporates. The new task which emerges is to start from the needs of the particular nursing situation. Someone must determine what clinical work is required, what management work is required, and how this work can be organized into personally-satisfying and organizationally-suitable jobs for nurses or others. In other words, posts of a variety of kinds are necessary. Once the kind of work is clarified, the degree of responsibility can be determined and a grade can be assigned to the posts Central directives and political or union organizations of nurses cannot make such judgements. The work to be done and the options for doing it should be a matter for dispassionate inquiry by local managers. It may be that some posts do not require to be filled by a member of the nursing profession

In our research, we have found that there are a number of distinct jobs graded SN7 and SN8 that are loosely labelled as Nursing Officers. Of great importance, but relative rarity, is the job of being the main line-manager of ward leaders, a job which we will be discussing in more detail in the next Chapters. Far more common, however, are a large variety of *top L-2 roles*. It is to be emphasized that many of these jobs are not substantially more complex or more responsible than ward leader jobs. Some are less onerous. They fall into four categories as follows:

- Clinical specialist roles
  e.g. diabetic nurse; stoma care nurse; control of infections officer
- Staff officer roles (i.e. assistants to the L-3 main line-manager)
  e.g. nurse education coordinator; information officer.

•High-level clinical supervisory roles
e.g. night nurse responsible for part of a hospital; hospital supervisor.

•Ward-manager-type or Professional-nursing-type roles
e.g. ICU nurse-in-charge; top nurse in a small cottage hospital; community nurse manager.

As to whether people without nursing qualifications could carry out the above work, it seems clear that clinical specialists, clinical supervisors, and ward-nursing-type roles absolutely require to be nurses. However, some assistants to the L-3 line-manager may not need to be nurses.

Implementation

As these roles all serve either to provide services directly to patients or to assist in the management of provision of patient services, the person responsible for main line-management of nurses and wards—the Level 3 line-manager—should make detailed suggestions about the staff and posts needed. However personnel and post control is typically a Level 4 responsibility. The changes and resource implications of resolving the Nursing Officer problem are potentially so substantial and controversial that the lead needs to come from the Director of Nursing Services and/or the Unit General Manager, probably with support from the District General Manager and the District Health Authority.

There is also a sensitive personnel handling problem. Our experience is that the abilities of those graded as SN7 and SN8 vary greatly. Some are capable of Level 3 work, but many are not. Some will be capable eventually of Level 4 work, or perhaps even higher. The assessment of potential abilities is usually best carried out by the manager-once-removed i.e. the DNS or UGM.

QUESTIONS & OBJECTIONS

Q: *Will Nursing Officers in the various roles continue to be responsible for units?*

A: The persistence of the term 'Nursing Officer' after its official demise is associated with the continuing reference to the 'unit' for which SN7s and SN8s are frequently responsible. The unit was the Salmon term corresponding to the Grade 7 N.O. Now, however Unit (as in Unit General Manager), means something completely different, and retention of the term by nurses is confusing.* We argue in the next Chapter that the true L-3 manager will require a chunk of services, which we suggest might be called a Division to capture its substantial nature. Such Divisions should not routinely be further divided into segments for SN7s or SN8s as recommended in the past. Arrangements to coordinate ward leaders in this way encourages the formation of an extra and unnecessary tier of management.

* Throughout this Document the term Unit will always refer to the Unit created in the 1982 reorganization.

Q: *Will the new roles solve the problem of careers for clinical nurse specialists?*

A: The suggestions in this and later Chapters should help to clarify the place of the clinical nurse specialist within the total nursing organization. But such posts must mesh in with other health professional activities. District policies and priorities will therefore be important e.g. a District placing a major effort on improving care for patients dying with malignancies will tend to support the creation of a 'nurse coordinator for lymphoma management', and so on. Local judgement will be essential, however, in deciding which clinical nurse specialist roles can be usefully developed, and exactly what combination of responsibilities are viable and necessary to create a satisfying job.

Chapter 7

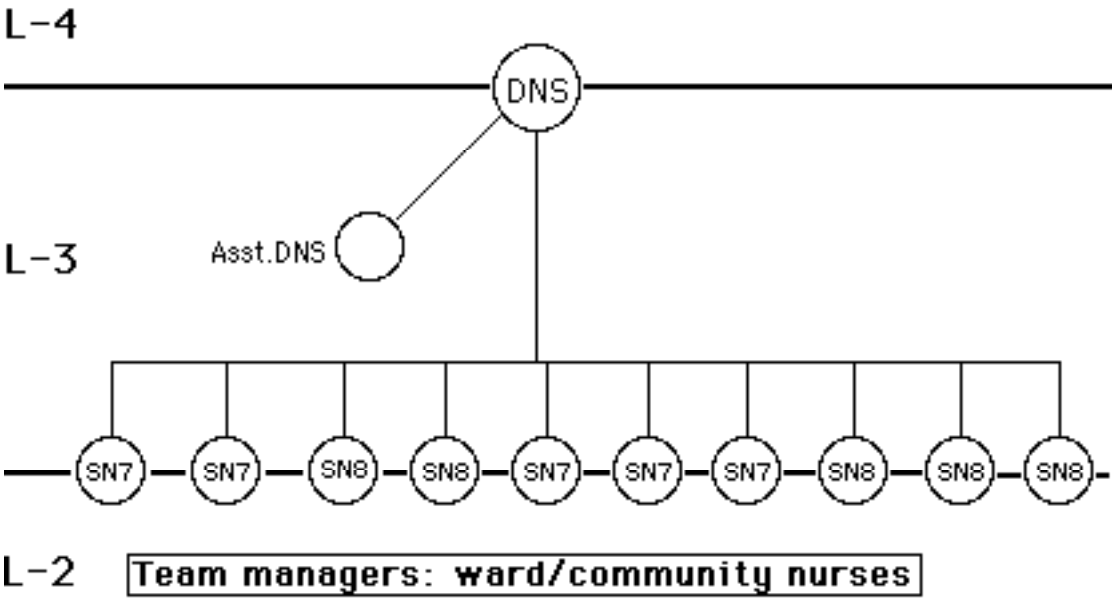
CREATING NURSING DIVISIONS

The Problems

Nurses on wards feel overworked. They claim their nursing skills and expertise are underused. They feel hampered by higher authority. They are subject to unacceptable delays in urgent supplies or repairs to faulty equipment. The bottom line is that they are often unable to ensure that patients are properly treated and protected from disruption. **Usually these problems are not the result of inadequate people at higher levels, but are a consequence of failure in the structure and system at middle management level.**

Figure 2 shows a typical nurse organization structure within a Unit (assuming retention of the DNS for the moment). Many of its characteristics have been noted already.

FIGURE 2: **Unsatisfactory organization of nursing managers in a Unit**



[The DNS and SN7/SN8 roles are drawn on the boundary line to indicate the lack of clarity of the level of work assigned. Sometimes the SN8 posts are arranged as if subordinate to SN7 posts.]

Let us summarize the organizationally important features which usually emerge from on-site analysis of staff working within a structure such as that in Figure 2:

- The DNS is the only clear line-manager of all the wards and all nurses in the Unit.

- •The large number of SN7 and SN8 roles are too great to be fully managed by the DNS.
- •The SN7s and SN8s are not well-placed to be strong line-managers of the wards.
- •Many cross-ward issues require the use of committees to make decisions.
- •Some SN7 and SN8 individuals are capable of Level 3 work, some only of Level 2 work.
- •Assistant DNSs (often SN3, SN4 or SN5), usually in Level 3, become drawn into line-management tasks.
- •The DNS is dragged down into performing too many Level 3 and even Level 2 tasks.

In order to understand and strengthen, Level 3 management, it is necessary first, to be clear why ward size is limited; and second, to understand how wards or other L-2 entities can (and must) be combined to produce a chunk (a 'Division') which demands systematic provision of services at L-3. In the next Chapter we will examine the work of the L-3 (Divisional) Nursing Manager in more detail.

Limits to Ward Size

The prime limit to the size of a ward, that is to say to a 'Level 2 entity' within a hospital, is the number of patients that can be efficiently and effectively managed by a team of nurses headed by a ward leader who maintains direct contact with each patient. Depending on the type of patient, this is usually between 15 and 35 patients. When these patients are distributed in two large rooms, the ward leader may be sometimes confusingly described as running two wards. It cannot be over-emphasised that 'ward' as in 'ward-leader' should not just be used as a geographical term but should refer to a specific set of responsibilities. Hence a ward may well extend over more than one room.

In some parts of a hospital (like out-patients) the Level 2 entity may be less clear. In the community it should be usually based on a locality. As noted previously, the L-2 entities concerned will typically not be large enough to assign their managers full responsibility for systems, methods, standards, workload and staff control, budgets and service evaluation—i.e. to expect Level 3 work to be done within each of them.

