TALKING POINT

Making Salmon work

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"Why does a surgical ward sister become a district nursing officer?" This question is often asked, and one answer is that, having achieved her first priority of training good registrars to become good consultant surgeons, she can turn her attention to providing a good nursing service to help look after their patients. But how does a DNO provide this good surgical nursing service? The answer to this should be by using the much maligned Salmon philosophy.¹ We have done this at North Tees and, though the service we provide is not perfect, our achievements have been based on frank discussions with the consultant surgeons. Co-operation between the nursing and medical professions, as well as support from other sources, is necessary for adequate patient care.

The comments on the nursing service in part I of the evidence to the Royal Commission on the NHS from the Royal College of Surgeons of England make sad reading.² In many areas of the country there is still little or no true communication between the two professions. The Salmon Report is blamed for the general shortage of clinical nurses, for nurse training being conducted by the use of the "block" system (which was already widespread in the 1950s), for the fact that senior nurses are not seen bed bathing patients, and for low standards of patient care. The RCS also complained that nursing shortages caused a lowering of standards, that junior nurses were left in charge of wards at night, and that unemployment among trained nurses was a serious problem.

No new problem

But these fears are not new. In 1941 the Rushcliffe Committee for England and Wales and the Taylor Committee for Scotland were convened to look at nurses' gradings and salaries in the hope of providing a solution to the shortage of trained nurses. This work formed a basis for the work of the Nurses and Midwives Whitley Council, which was established in 1948.

Our experience of implementing the Salmon proposals came at a time when plans were well advanced for the transfer of hospital provision from four old hospitals into the second phase of our new 1000-bedded district general hospital. Phase one had been open for obstetrics and psychiatry since 1968. I became chief nursing officer of the North Tees HMC in May 1972 and my immediate tasks were to reorganise the nursing service and nurse education to meet the needs of the new hospital and, initially, to be the main avenue for nursing advice during the commissioning stages. Most of the problems which faced us in 1972 were overcome with the help of the Salmon philosophy. Since the 1974 NHS reorganisation the philosophy has continued to be used and extended to improve patient

care. In 1972 we had 866 beds, together with the usual departments, scattered between five widespread hospitals. These consisted of two old general hospitals, a children's hospital, a geriatric hospital, and phase one of the new DGH. There were 561 nurses in post (funded establishment 587.5), of whom 33 were matrons, their deputies, and assistants, and 108 were nurses in training. We needed an additional 280 nurses to staff the DGH at the minimum levels outlined in the DHSS formula. This assumed that all nurses employed in the old hospitals would move to the new hospital.

It was difficult to discover how many nurses lived locally and wanted to work. I discussed two possible courses of action with the medical staff committee—firstly, that we opened only the wards we could staff adequately or, secondly, that we should, as a priority, train our own nurses. The second option meant that the priorities of the completion and handover of buildings would have to be altered so that the teaching centre was in use well ahead of any clinical areas in order to accommodate a large increase in the number of nurses in training. The medical staff would have to come to terms with the fact that, for at least three years, there would be a gross

imbalance between trained, in training, and untrained nurses, particularly an under-provision of trained nurses. But we thought that if the consultant medical staff and the senior nurses could work in partnership by the end of the lean years there would be well-trained, highly competent, qualified nurses.

If the second option was adopted, nursing and medical staff would have to work closely together to ensure that seriously ill patients were cared for in the few places where there would be a concentration of trained nurses—that is, coronary care unit, intensive therapy unit, operating theatres, and the accident and emergency department. We also made the point that, whichever option was finally adopted, we must ensure that we made the best possible use of the trained nurses available to us. So we discussed the Salmon philosophy and how it could be used and extended to assist us in achieving our common objective.