The effort to get Level 3 work done is worthy, but the effort to organize it on a ward basis is seriously misguided. There are two main arguments against such an approach. First, the number of nurses to be managed on a ward is not sufficient to generate a full-time L-3 job efficiently —in exactly the same way that an average ward size of 5 patients would be regarded as inefficient. Second, the ward is usually not a natural self-contained entity in regard to the flow of any particular type of clinical case or type of clinical nursing, and a multiplicity of systems/standards would develop which would then require coordination and decision by committee—the very obverse of strong management.

To deal with these arguments, expanding the ward in size has been suggested. The point here is that such efforts are a contradiction in terms. If the ward size increases significantly, the focus on the individual patient and his or her needs by the ward leader, the very essence of the ward and the ward-leader role, will become impossible. Level 3

work only focusses on the individual case insofar as it reflects a disruption to the system set up for delivering care; and so Level 3 and Level 2 work cannot be combined in the ward leader role without endangering nursing care. To avoid this, the next step is formation of teams of nurses, headed by a quasi-autonomous coordinator, each responsible for part of the super-large ward. But this then re-creates the original ward (the Level 2 entity) by another name, but of a small inefficient size.

Our conclusion is that the (conventional) ward is one of the few management entities in nursing that has stood the test of time. The ward with a strong ward leader is a structure that has existed for many years, is well-understood and can deliver first-class care. We strongly advise managers not to tamper radically with one of those rare management structures that actually works!

Limits to Division Size

Given that the ward leader cannot operate at Level 3, the next possibility which must be examined is whether the L-3 main line-managerial role in nursing might appropriately be carried by the DNSs in charge of the whole of nursing in the post-1982 Units of management. In such an arrangement, all ward-leaders and professional nurses would be immediate subordinates of the DNS, although a variety of L-2 staff assistants would presumably be instituted. After 1982, some small Units were constructed in which this indeed was possible. However Units should have been constructed to operate naturally at Level 4 then, and following the Griffiths re-structuring most Districts have correctly aggregated small Units into viable Level 4 entities. The consequence of this is that the number of clinical specialties in the Units has increased and the numbers of nurses in such Units is frequently of the order of 800-1000 or more. The extent and variety of work for which systems must be developed and implemented is far too great to be handled by one single Level 3 manager, no matter how many assistants she has. Furthermore, experience in many settings has suggested that approximately 400 staff (L-1 and L-2 staff combined) is the maximum size of a Level 3 entity. This is because the Level 3 manager should know by name and recognize all those working for him or her. In a professional situation like nursing, the maximum number of staff is probably significantly lower, perhaps 150-250.

Dividing the Unit

The conclusion that follows from the above is that the typical ward and the typical Unit are both inappropriate for the L-3 nursing management role. Some entity in-between is needed, a grouping of wards and other nursing activities (e.g. out-patients, theatres), or a chunking up or dividing of the Unit. We suggest that this entity might best be called a 'division', and will use this term in what follows. Of course such grouping (from the bottom) or chunking (from the top) is not a new idea in nurse management. But our finding is that such groupings are mostly too small and too incomplete or incoherent to be effectively operated at Level 3 or to merit being labelled a division. The work of running such small groupings does not naturally facilitate a strong L-3 line-management outlook because changes in systems (e.g. nursing procedures or catering arrangements) will usually involve neighbouring groupings and thus cannot be undertaken and pushed through by any one manager. Also the numbers and so the cost of support staff escalates, and therefore assistance is not properly provided. Unnecessary

duplication of work develops, and other work does not get done at all. Central coordinating staff increase in numbers, and higher levels feel obliged to interfere repeatedly.

If nurse managers at L-3 do not have a large enough and coherent enough division to manage, then they will not have enough flexibility to make changes to benefit patient care through altering nursing systems or redeploying staff to meet workload fluctuations. For example, there will be nowhere to move the excellent qualified nurse who nevertheless irritates her current ward leader. The likely effect of such divisions will be intrusion by the manager into the ward leader's sphere of operation and depression of her level of work; or the L-3 managers will make excessive demands on their colleagues which will require intervention from the next level up and so bog down higher management.

The problems of divisions which are too large have been indicated in considering whether the Unit could be run as a single L-3 enterprise. Although L-3 divisions may be too large or too small, there are factors apart from size to be taken into consideration.

These include:

- •range of nursing services
- •number and geography of sites
- •architecture of the building(s)
- •plans for service development
- •medical consultant preferences
- •district policies for nursing
- •recruitment possibilities
- •cost constraints
- •etc etc

As a result, the decision about L-3 divisions within any particular Unit should be a matter of choice amongst a variety of options—and not regarded as self-evident. The prime consideration from the nurse practitioner's viewpoint will be medical or clinical criteria (e.g. paediatrics, theatre work) rather than geographical or administrative criteria, but it must be emphasized that structuring an organization is an exercise in pragmatism in which many factors must be considered. In other words, just as size is not the sole determining factor in forming an L-3 management division, neither is nurse specialty or care group.

Responsibility for carrying out the restructuring of middle management from a severely unsatisfactory starting arrangement, such as indicated in Figure 2 (p.39), must lie with a UGM and his DNS. The work is located at Level 4, because it involves not merely (re)grouping wards but **restructuring the whole system**—with all that entails in terms of altering nursing customs and practices, dealing with consultant preferences, recruiting and moving personnel, developing new policies and procedures and so on. In restructuring, the manager has some flexibility in the sense that there is always some choice in the kind and number of chunks. In general, it appears that at least 4 and rarely more than 6 chunks are required. However larger L-3 chunks will generally be more demanding to manage than others and will usually deserve higher gradings and possibly more support staff. Grades suitable for the L-3 line-manager (if a nurse) would be generally between SN2 and SN5, but probably not lower. Equivalent grades on the administrative scale would range from 14 to 23.

Examples of Nursing Divisions

Examples from the field may illuminate the above arguments. In these examples, we have indicated the grading chosen by the responsible manager where available. It is impossible to go into all the detail required to justify either the way the nursing services have been divided up or why a particular grading was chosen. Gradings were never chosen, however, to suit individuals: gradings reflect the work expected in the job.

Unit A: Teaching Hospital

Division 1: Crisis nursing—theatres, anaesthetics, recovery rooms, major accident and emergency, intensive care.

Division 2: Surgical ward nursing—general wards, five-day wards, gynaecology, plastic surgery, orthopaedics.

Division 3: General medical nursing—main medical wards, main outpatients, fracture clinic.

Division 4: Subsidiary hospital—geriatric nursing, outpatients.

Division 5: Paediatric nursing—specialist hospital, main hospital wards, paediatric outpatients.

Unit B: District General Hospital

Division 1: Midwifery nursing in hospital and community; paediatric nursing services (SN3).

Division 2: General surgical wards, gynaecology wards (SN5).

Division 3: Orthopaedic wards, out-patient nursing services, accident and emergency (SN5).

Division 4: General medical wards (SN6).

Division 5: Geriatric nursing services—subsidiary hospital and main hospital wards (SN4).

Division 6: Theatre services, recovery ward, day ward, intensive care unit (SN5).

Unit C: Mental Illness Unit

Division 1: Acute admission wards, outpatients (SN4).

Division 2: Hospital undergoing decommission (SN5); post to be removed within 2 years possibly to provide a second L-3 community services nurse manager.

Division 3: Community services including nurses in residential and day facilities, and mental health teams (SN5).

Division 4: Long-stay wards (SN4).

Unit D: Community and Mental Handicap Unit

Division 1: Community Team Manager–Locality A (SN 2).

Division 2: Community Team Manager–Locality B (SN 4).

Division 3: Community Team Manager–Locality C (SN 4).

Division 4: Mental Handicap Hospital Team Manager (SN 3)

Division of secondary hospitals which are part of a Unit often turns on the amount of medical activity present. A cottage hospital is little more than a ward and is part of a division whose main components are based elsewhere. A small hospital of up 100 beds may well be a single L-3 division for nursing; and we have seen a hospital of 400 beds requiring only two divisions, one of medical and geriatric wards and the other of surgical and gynecological wards. In medium-sized active hospitals of 100-300 beds, there is usually a need for two or more divisions.

Some Districts have formed mega-Units (with budgets of £40 million and greater) which are in effect several (L-4) Units with the same UGM. In these cases, it may be useful to clarify the L-4 nursing tasks prior to examining options for L-3 division. We will return to this problem briefly in Chapter 10.

Nurse Management at Night

The division of the hospital into separate day and night services with each operating at Level 3 is one way of chunking the work of nursing—but not one that suits patients or the rest of the institution. As already pointed out, strong 24 hours responsibility then becomes difficult if not impossible at ward level. In any case, except in small hospitals, further chunking is always necessary. Separate organisation of night nursing also means that 24 hour responsibility of the L-3 line-managers is interfered with, and the end result is a proliferation and duplication of nurse managers.

At night, all the work of nurse management is situational response (L-2). Where there are L-3 Night Nurse Managers, they carry out the bulk of their L-3 responsibilities during the day. Under a system where both the ward leader and the L-3 nurse manager have 24 hour responsibility, there will still be a need for one or more Night Nurse Supervisors—but now as subordinates and assistants of the L-3 nurse manager. One of these supervisors may have a concern for issues involving the whole hospital/Unit, with corresponding powers to instruct nurses anywhere in the hospital. However, this authority does not imply main line-managerial status (cf. Chapter 2).

We are now ready to make a detailed examination in the next Chapter of the work of the L-3 nurse manager and the support she needs to perform it. Doing this will pave the way for the further decision as to whether the post-holder should or should not be a nurse.

QUESTIONS & OBJECTIONS

Q: *Our Unit is divided up by Sites and there are Site Managers who are fully responsible for staff irrespective of professional group. Are special divisions for nursing really necessary?*

A: To respond generally: the question reflects a desire to organize Units in a single dimension; whereas a matrix arrangement of multiple dimensions is required with main-line management in disciplines and monitoring and coordinating across disciplines (see Chapter 11 for further discussion).

To respond more specifically: all sites do need to be managed, and nursing divisions may or may not parallel such site divisions. Divisions for nursing management must be independently scrutinized with geographic considerations regarded as just one factor. In any case site managers do not carry the above responsibility as claimed, for example they are not responsible for the Consultants or their Junior Medical Staff. We argue strongly that nurses and other professionals require their own L-3 organization. Front-line staff cannot simply be tossed into a big pot to be divided up according to 'general management' convenience.

Q: *Our Unit is divided up by Consultant specialties. Do nurses need to organize themselves to match medical divisions?*

A: Again: **No**. This question follows the style of the last in trying to force a single organizational dimension on the Unit. Units often require organization in several dimensions—by site, by specialty, by care group, by staff group. And the various staff groups have their own logic of division. Sometimes these dimensions align wholly, sometimes partially and sometimes not at all.

Chapter 8

ESTABLISHING STRONG MIDDLE MANAGERS

A New Conception

As we have said, a Level 3 nursing management system is constructed by forming divisions: grouping wards or other Level 2 nursing entities in some appropriate fashion to permit one nurse line-manager to be realistically assigned **total (i.e. main line–managerial) responsibility day and night for the nursing work and nursing workforce** within the system.

Such a L-3 line-manager post, though it exists more or less well-developed in places, must be recognized as a ***new conception*** *in the NHS.* Most staff in moving to such posts will need to develop a new approach to their work. They must move away from dealing with many particular needs and problems on a one-by-one, shift-to-shift or day-to-day basis, although they will always zoom into such from time to time. Instead they must be expected to control and develop clinical nursing in their divisions, looking and planning ahead many months, even a year or two into the future. This is a full-time career post. It will rarely be satisfactory to combine it with a separate nurse education or nursing research post.

The notion of the nurse as a responsible professional which we have been supporting suggests that the Level 3 nurse manager should not be regarded as 'delegating' patient care to registered nurses. Rather she provides staff resources and sets up operational systems and procedures for the ward leaders or team leaders to use in providing care to patients. She mediates between these front-line staff trying to provide a maximal standard of care to individuals, and resource availability as decided by higher levels within the District. She should therefore see her primary task as developing nursing practice and facilitating the work of professional nurses.

Main Responsibilities

We must now look in detail at the main responsibilities of the L-3 line-manager of nurses. As indicated earlier, the work at L-3 always concerns developing practical systems to deal with some category of situation, need, patient, condition, or problem. There is an important difference between designing, implementing, evaluating and modifying a system, and operating that system on a day-to-day basis, including dealing with crises. The L-3 responsibility is not to deal with a crisis when it happens, but to ensure that there are systems to prevent or minimize the occurrence of crises, systems to deal with them when they eventually happen, and systems to ensure that review will occur if the crises become too frequent or are poorly handled. Dealing with the crisis when it occurs is usually a L-2 and/or L-1 duty. Most of the systems will therefore be operated by registered nurses including ward leaders, or by assistants of the L-3 managers. Handling system-breakdowns and nursing-crises are similarly L-2 tasks, as a

crisis must, by definition, be responded to according to the needs of the situation. From the perspective of the L-3 manager, **all crises are predictable**! If they have happened in the remembered past or could possibly happen, then they may, indeed will, occur sooner or later.

The main areas in nursing where system development is urgently required are:

- •controlling workload, priorities and staff deployment
- •developing nurses and nursing practice, and enhancing quality of care

Maintaining morale depends on the balancing of quality enhancement and nurses' individual needs with workload pressures and other organizational demands. We will examine these two areas of work before turning to other management tasks at L-3.

Controlling Workload

The focus in work at this level is on flows of work and availability of actual staff. At L-3 the work flows are generally studied over a 1-2 year period. The actual flow of work is the workload. To develop a system it is necessary to have regular information on the work required, and to be able to assign immediately available staff to do this work. Note that an establishment budget is irrelevant in this regard. Both the workload and actual staff resources are continuously fluctuating. Some fluctuations are known in advance, e.g. holidays, seasonal patterns of referral; but many fluctuations occur at more or less unexpected times. The system must handle both types of fluctuation. Predictable fluctuations can be dealt with by rotas and scheduling for staff allocation and nurse trainees. Unexpected fluctuations must be handled in a variety of ways including sanctioning overtime and the use of agency nurses. To aid control of such variable expenditures, a budget is useful.

As it is never the case that resources and workload exactly match, *understaffing and hence overworking of nurses means that workload has not been properly controlled*. The L-3 manager must be vigilant in ensuring that her staff are not overworked or expected to work beyond their capacities. However, under-using abilities and expertise is demoralizing and must also be avoided. So, to enable frontline staff to work properly, the L-3 manager has to set overall workload priorities and realistic standards of care. She should be prepared to alter these—without breaching the limits of what is regarded as professionally tolerable—to meet an increased workload. Maintaining morale in such situations is very much part of the job, and it typically depends on developing nursing practice and nurses.

Developing Good Practices

Systematic improvement of nursing work in one or more clinical fields requires that the L-3 nursing manager keep abreast of developments, and ensure they are systematically introduced and evaluated. This might involve preparing cross-ward arrangements and procedures; setting up in-service education schemes; and sending selected nursing staff on specific courses required by changes in the work of her division. The L-3 manager might well act as the prime coordinator for developing and implementing medically-inspired initiatives to improve clinical management of patients.

Although higher policies and resource constraints may mean that quality standards are lower than desired, the L-3 manager must still be committed to enhancing and increasing the quality of care and remedying breaches. To this end, she should be

responsible for ensuring that quality of care issues are fully considered in the design of systems, and that quality assurance procedures are introduced. She also needs to be personally aware of the strengths and weaknesses of her nurses and able to discuss these with them in the light of organizational pressures.

Other Management Tasks

•The L-3 manager must be a strong and direct boss not only for the ward sisters but for all qualified nurses in her chunk, with a major say in their selection and with full responsibility thereafter for their induction, ongoing appraisal, development and (in extremis) transfer or dismissal.

•She must plan and manage overall expenditure on nursing supplies, equipment and other workload related items like variable staff costs, against a given budget.

•In order to manage workload and budgets, and systematically evaluate her own work, she will need to develop her own systems for collecting and analysing information. This information will overlap but not be identical to the Korner data set. It will be information uniquely required by her to do the job in her particular division.

•She will be a key link with the nurse education system, with other Level 3 departments providing health and ancillary services, with consultant medical staff, and with non-hospital agencies whose systems are relevant to her sphere of work. In every case, she is the person who should be expected to monitor and act determinedly on persistent problems generated outside the nursing service which disrupt patients. This role is therefore a key component of quality control in general.

•The L-3 nurse manager is a most important change agent within the Unit. Many detailed changes organized at Level 4 require, eventually, to be analysed in detail as regards nursing and implemented by her.

Taking Charge of the Hospital

In small hospitals, not themselves a Unit but with two or more nursing divisions, there is no reality in making one of the L-3 managers the 'boss' (i.e. main line-manager) of the others. However, one of the existing L-3 nurses usually does need to act as a coordinator in order:

•to provide someone 'in charge of nursing in the hospital'

•to ensure that the L-3 line managers work together or to handle implementation of hospital-wide policies in relation to nursing.

•to act as a focus for communication from within and without nursing in relation to the hospital as a whole.

We will defer to Chapter 11 the question of who might be the 'leader-manager' in the hospital as a whole.