Using Salmon

We agreed completely with the opening sentence on nursing administration in the Salmon Report: "The starting point is the patient..." This meant that the new hospital must provide im-

Professional and managerial group

Evidence submitted to Chancellor

The managerial, Professional, and Staff Liaison Group (28 January, p 253) are submitting a detailed case to the Chancellor of the Exchequer and the Secretary of State for Employment drawing attention to the adverse effect which incomes policies have had on their members. The group, which includes the BMA, has explained the serious consequences for incentives and professional standards. Workers in many professions are unable to take advantage of self-financing productivity schemes unless they introduced practices which would have adverse effects on the quality of professional services. The paper illustrates the disproportionate way in which differentials have been eroded and gives examples of the unfair treatment members have received since 1973. When representatives of the unions concerned had met Ministers and officials of the Treasury and the Department of Employment in July 1977 they had been told that if their members were treated fairly there would be a wages explosion. In the picture are Mr Tony Thistlethwaite, chief press officer, BMA; Dr Maurice Gillibrand (Association of Professional Scientists and Technologist); and Dr John Havard (principal deputy secretary, BMA), chairman and secretary of the group.

mediately an adequate service to the surrounding population and endeavour to meet the health needs apparent in that population. So we decided that only the second option was tenable and negotiations with the contractors resulted in the teaching centre being handed over ahead of schedule. We received help and advice from the General Nursing Council, one of whose inspectors came to inspect the existing training schools and to discuss training experience likely to be available in the new hospital. She also advised on the interim expansion of the school of nursing in the light of the expected experience which would become available as the new hospital expanded.

For senior nursing staff we decided to make the appointments to the new hospital, though with initial responsibilities in the old hospitals. A preliminary survey of existing nurse administrators showed that of the 33 then in post, only two, on grounds of existing salary scales, qualified for consideration of Salmon posts at grade 8 or above. One of these was the matron of the maternity wing and the other was due to retire before 1974. One of the first senior appointments was the senior nursing officer (education), who was given broad guidelines but left alone to commission his own department, staff it, and organise his training programmes and the expansion of the numbers of nurses in training.

Consultants have been true to their word and continue to give generously of their time in the interests of nurse training. Not only do they give the required lectures in the school of nursing, but all the clinical consultants do a ward round each week for nurses in training and for anyone else who wishes to attend. A nursing officer, senior nursing officer, divisional nursing officer, or I participate in each of these ward rounds. All the senior nurses enjoy them as it enables them to keep abreast of current clinical practice and brings them closer to the patients, the doctors, and those nurses concerned in direct patient care.

The senior nursing officer (commissioning)—a two-year appointment—was able to relieve me, as chief nursing officer, of much of the detailed work. This nurse helped with planning and evaluating new equipment to enable us to obtain those items most suited to our needs. The divisional nursing officer (general division) and I then embarked on a public relations exercise to ensure that senior nursing officer and nursing officer posts were filled by people adequately prepared to accept the responsibilities of the grades as we saw them. We maintained that all nurses from the most recently recruited nurse in training (grade 1) through to me at grade 10 were "nurses before we were anything else." We should be seen to be concerned with the welfare, care, and treatment of our patients, to be in a position to teach the art of nursing to those in training, and to advise inexperienced staff on care and management. Our attention was focused initially on the 33 administrative nurses and on the ward sister/charge nurse grade. We pointed out to the administrative nurses that, after years of book work and of implementing decisions taken by matron, they had to prepare for a new task. As nursing officers or senior nursing officers they would be expected to know their areas and units inside out.

Senior nursing officers

The senior nursing officers would need accurate knowledge of work loads and staffing levels and they would need a high level of nursing knowledge and expertise. Working within these guidelines, they would be expected to manage the nursing service in their areas and would be held accountable for their decisions. A budget would be allocated to them which would not include money for nurses in training. From this budget they would be expected to "buy" trained nursing staff and nursing auxiliaries according to the expected work load. Though it is possible and right to delegate work and functions, it is not possible to delegate responsibility. So, together with the divisional nursing officers, I reserved the right to question

the ratio of trained staff to others, and, in the last analysis, the right to override their decisions. (I have never found it necessary to do so, though I have sometimes sought explanations.)