Support Staff

In order to carry such substantial responsibilities, the L-3 manager will require assistants of several kinds, including:

•clinical specialists

•staff assistants

•night nurse managers

Clinical Specialists

The constitution and nursing activity of the division will determine whether clinical specialists are required. As an example, we may consider a L-3 Division which principally covered nursing within the maternity services, but also included the nursing services on two paediatric wards and in a paediatric day-centre. The background of the L-3 manager was, appropriately, midwifery, but to assist her in the clinical management of the paediatric nursing service, an SN7 clinical specialist in paediatric nursing was appointed.

If medical or service policies result in the need to provide numbers of a particular type of patient with specialized nursing attention, then posts of nurse coordinator for that patient group may be appropriate. Current examples include nursing care of the terminally ill, nursing of patients with cancer, nursing care for diabetics.

Clinical specialists are in danger of coming into conflict with ward leaders, particularly if they are labelled 'nursing officers'. It is essential that the clinical specialist act as a direct service provider or as a consultant to the ward leader and not as her superior. These specialist roles can appropriately combine clinical work, teaching work and certain administrative duties.

Staff Assistants

As cross-ward issues in regard to workload changes and staff deployment will develop repeatedly and rapidly, the L-3 nurse manager will require at least one assistant with a nursing background (SN6, SN7, SN8) to assist with rotas, scheduling, workload management, and quality monitoring. If there are additional sites, or other specific responsibilities, then a second assistant may well be required. Secretarial and clerical officers (L-1) are needed and, if budgetary and information developments continue apace as seems desirable, support by a non-nursing administrative assistant (L-2) might become essential. Such assistants carry staff-officer authority as described in Chapter 2.

Night Nurse Management

At night in hospitals, we have argued generally for the provision of at least one L-2 registered nurse per ward as a shift leader. Although this may phase out the Night Sister role in some divisions (as described in Ch. 5), there is still a need for one or more night nurse supervisors to assist the L-3 manager. In some Units, two or more L-3 managers might share a night supervisor. A night nurse supervisor may have to be in charge to handle any problems involving the whole hospital/Unit, but she does not need to be a main line-manager of other night supervisors (if any), or of shift leaders. Working within systems set by the L-3 nurse manager, the night nurse supervisor must deal with cross-ward issues, and with staff redeployment to meet workload fluctuations. As well as controlling information of use to her immediate work, such as bed state, patient state, requirements for supplies or equipment, staff availability, activity in Casualty and so on, she should be responsible for information collection on behalf of the L-3 manager. The night nurse supervisor would have a supervisory relation (Ch.2) with L-2 shift leaders on wards, coordinating clinical work across wards when necessary, but not teaching student nurses or dealing directly with individual patients except to help out on the rare occasion or in an emergency. She would be the key link for medical staff in case of disputes with ward nursing staff.

The night nurse supervisor will conduct rounds, but obviously in a different way to that performed by the multi-ward Night Sister. For example, she should be monitoring the work of shift leaders and activity on their wards in regard to quality standards and clinical policies and procedures laid down by the L-3 manager, and possibly discussing the needs of particular patients; but she should not be deciding patient-care priorities or acting as line-manager of nursing auxiliaries.

The night nursing supervisor is a form of hospital administrator in that she is the person immediately available at night to interpret and enforce hospital rules, Health Authority policies, or DHSS regulations. She also has specific responsibilities to ensure the night time availability and integration of the non-nursing services and requires the authority to enter the otherwise exclusive domain of specialist Departments.

Disciplinary Base

We may now return to the question of the disciplinary base of the L-3 nurse manager. The post requires someone who can manage nurses and manage nursing work in general, but is not expected to manage patients or wards. Could this task be carried out by an administrator trained in management, or by a doctor or paramedic interested in general management?

Although the Level 3 nurse manager, by and large, does not herself lay hands on patients and could not possibly know the details of all the patients in her wards, she is the crucial bridge between the practice of nursing and general management. As we have indicated, it is intrinsic to the role that she is up-to-date in appreciating the practical implications of changes in nursing practices. Unless she is clinically competent and seen to be so, she will be unable to set up technical systems to ensure consistency or integration of nursing work on a number of wards . Nor will she be able to appraise the nursing work in the wards for which she is responsible. She will also be unable to deal with ward sister-consultant conflicts, to handle differences between the ward sister and her qualified nurses, and to know which qualified nurses can be given ward responsibilities. *Sensitive management of workload requires her to appreciate the details of the nursing work required and the exact qualities and abilities of the available nurses.*

If such detailed knowledge and expertise relevant to the nurses and nursing is essential as indicated above, it seems most unlikely that the work could be done by anyone not well-trained in nursing.* However as this level of work is predominantly management, it holds equally true that a substantial amount of previous experience as a clinical nurse is not a necessary prerequisite.

Titles

Correct titles are important. Given the use of the term division, we incline to 'Divisional Nursing Manager' followed by an indication of which division e.g. midwifery, geriatric nursing. Note that the nurse manager is not the Maternity Service

* The one exception seems to be where the number of nurses involved is not great, as in some Radiology Departments or Mental Handicap provisions. Even here, however, the importance of ensuring some link between nurses and a L-3 manager who is a nurse cannot be over-emphasized.

Manager or Geriatric Services Manager, because maternity and geriatric services are not controlled by nurses but are provided by a multidisciplinary group. Other common qualifiers indicating L-3 responsibilities include: 'Principal', 'Chief' and 'Head'. 'Senior', the current grade label, is particularly unsuitable as a post title as it commonly implies upper Level 2 work (cf. physiotherapists).

QUESTIONS & OBJECTIONS

Q: *How can the changes be implemented locally and would special management training be necessary?*

A: Management development of staff is best associated with organization development. The first task therefore is to realize the work to be done and set up the appropriate posts. Assistant DNSs, some Senior Nurses, and indeed many former DNSs would find such posts natural. Once in post a variety of in-house and external educational activities should be sanctioned by the DHA/DGM and arranged by L-4 staff at District and Unit levels.

Q: *Could current staff really do the job described, and will the sisters really accept them as their boss?*

A: The role suggested is closer to where many DNS roles have been pitched in the past, and is much closer to the old Principal Nursing Officer grade, than the former Nursing Officer or Senior Nursing Officer grades. As indicated above, we have no doubt that there are many nurses (though not necessarily staff currently in ambiguous posts) who could successfully tackle the work as described. Ward sisters welcome managers who can really do things for them.

Q: *What are the difficulties in introducing this new role?*

A: New structures and role conceptions, if correct, are met with a mixture of relief and anxiety. Those not directly involved, such as DNSs and the ward staff, may be generally enthusiastic, but for those directly involved the anxiety will be great. Intense opposition or undermining of the change process is therefore likely. Even for those likely to benefit, the introduction of strong L-3 management will be experienced as a major culture change with all the problems that entails. Treating people sensitively while not losing sight of what is required by the organization is a prime requirement during the transition.

Q: *Should action be taken nationally?*

A: This is a matter for nurses. Unfortunately there is an ambivalence in the nursing profession about higher level management. It is not possible to be a nursing tutor without a specific qualification, but no training is expected of nurses who will control large numbers of professional nurses and public resources. Once nurses take management seriously, then specific ways of accelerating the training and experience of nurses who have aspirations to management could be found.

Q: *Your analysis is excessively hierarchical—why do you want to increase the numbers of managers when what is required is more nurses?*

A: There should be a *reduction* in the numbers of real line-managers, not an increase. There may also be a *reduction* in the numbers of hierarchical levels. These new managers will be really expected to manage. If the model is applied, there will at last be managers who can decide and take responsibility for the amount of work that will be done by the actual numbers of nurses the DHA will pay for or can recruit.

Q: *How can these new managers control workload when this is determined by the medical Consultants?*

A: That is the point. Many of the present managers cannot argue on equal terms with Consultants, and this is to be expected if they are working at L-2. The L-3 manager will be expected to have the power and calibre to confront Consultants individually and in Committee, explain to them the implications of their actions, provide detailed analyses with information and statistics as required, work out a compromise, and in the last resort take action to prevent overloading of nurses. If the matter is taken over the manager's head to the Unit Management Team, she must be able to present a powerful, reasoned and well-documented argument to justify her views and proposals.

Q: *There are L-3 nurse managers who work much as you describe, but they are not given the resources to do the work properly. For example, evaluating quality is costly in staff time.*

A: The L-3 nurse managers must be properly resourced and must work within a framework set at L-4. This includes indicating the priority that evaluation of quality should be given. A close relation between the L-3 nurse manager and L-4 nurse manager (or UGM) is essential, as there will always be more work for the L-3 manager to do than there are resources available (just as in clinical nursing work). This matter will be discussed further in the next Chapter.

Q: *You are denying the reality of NHS life. It may be true that nurse staffing is often insufficient unreliable and unbalanced, but this is because nurse managers are doing the best they can with insufficient resources. How can any manager cope with such a situation?*

A: Inadequate staffing is a major problem. We do not deny it. We do deny that there is only one response to this: increase the numbers of staff. Decisions about numbers must depend on balancing resource availability, workload policies and priorities. Finding the balance is what management is about. Leaving front-line nurses floundering with a workload they cannot handle is an abdication of management and leads to demoralization.

Q: *Would there be a direct patient-care element in the role?*

A: The L-3 nurse managers, as described, need to understand patient care, would be on the wards often (probably daily), and would from time to time zoom into issues concerning a particular patient. However, they could not be expected to undertake personally any significant amount of immediate direct clinical work within their wards or departments. For example, their primary solution to a staffing crisis should not be to lend a hand, but rather to develop systems to anticipate such events, or to improve performance of her staff, or to change workload management procedures, or to reduce

the workload. In certain centres of medical excellence, a greater involvement of the L-3 manager in clinical care might be appropriate.

Q: *Would it be impossible for a L-3 manager to run a ward within their division?*

A: As with clinical nursing, in certain specialized parts of nursing, perhaps in teaching hospitals, a manager working at 2 levels simultaneously might be possible or even necessary. However, it should be an exception. It inevitably leads to the creation of small divisions (eg 3 wards), which leads to undergrading because of the cost of having many middle managers.

Q: *Can the L-3 nurse manager operate over more than one site?*

A: Yes, in principle. Field examples include paediatric services on more than one site; and a geriatric service which included a 100 bed hospital plus 2 wards on the DGH site. The registered nurses and auxiliaries must expect to move between sites. The L-3 manager would have to be on each site almost every day and must not be experienced by the practising nurses as a remote absentee manager who only works through assistants. When this occurs, the assistants become an extra level of management and the whole structure comes into disrepute.

Q: *Should these L-3 managers of nursing be expected to manage other disciplines within their division as well, such as the paramedical staff or domestic staff?*

A: No—not generally—if by manage you mean line-manage. If you mean monitor and coordinate, then yes this can be expected of them; and, of course, in this latter sense, they may also be expected to manage the consultants. The argument against expecting multi-disciplinary (or 'general') line management at Level 3 and below is presented in Ch. 10.

That being said, occasionally it does seem appropriate for some non-nursing staff, usually not themselves fully professionalized, to be line-managed by the L-3 nursing manager e.g. ODAs by the theatre nursing manager; the clerks, porters, domestics and gardener in an isolated small hospital.

Q: *Could a UGM in a L-3 Unit of a small L-4 District act as the main line-manager of the nurses with staff support?*

A: In such a Unit, there will usually be a number of L-3 staff and the nurse who is in the staff-support role would probably be working at L-3 serving as the de-facto line-manager (or perhaps conjoint line-manager). If there was no strong L-3 nursing input to the Unit, then a UGM alone (with no nursing background) is most unlikely to be able to do a satisfactory job in the long term.

Q: *The proposals are all very obvious. In fact such an arrangement exists in my Unit and works well.*

A: If this is so, we are pleased and our findings are confirmed. Your colleagues should visit you, because we know the ideas have not generally been implemented.

Chapter 9

SPECIAL ISSUES IN COMMUNITY NURSING

Inasmuch as development of community nursing is still comparatively recent, and as our field work there has been limited in comparison to the work done on hospital nursing, we have not a great deal of analysis to offer on this topic. Nevertheless members of the Centre have had some experience in this area. These notes are included in the hope that they may be helpful.

Problems

The problems in the community nursing reflect those in the hospital sector combined with low financing and low prestige. Compartmentalization has gone further in that unrealistic and unnecessarily rigid boundaries have developed within nursing itself at the level of professional practice. Inter-professional boundaries are particularly difficult to manage because of the nature of general medical practice and the importance of social services provided by the Local Authority for patients. The recent emphasis on prevention and on more domiciliary and community care has brought to the surface the lack of coordination and duplication of effort that is widespread.

The initiative of the Cumberlege Report [13] may assist managers to remedy some of these deficiencies. Our research suggests that its thrust is correct. Unfortunately, *the Report failed to make the crucial distinctions in regard to the levels of work required for the managers in the community*. As we have insisted throughout this Working Paper, without clarity here, implementation is virtually doomed to failure.

General Principles

Although the kind of nursing work done in the community is somewhat different to that in hospitals, and the context is substantially different, the general principles of nursing organization and management as developed in this Working Paper apply equally to community nursing. Thus registered nurses such as district nurses, health visitors, community midwives, school nurses, community psychiatric nurses and others must be expected to work at Level 2 and not used primarily for Level 1 tasks as commonly occurs. In certain situations, it will be advantageous for the registered nurse to work with Level 1 assistants. In those areas, like mental handicap [14] where there is to be extensive development of care assistants or patients aides, the registered nurse will need to develop and use managerial skills beyond the extent to which she may have been accustomed.

Registered nurses concerned with general health care and prevention need to work in nursing teams within localities to ensure coordination of effort, coverage of the community, and proper liaison with other disciplines and agencies. These teams will

need to be managed by a 'team leader' at the top of Level 2. The entity for L-2 team work in the community is the locality or patch or neighbourhood. The Cumberlege Report suggests a population of 10,000-25,000 which is also the catchment recommended in 1961 by the DHSS for a typical health centre for a number of GPs [15]. The suggested numbers of nurses in the team is appropriately placed at 10-15 plus some auxiliaries and assistants. On this basis, the team leader will also be working at Level 2 (much like the ward leader). We would expect her to be usually graded at SN7 or SN8, but no higher.

The locality nursing teams will need to be grouped into one or more divisions each run by an L-3 nurse manager. Divisions should be made large and powerful. Cumberlege suggests that no senior nurse manager should be responsible for more than 10 Teams; to which we may add, nor less than 4-5 Teams. The exact structure will depend on the local factors such as Unit composition and size, geography, District policies and so on.

The role and responsibility of the L-3 community nursing division manager should be similar in principle to that described for the L-3 divisional nurse manager in the hospital. The kind of work required is somewhat different, and Checklist B of the Cumberlege Report indicates what needs to be done.

Multi-disciplinary Community Teams

In the case of community nursing work in mental health and mental handicap, nursing teams as such may be less appropriate than multi-disciplinary teams (MDT) with some suitable arrangement for joint management so that the multi-disciplinary team leader can be an effective operational manager. The need for multi-disciplinary community teams at both Level 2 and Level 3 and their many potential problems are now well-recognized. Exactly how multi-disciplinary teams should be set up and managed has been examined in depth in separate Working Papers of the Health Services Centre—one devoted to this topic [16]; and another concerned with the requisite organization of mental illness services [17]—and the interested reader is referred to these.

Relations with Social Services

Health and social services have distinct responsibilities but must work closely together. Clear definition and appreciation of the proper boundaries between these two services are essential in community nursing. When a patient comes into hospital, it is usually possible and natural for the health services to take over many of the patient's basic social needs. However in the community, it is essential that nursing services and other health services are provided in addition to any social services, not as a substitute for them.

Where social services provide home care for a client, this can be seen as a replacement for the kind of help which the person or his family would normally have provided. If the client now develops a medical condition, and is accepted as a patient by the NHS, then the initial task may be to see whether a slight increase in home care by the social services is possible and sufficient. If regular nursing assessment and substantial

basic nursing care at home are required, then a care assistant or patient's aide working under a registered nurse may be provided by the NHS. The registered nurse must work together with the L-2 Home Help Organizer to ensure that both L-1 staff, the home help and the patient's aide, share out tasks and times of visiting appropriately. The home help concentrates on the physical environment. The patient's aide concentrates on the personal needs of the patient such as bathing, feeding, taking prescribed medication, mobilization and social stimulation. Naturally practical exigencies lead to overlap at times, but confusion of role can and must be avoided.

QUESTIONS & OBJECTIONS

Q: *The Cumberlege Report refers to the top nurse manager in the community as both a 'Senior Nursing Manager' and 'Director/Assistant Director'. What does this mean?*

A: It means there is confusion in the report about how management is to be structured. The description of the Team Leader role on p.24 seems to pitch the work at L-2 (correctly); whereas Checklist B seems to pitch it at L-3. If it were at L-3, then the superior would have to be a Director of Nursing Services (at L-4). If an 'Assistant' is a staff role, it should not be combined with that of line-manager of a substantial chunk of services.

Q: *Perhaps Cumberlege did want L-3 management in each neighbourhood. Is this possible?*

A: It is possible, particularly if an enhanced multi-disciplinary team led by the nurse team leader were developed for each locality. However such a move would have substantial cost implications, and so it is difficult to imagine in the near future that 10-20 SN5 nurses would be appointed. The worst and most likely result for nurses is that higher managers once again will expect nurses to do work which is beyond them, and once again will organize muddle around the Level 2/Level 3 boundary.