When devising the senior nursing staff structure we decided that it would be inappropriate to opt for strict comparability between senior nursing officers in terms of numbers of beds—they should be recognised for their nursing excellence in their own specific field. We therefore appointed four senior nursing officers to the broad specialties of midwifery, psychiatry, medicine, and surgery. Recent legislation—for example, the Employment Protection Act, trades union and labour relations legislation, and the Sex Discrimination Act—has placed a far greater burden on the SNO. Paper work has increased, particularly as a result of such agreements as the Halsbury pay award. This makes it essential to differentiate between annual leave entitlements and statutory holidays and detailed records are required for each nurse employed. We estimate that the as yet unimplemented agreement that uncertified sickness may be extended from three to five days will cost this district the equivalent of £20 000 pa in terms of an increase in the number of lost nursing hours.

This and other agreements, such as the extended period of time an employee may take off for maternity leave, have made the SNO's day-to-day management task more complex than was ever envisaged when the Salmon Report was published. Though a SNO carries responsibility for the employment of about 150 whole-time-equivalent nurses, this represents a far greater number of people, as a considerable proportion of nursing is done by married women who work only part time, but for whom full records must be kept if their salaries are to be accurately calculated.

Nursing officers

At the nursing officer level, we made it clear that we were looking ideally for an experienced ward sister. This is in line with the recommendations in the Salmon Report. The report stated that, though ward sisters found their jobs satisfying and were able to enjoy full scope for the exercise of their professional and managerial skills, there were factors which made their jobs increasingly difficult. There was too much work. The throughput of patients per bed was increasing annually at a time when nursing hours were officially decreasing. A ward sister spends an increasing amount of time administrating and a decreasing amount of time nursing. The attempts to relieve the ward sister of non-nursing duties and an increase in the number of nursing grades have resulted in a more complex team to co-ordinate. The team now consists of State-enrolled nurses, pupil nurses, nursing auxiliaries, ward clerks, ward orderlies, and domestic assistants, in addition to the traditional grades of staff nurses, student nurses, and ward maids. Medical knowledge and technology has resulted in more work for ward staff.

It was a novel idea to some of my medical colleagues when I attached a revenue consequence for more nurses to their proposals for consultant expansion. "If you do that, we won't get the extra consultant," they protested, but I'm glad to report that they did see there was no point in getting an extra consultant if there were insufficient nurses to care for his patients. The nursing officer is seen in the Salmon Report, and in the manner in which we have tried to implement it in this hospital, as a way of retaining the services of older, more experienced ward sisters in clinical work. Before the creation of this post sisters who found the increasing stress of the job too much could retire early, or become a home or administrative sister. This meant the loss of much clinical experience and expertise.

A nursing officer's unit normally consists of 80-150 beds, depending on the specialty. Her primary function would be to advise and support inexperienced staff, newly appointed sisters or charge nurses, or their staff nurses or State-enrolled nurses when they found themselves in

Briggs delayed: RCN dismayed

The Government has announced that it cannot find time in the present parliamentary session for legislation to reorganise nurses' training, though it remains committed to a Bill. Legislation was to be based on recommendations of the Briggs Committee on Nursing, which reported in 1972. On 7 February Mr Roland Moyle had said that if time could be found the Government would introduce a short Bill to implement the recommendations "relating to a new statutory framework for nurse education and training" (18 February, p 45).

The Royal College of Nursing is extremely disappointed at the announcement. Joint working groups with the DHSS to prepare for legislation have been meeting since last spring. The College says that it intends to exert every pressure to ensure that the Bill is introduced as soon as possible. Legislation to establish a new structure was only the beginning of a reform that the nursing profession had long awaited, the RCN maintains.

charge of a ward or department. In the absence of a suitable deputy for the ward sister, especially in the early days while our trained staff levels were particularly low, it was not unusual to find the appropriate nursing officer running a ward. So the nursing officer has to keep up to date with the treatment and progress of all the patients on her wards or unit, accompanying the consultant at least once a week when he does a full ward round. This enables her to support the more junior ward staff and also to help the sister at times of peak work load by caring for patients or, more usually, by taking a more junior nurse and teaching her how to care for a particular patient. The nursing officer is also able to help the ward sister, the staff nurses, and the clinical instructors in clinical teaching sessions for the nurses in training. The nursing officer's administrative duties are designed to release the ward sister for those tasks concerned with direct patient care which are her prime responsibility.