Q: *Can Community Psychiatric Nurses (CPNs) be part of the locality nursing team? Or is their work too specialized to be properly managed by an L-3 community nurse manager?*

A: In certain Districts with minimal psychiatric services, it may be desirable for CPNs to included in Locality Teams rather than in multi-disciplinary clinical teams. Their work, though specialized, is not part of another profession, and it is possible for them to be managed by someone with a community nursing background, but special arrangements to ensure the quality of the psychiatric work may need to be made.

Q: *Will other professionals (for example occupational therapists) work in the locality nursing teams?*

A: It may be convenient to organize multi-disciplinary work. The teams should not then be called nursing teams. Participation of paramedicals happens in hospitals when therapists are assigned to wards. Here and in the community this does not remove the need for appropriate L-3 control of each professional group.

[These questions and other issues of team work have not been examined in this Working Paper because detailed discussions are available in other publications of the Health Services Centre [16, 17].]

Chapter 10

PROVIDING TOP MANAGEMENT

We have now discussed nursing of patients and managing wards and localities, areas where the existence of nurses is uncontentious. We have also examined and asserted the need for nurses as managers at middle (or senior) management level, where some doubt exists as to the validity of such a role. We now turn to the place of nurses in top management within the Unit and District. Until recently a place for a nurse was permanently assured: now it is a matter for intense debate and disagreement. The problem focus here is therefore whether top nurse managers, Directors of Nursing Services and Chief Nursing Officers, are needed at all.

The Need

It is the job of the Level 3 nurse managers, as described in the last Chapter, to develop systems to rationalise the work of ward sisters and to ensure effective use of staff and material resources. Their focus is both on patients' needs, mainly as interpreted by the ward leaders, and the needs of particular services, mainly as indicated by the medical staff. Attempts by medical staff to introduce 'creeping developments' require to be firmly confronted by the L-3 nurse manager, but legitimate attempts to develop new services emanating from consultants or other staff cannot be dealt with by the L-3 manager. At some point she has to refer them to a higher level because L-3 work does not include responsibility for services that do not currently exist.

Deciding on significant service changes and making overall District policy in nursing are concerns distant to the *immediate* needs of clinicians and patients and often in apparent conflict with these needs. These concerns are however legitimate and crucial for nursing and make up the core work of general management: Work Levels 4 and 5 in our schema. Without staff in each District working on these matters, the nursing services will stagnate, be excessively reactive to developments originated by administrators or doctors, and be unable to respond creatively to local opportunities or to national guidelines.

So the question emerges: how is the necessary Level 4 and Level 5 work in respect of nursing to be done? And does it always need to be done by staff from a nursing background?

In approaching this subject, we will consider nursing work first at Unit level, and then at District level.

Top Nursing Management in the Unit

Many of the post-1982 Units were not set up to work at L-4 and the DNSs were often in effect appointed to work at L-3, even though the Unit was too large to be managed as a single L-3 nursing system. Fortunately, post-Griffiths, the Units have been generally (and correctly) consolidated into viable L-4 entities headed up by a Unit General Manager. The question then arises as to whether there is a need for a DNS to do the Level 4 work in nursing.

Whether or not there is a designated nurse-DNS to manage nursing at L-4, it must be stressed that *there is always L-4 main line-managerial work to be done by someone in respect of nursing*. This work includes:

- deciding nursing service priorities and policies;
- planning, costing, implementing & evaluating developments in nursing services;
- detailed control of the nursing budget and the nurse establishment;
- restructuring nursing services and roles;
- managerial control and development of L-3 nursing staff;
- appraisal and development of the work potential of L-2 nursing staff.

If no-one is appointed specifically as the L-4 nurse manager, then the above responsibilities will have to be carried by the UGM himself. In principle this is possible. *However it must be clear that the UGM **cannot** do this in name only, hoping to delegate all the real work to an L-3 nurse staff-assistant*. L-3 assistants cannot be expected to perform L-4 work. The use of an L-3 staff assistant may be possible if the UGM's disciplinary background is nursing.

As nurses constitute the largest single group of staff in a Unit, with highly specialized problems and needs and their own regulatory bodies, a tight grip on their management is essential. Such a grip requires a detailed understanding of nursing and, we conclude, will in general be best provided by a DNS working at Level 4. This probably applies even if the the UGM has a nursing background. (Further possible responsibilities of the DNS as a member of the top management team of the Unit will be discussed in the next Chapter.)

In the case of mega-Units which comprise two or more undisputable Level 4 entities, say a £13 million Mental Illness sub-Unit and a £10 million Community Services sub-Unit, which have the same UGM, it might well be appropriate, even essential, for each sub-Unit to have its own DNS with Level 4 responsibilities.

The appointment of a L-4 DNS almost certainly implies the appointment of at least one L-3 nurse as staff assistant, but other support might well be provided by the UGM's own staff.

Top Nursing Management in the District

Having argued that there is regularly a need for a top nurse line-manager (DNS) at L-4 in Units, it might seem that the way lies open for an even more senior nurse at L-5 to operate at District level. However analysis of the work to be done, essentially that of

altering the local definition of nursing, suggests that there is little scope for full-time L-5 work in nursing in any but perhaps the very largest teaching Districts with explicit intentions to be centres of excellence in nursing. Such L-5 nursing decisions as there might be, for example in distinguishing nursing from non-nursing responsibilities in existing or new services or altering the range of nursing services, would be proposed by the DGM with appropriate nursing advice and sanctioned by the DHA. Nurses of L-5 ability therefore need to become DGMs (or possibly UGMs in large teaching hospitals) or otherwise must move into academic or political realms of nursing work.

However, even if there is no scope for a full L-5 nurse line-manager post in most Districts, DGMs, particularly in larger Districts, may often require a District-level Nursing Officer (i.e. a DNO) to provide specialized advice and coordination. This work would be at L-4.

In this case, the DNO would be a staff officer or assistant to the DGM, and not a main line-manager (or top boss) of the DNSs and other nurses. A DNO would seem particularly important if one or more UGMs decided against appointing a DNS in their Unit. The DNO would work directly with the UGMs as well as with the DNSs. Her responsibilities might include:

- •assisting with all planning and budgetary negotiations affecting nursing;
- •monitoring actual Unit activity in nursing;
- •proposing District nursing policies to the DGM; and
- •helping with appointments, appraisals, career development of nurse managers.

Some support staff might be required depending on the extent of these and any other responsibilities such as for quality assurance. Note that such a DNO would not be permitted to set nursing policies unilaterally; or to allocate resources to nursing; or to make decisions about nursing within Units which were in effect a re-allocation of resources; or to decide strategic or operational options for nursing.

In the absence of a full-time nursing post at District level, the DHA may still require some designated 'District Nursing Adviser' (DNA), and this role could be filled by one of the DNSs. Inevitably the responsibilities assigned to such a DNA are likely to be far more limited than would be assigned to a full-time DNO. The DGM, however, may still require specific nursing advice for the formulation of District-wide nursing policy. It would then be natural for him to turn to the DNSs as a group, including any UGM who is a de facto DNS. The group would then be functioning as the 'Top Nursing Management' body. The authority of any coordinator (or chairman) of such a group, possibly the DNS who is the DNA, would derive solely from the DGM. For the group to operate effectively the coordinator needs to be able to exert natural authority and to be solidly backed by the DGM. The DGM might himself chair the meeting regularly or on occasion.

In those small Districts set up to work at L-4 with Units at L-3, a DNO working at L-4 with full line-managerial authority over all nurses in the District is essential for the same reasons which justify a top nurse in L-4 Units.

District Nursing Advisory Committees

A formal District Nursing Advisory Committee (to be sharply distinguished from the group of DNSs referred to above) may be useful. Although they have not functioned very effectively in the past, part of the reason lay in the politically powerful role of the old DNO. Now that the whole balance of influence in Districts has tilted away from nurses, such methods for ensuring a nursing perspective is provided on District policies and DHA deliberations have greater salience. In those Districts where nurse management has been severely cut-back or effectively undermined, they could be more needed.

The natural membership of an Advisory Committee should include registered nurses only —all DNSs together with representatives of registered nurses, of ward sisters, of L-3 line managers and possibly of other groups of nurses. Clinical nurse specialists might be coopted as required. UGMs would be excluded.

These Committees need to be essentially *local political* bodies—and hence must be kept distinct from Unions which are nationally organized. An Advisory Committee is not responsible for management action and if one is to function effectively, it needs to develop a non-hierarchical identity, articulating and advancing the interests of nurses and nursing—much as the District Medical Advisory Committee does for doctors and medical work. Should nursing professionalism and specialization develop strongly, then the constructive use of such bodies might be expected to increase.

QUESTIONS & OBJECTIONS

Q: *Could a DNA or a DNO in a staff role to the DGM provide the necessary 'professional leadership' for the nurses within the District?*

A: There would indeed be difficulties as leadership in organizations without the ability to deliver the goods promptly is weak. However other factors need to be considered. The capability and attitudes of the DNO or DNA and DGM are probably crucial. The view of the DHA will be important. So is the presence of DNSs who will provide a natural alternative professional leadership. If DNSs are absent, a well-functioning District Nursing Advisory Committee might give the DNO/DNA a useful platform.

Q: *Is a DNA role described in the Chapter more or less problematic than a full-time DNO role?*

A: The DNA role is likely to be a very difficult one indeed because there are two inherent conflicts in the DNS-DNA combination. First, the post-holder will have a mixture of line and staff responsibilities which was identified in Ch.2 as unsatisfactory. Second, the post-holder will experience powerful urges and pressures from colleagues to 'fly the flag' for nursing (the representative role) which runs counter to the urge to abide by the views of the DGM and support these (the officer role).

Unfortunately, a full-time DNO post is not necessarily a better alternative in the average-sized district which has DNSs.

Q: *It is said that the DNS or DNO can bypass the UGM or DGM on professional issues but not on management matters. Does this make sense?*

A: No. Although work and authority can be divided up and accountability partitioned, the idea that this division takes the form of professional versus management work at these high levels is a face-saving political convenience. Clearly, top nurses can oppose and even bypass their general managers but they would be advised to do so only very occasionally and only when on very sure ground.

Q: *Does a 'nurse advisory committee' have real work to do?*

A: There is work to be done, but only if the appropriate political skills exist or can be developed and only if participative rather than hierarchical values are a priority for cultural change in the District. This is quite a demand. However, nursing staff are unlikely to encourage participation by patients and public (the 'consumerist' drive) if they themselves are treated very differently. The NHS may not be ready for this development and any experiments will probably need careful nurturing if they are to be productive.

Chapter 11

INTEGRATING NURSING AND GENERAL MANAGEMENT

The Pendulum Principle

Following 1974, the NHS witnessed an unprecedented and excessive development of multi-level hierarchies in a wide variety of functions. No matter whether there was any work to be done, managers were often appointed at site, sector, District, Area and even Regional level. One unfortunate effect was to encourage isolationism in the functions. Most of the unnecessary posts were abolished following the 1982 reorganization, but an excessive separateness of the major disciplines continued. Fieldwork after 1982 revealed that whereas the UMT and DMT frequently worked well as teams, the two tiers of teams rarely met because all meetings were carried out on a functional basis: DA to UA, CNO to DNS, DWO to UWO and so on. Decisions reached in these uni-disciplinary meetings frequently undermined the corporate team work. Even more seriously, an atmosphere had grown up in which it was often impossible to carry out even simple tasks which crossed disciplines. In the upper management tiers, asking for information, insisting on report completion, ensuring attendance at a meeting, or challenging a conclusion across disciplinary borders were tacitly or noisily blocked again and again.

This sort of organizational dysfunction cried out for high-level political action. The Government responded by commissioning Griffiths to inquire and report. He indicated that the establishment of the 'general management' function would, among its other virtues, deal with the problem of cross-disciplinary integration. Although, in our view, the previous arrangement could have been made to work, the advantages of general management as advocated by Griffiths (at Unit, District, Region, and Nationally) are immediately apparent, given the will to implement it. We therefore believe that general managers are here to stay. But, as we shall argue below, general managers as identified by Griffiths must have responsibilities which we would assign to Level 4 at least; and he only argued for their extension down to Units, i.e. to structures which in our view require to operate at Level 4. In industry, a manager at Level 4 (= Unit level) is normally referred to as a general manager, often given the title of 'Director', and usually has a place on the 'Board'. In the army, the rank of General also appears at Level 4. Griffiths did not note the anomalous Districts which needed, usually because of their small size, to operate Units at Level 3. Many of these have wisely formed themselves into a 'one-Unit' District.

Many staff in the NHS had no choice but to become enthusiastic about general management. However, it is possible to be carried away by enthusiasm. The extreme reaction against disciplinary compartmentalization and the advocacy of general management has led to the notion of pushing general management the whole way down the organization to areas where it simply does not belong. Thus ward sisters are being referred to as general managers, and hospitals and services of every sort are being set up with general managers. Indeed our support in workshops for the notion of functional

management has sometimes been identified with an attempt to undermine the necessary managerial revolution begun by Griffiths.

Revolutions devour their makers. Griffiths, like Salmon, will come to be blamed for what he never recommended. The pendulum swing against functional management is to the long-term detriment of the service to patients. As nursing and nurse managers are likely to be the chief casualties of this extremism, it is appropriate that we examine exactly what is required below UGM level in order to integrate nursing into the service as a whole.

The Sphere of Functional Management

Those who depreciate the ability of staff of different disciplines to cooperate have obviously never seen a multi-disciplinary group of staff care for a patient in hospital. There is no difficulty about giving instructions, asking for information, or convening meetings. For many years such L-2 multi-disciplinary work has occurred without any member being the main line-manager of the others. Frequently the consultant has taken a lead role in regard to diagnosis and medical treatment; but the nurse takes the lead role in regard to the patient's general care; and often paramedical professionals contribute quasi-independently. Problems do exist in these relations, but no one would suggest that they indicate that the professions concerned should be dismantled and one general clinical manager be appointed.

The major problems in cooperation have been at Level 3: the development of systems which integrate services provided for patients. However the analysis presented in this Working Paper and confirmed repeatedly in the field is that **this is not due to *excesses* of functional management, but rather to *deficits* in functional management.** L-3 main line-management is weak, and not only in nursing. We can confirm that similar problems have existed in the paramedical professions and most of the support services. In medical work too, the consultants commonly fail to do the necessary L-3 management work in regard to their own services. However—and this is the main point which we know to be unpalatable to many UGMs and DGMs—*an absence of a needed L-3 functional main line-manager in any one discipline will not be put right by automatically appointing a L-3 general manager from another discipline.*

Work from L-1 to L-3 is inherently 'specialist', not 'general'. We have described how specialist knowledge of nursing is essential at L-3. The same argument goes for physiotherapy, works, pharmacy, and the medical specialties. If nurses are appointed to these 'service manager' roles, then nursing may possibly benefit, but it is unlikely that other disciplines will. Even nursing management is likely to suffer, getting less attention than it requires, or being forced to form divisions that are too small. If a nurse is not appointed, and this must be a possibility if the conception is that of 'general' management, then, for the reasons outlined in earlier Chapters, nursing (and hence patients) may suffer seriously.

Managing Multi-disciplinary Services

The unsuitability of true line-general-managers below Unit level does not mean that cross-disciplinary arrangements need not be developed. Indeed they are as essential at the system level (L-3) as they are at the patient level (L-2). Every single site and every Department or hospital section requires its own leader-manager. In a hospital, for example, entities requiring oversight include the Outpatients Department and the laboratories. Unless someone is appointed to be responsible for inter-disciplinary integration and for catching problems that fall between disciplines, then the service will be unsatisfactory.