Nurses in training are allocated to units for experience and the nursing officer has to apportion them according to the business of the wards. Having ensured that the job of the nursing officer is primarily clinical and that she undertakes only such administrative duties as might otherwise have been done by the ward sister, we are gradually extending the nursing officer's clinical work.

CONSULTANT IN NURSING PRACTICE

Our first experiment with the nursing officer grade as a "consultant in nursing practice," without the responsibilities of wards and nurses, was a nursing officer in stoma care. The nurse in this post now has had a wide range of experience; holds the Joint Board of Clinical Nursing Studies Certificate in this specialty; and has worked as a surgical ward sister, a staff midwife, and a community nursing sister. She has her own weekly outpatient clinic and meets the patients (and their families) before they have their operations. At the request of the ward sister she

will advise or help with the care of the patient in hospital and then follows the patient home, either on the day of discharge or the following day. She meets the community nurse and they decide when the patient should be handed over. She is available to all nurses, in both the hospital and the community, for advice on the care of their patients; she discusses with hospital medical staff and general practitioners the care and progress of the patient and will co-ordinate the work of non-NHS agencies to the benefit of her patient, even, at times, negotiating with employers about the patient's return to work.

This service has been so successful that we are experimenting with other nurses carrying similar responsibilities. The nursing officer with responsibility for general surgery has been running her own (rapidly expanding) gastric follow-up clinic. One of the community nursing officers is responsible for a diabetic clinic and for advising community nurses on the care of diabetic patients who are learning to adjust their own insulin treatment.

Conclusion

Cries about too few nurses and inexperienced nurses predate reorganisation, Salmon, and even the Health Service itself. Even if not the result of the Salmon Report

there is no justification for inadequate staffing levels. But concepts of quality are relative: the number of nurses we can afford is part of the larger issues of how much health care the country can afford and the efficient use of resources. Apart from the obvious major priorities there are other, more mundane, ones. For instance, do consultants going on holiday, study leave, etc, consult with their nursing colleagues about the underuse of beds so that nursing staff might be encouraged to take their own annual leave during periods of lower clinical activity? Are nurses ever asked about new consultant appointments? The RCN's Royal Commission evidence³ stated that "The work of the trained nurse has been affected by an 185% increase in consultants during the past 25 years. Consultant appointments carry a nursing consequence, and the esoteric specialities a heavy consequence."

Medical staff at this hospital find that most matters concerning day-to-day management of their patients can be settled with the ward sister or, if the problem has wider implications, with the nursing officer. The senior nursing officers attend meetings of the relevant cogwheel divisions, and the medical members of the divisions are always more willing to listen to advice from their SNO than from

the divisional nursing officer or from me.

Though pay awards have been agreed for nurses and junior doctors, little thought seems to have been given to the revenue consequences—which may be only partly funded. There is insufficient money to employ additional staff to cover the extra statutory holidays. Did anyone realise the effect of the junior doctors' new contract on continuity of care or on medical training? Doctors and nurses have complementary jobs in providing health care and unless both understand each other's aspirations their potential in providing patient care will not be achieved.

References

- ¹ Ministry of Health, *Report of the Committee on Senior Nursing Staff Structure*. London, HMSO, 1966.
- ² Royal College of Surgeons of England, *Evidence to the Royal Commission on the NHS*, Part 1. London, RCS, 1977.
- ³ Royal College of Nursing, *Evidence to the Royal Commission on the NHS*. London, RCN, 1977.