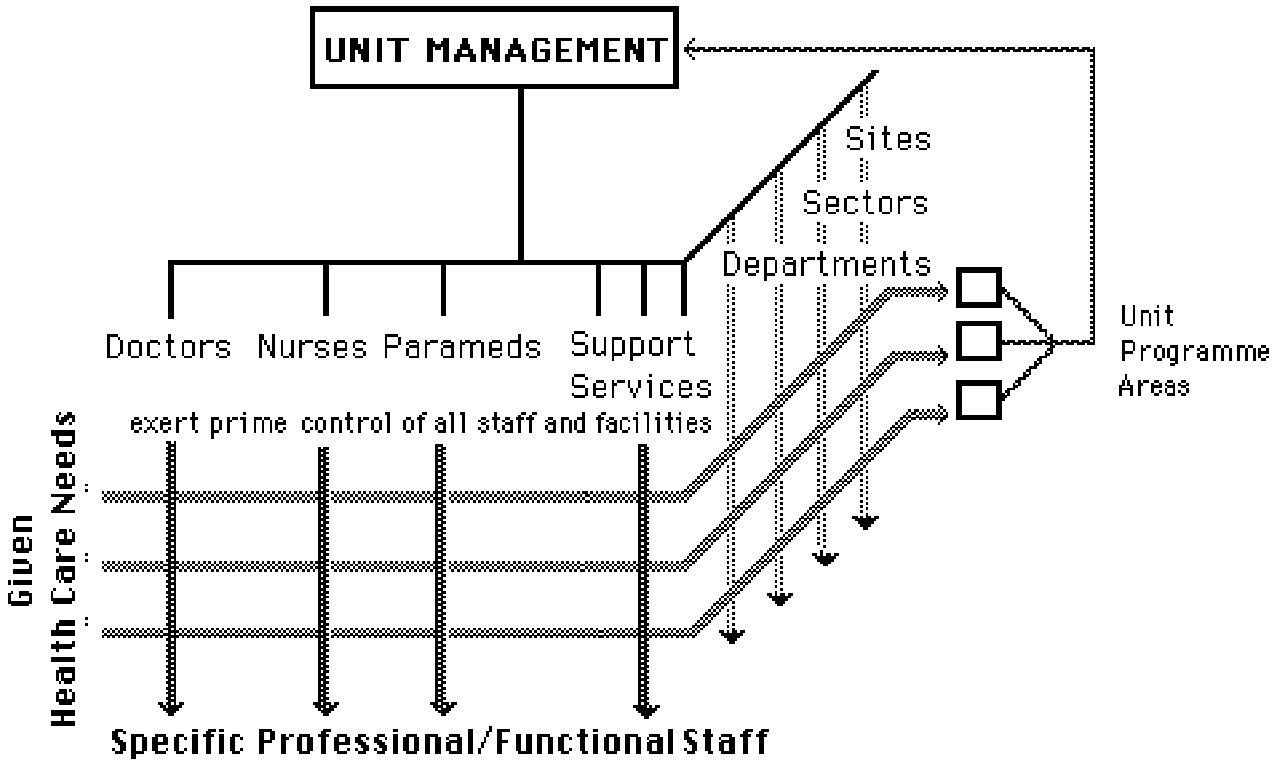
As defined earlier, such an L-3 manager need only be a *coordinator and monitor* in regard to staff from other disciplines. The most suitable person and discipline for the job will depend on the entity and on the people available. Because the coordinator is not responsible for appraising and developing staff or being up-to-date in all technicalities, he may come from any discipline. The idea that coordination is weak stems from the old NHS culture. The role will be as weak as the UGM who creates the role and decides its authority. A coordinator, working properly, can get information, give instructions, formulate proposals, overcome obstacles and so on. He does this through the cooperation of line-managers in the various functions. If this cooperation is unavailable for any reason, then the UGM must be prepared to step in to support the coordinator, or if this is a repeated problem, it may be that the coordinator or the structure is unsuitable.

The Matrix Principle

Much of the current emphasis on general management is associated with the need to obtain budgetary and workload control. Admirable as this may be, the needs of the patients must also be considered. It is our experience that NHS managers are largely unaware that they are not organizing with a direct concern for patients. This can be rectified. At Unit level it must be realized that there are two different structures required which form a matrix (see Fig. 3).

Up to now we have been discussing the vertical structures. These vertical structures are *the primary accountability structures*. They are the methods or means whereby health care needs are met. These operate in two dimensions: the main dimension is that of the discipline, the secondary dimension includes the sites, sectors and departments. In other words, although the NHS was not set up to run out-patient departments or provide employment for nurses, these are amongst the various ways by which the main purpose of the NHS, health care, must be met at present. Accountability structures are devised for strict control of people and things and for the closely specified allocation and monitoring of work. They provide the tightest possible grip on costs.

FIGURE 3: The Matrix at Unit Level



It is necessary to sharpen the focus on the purpose of the NHS by creating a second structure. This is the horizontal structure in Figure 3 which crosses disciplines, and sites or departments. It is necessary because no patient or set of patient needs will be ever be the sole responsibility of any one profession; and it should never be assumed that any particular site or any department is the sole means by which health care might be delivered. For example, out-patient department care following discharge should be seen as a common but by no means sole approach to patient follow-up. Clearly the OPD manager cannot be expected to manage or plan for the variety of other ways in which patients can be followed up.

The second horizontal structure may be called *the programme structure* and the areas defined by it the 'Unit Programme Areas'. It provides the primary control of health care objectives and priorities. In businesses, it corresponds to the product divisions—in contrast to the development, manufacturing and marketing divisions which apply to all products. The Programme Structure requires work at L-3 (system development and workload control), and at L-4 (programme development and budgetary control). To ensure pursuit of programme objectives, a whole set of complementary structures to the accountability structures are required: specific roles and responsibilities, policies and procedures, information and budgets.

Detailed discussion of programme structures is beyond the scope of this Working Paper but to give an idea of the distinction from the accountability structure, an example from a Mental Illness Unit might be helpful. Here the normal range of health professions were employed, and the service was divided for management purposes into three hospital

sites and two community divisions. Nursing closely but not exactly paralleled this division. By contrast the main programme areas were: dementias, neuroses and personality disorders, functional psychoses, substance abuse, metabolic and other disorders. Services to meet these differing patient needs were not specifically aligned with one particular site or profession, but drew upon many. Each programme required its own coordinator, chosen according to his expertise in the programme area and management qualities rather than according to his discipline.

Relationships on the Unit Management Team

If the UGM is working at L-4 and a DNS is also appointed to work at L-4, then according to the framework offered in Chapter 2, the UGM cannot or should not be the main line-manager of the DNS. This requires some further exploration. First, it must be emphasized that a L-4 nurse is not in a unique position in this regard. The UGM is not the main line-manager, in the full sense, of the Consultant medical staff. He cannot interfere with clinical autonomy, and he is unlikely to be able, with any ease, to reorganize their tasks and responsibilities or lay down clinical policies for them as he could for his own direct subordinates. It will be to the advantage of the UGM to have a Unit Medical Representative capable of L-4 work; and, if the Unit is of any size, probably a Unit Finance Officer of similar ability. In some large Units we have also found the need for an L-4 Unit Works Officer.

We have therefore concluded that the UGM usually needs to see himself as heading up a top *Unit Management Team* which includes at least one and possibly more L-4 colleagues, one of whom is usually a DNS. This is convenient because the numbers of L-3 subordinates requiring L-4 management is probably not less than 12-15 in most Units. This excludes the Consultants, each of whom works at L-3. Our field work findings suggest that the UGM, in marked contrast here to his counterpart in the typical commercial enterprise, should not attempt to maintain command by avoiding recruiting L-4 staff. Strong and effective leadership is still possible as long as the UGM keeps a clear sense of his powers of decision.

The UGM is authorized to decide what the philosophy of the Unit should be; to decide on the form of the Top Management arrangements; to control agendas and chair meetings. Of importance is his authority to decide on the detailed role and responsibilities of other L-4 staff. For example, he may decide that an L-4 DNS should be responsible for hotel services delivered by L-3 staff; or he can decide on limitations to the budgetary power of the DNS, say in regard to virement. Of most importance is his decision on Unit priorities, that is to say determining where attention and effort is to be directed.

It may not be requisite, however, for the UGM to decide unilaterally on matters where the DNS is clearly expert, knows the detailed situation in the Unit and would normally be expected to implement decisions. Here consensus management is still required. If a UGM does insist on what he believes, and his DNS is strongly opposed, the UGM needs to consider whether it might be preferable either to take on the matter himself, or to attempt a different approach to the problem.

New Management Initiatives

It is clearly not possible to examine recent management initiatives such as Korner, management budgetting, evaluation, and quality of care. (It is hoped to tackle some of these in a subsequent Working Paper.) However some mention must be made in regard to the present recommendations for nursing. The major point here is the significance of the Level 3 middle manager. This is the person who should be maintaining services so that Level 4 management can set up new arrangements, and who will then be designing and operating many of these systems themselves. By providing such roles adequately supported, both efficiency and effectiveness will be enhanced. Without such roles, top management will feel itself being dragged down into detail, first line management and health professionals will be forced inappropriately to carry out administrative chores, and systems will break down or function ineffectively.

QUESTIONS & OBJECTIONS

Q: *Does your theoretical scheme imply that it is the DGM, not the UGM, who is the true line-manager of the DNSs?*

A: Yes. This area is still unclear to us and we are watching developments in the field with interest. We assume that if DNSs are working at L-4, then for some matters, at least for their own career development, they may need to have access to the DGM. For his part the DGM may wish to work directly with DNSs as suggested in Chapter 10.

Q: *Is the 'span of control' a deciding factor in deciding whether a DNS is required?*

A: No. Span of control in the sense of sheer numbers is rarely a deciding factor in anything. Since Moses tried to organize the Israelites [18], magic numbers for the correct span of control have been postulated—but research has found examples as low as 3 and higher than 30.

Q: *But surely span of control is important?*

A: Spans of control do have to be watched, but if they are judged to be excessive it is never correct to solve this by adding an extra management level beyond what the work requires. Better answers include rethinking the size of the base entity or employing staff officers or coordinators to help ease the burden of detailed line-management.

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