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Ancillary staff continued

which were perfectly clear in the circulars from the GMSC and the Medical Insurance Agency. The practitioners who had acted in the way they had were not irresponsible—they had acted within the confines of an agreement which had been freely made. The negotiators and the GMSC had acted honourably in the matter. Dr Riddle thought that the whole matter was a case of maladministration. Was it a case for the Ombudsman? If the committee did not take a hard line they would be in serious trouble with the Annual Conference. "We must not be seen to be creatures of the Department."

Two classes of GPs

Dr Michael Wilson pointed out that however many GPs concluded reasonable schemes before 6 March, there would be two classes of practitioner after 1 April—those who had managed to get a reasonable scheme in before 6 March and those who had not. One thing was certain: those who had not would want the GMSC to negotiate direct reimbursement for reasonable schemes after 1 April. Ancillary staff would gain from the scheme, not the doctors. Dr Mervyn Goodman told the committee. But if anybody were to suffer, it was the general practitioner, and that must be made clear to the public: family doctors had been given certain information and because they thought of the welfare of their staff they had taken out policies. Then the Department had reneged.

When the matter had been debated at the General Purposes Subcommittee, Dr B L Alexander reported, the question of a limiting percentage had been raised. At that time the DHSS had not been prepared to negotiate a percentage figure. All it had been concerned with was existing schemes up to the cut-off point. In his view, those schemes entered into before the cut-off point should be honoured. The reasonable scheme proposed by the MIA

had provided for two-thirds salary on retirement and conformed with the Inland Revenue rules. The DHSS was trying very hard to wreck it.

Dr J S Noble was disturbed to hear words such as "unscrupulous" and "irresponsible" relating to a group of people who had worked so loyally and frequently at low pay. An opportunity had arisen to give something to ancillary staff, which was long overdue, and it had been carried out in accordance with the Inland Revenue's rules.

The chairman of the Scottish GMSC, Dr Joan K Sutherland, pointed out the differences in the Scottish agreement and urged the committee not to be too militant. The Government had stated that where schemes had been entered into in good faith and were reasonable they could be taken up individually. There was no reason to suppose that they would not be met in full.

Dr Keable-Elliott made it clear that he attached absolutely no blame to any general

practitioner who had negotiated a scheme on the clear understanding that had been given by the Department. The fault lay with the DHSS. It was true that the spirit of the agreement that had been entered into on 16 February was for the reasonable protection of people who had existing schemes: but if the DHSS had written down, as it had done, that that meant total reimbursement until 1 April, and then when it had had an opportunity to alter it subsequently had made yet another agreement saying that total repayment would be up to 6 March, clearly the fault must be the Department's. He had every sympathy with GPs who had suffered personal loss for trying to protect their staff. But the Secretary of State had intervened and the committee had to be reasonably circumspect in making the best of what was a bad job.

Press conference

After the debate Dr Keable-Elliott held a press conference. The dispute, he said, had not only put a great many GPs, who had taken out private schemes on behalf of their staff in a position whereby they stood to lose considerable sums of money but it also meant that GPs' ancillary staff would in many instances not receive an equitable pension. "I have, therefore," Dr Keable-Elliott continued, "written to the Secretary of State asking him to tell his officials to revert to the original agreement. I am telling him of the background to the case and that we understand that the large majority of schemes have already been given prior approval by the Inland Revenue and should therefore be accepted as reasonable. Failure to do so will inevitably result in the deterioration of relationships between ourselves and Ministers." He added that he was concerned that this intervention by a Minister in the GMSC's negotiations with the Department had not been reported to him personally in a letter from either Mr Ennals or Mr Moyle.

ARM and craft conferences

The dates of the craft conferences and the ARM 1978 are as follows:

Saturday, 24 June: Junior Hospital Staff Conference.

Monday, 26 June: Conference of Medical Academic Representatives.

Monday, 26 and Tuesday, 27 June: Hospital Medical Staffs Conference.

Wednesday, 28 and Thursday, 29 June: Annual Conference of Representatives of Local Medical Committees.

Saturday, 1 July: Conference of Community Medicine.

Tuesday, 11 to Friday, 14 July: Annual Representative Meeting.

Some dates given in the programme for the ARM (18 March, p 731) were incorrect.