Nursing Grievances

III: Conditions

TONY DELAMOTHE

The thoracic unit doubled its workload in the past 12 months. The number of beds hasn't gone up, so in theory you shouldn't need more nurses. But in practice the workload has gone up tremendously. They've created a high dependency area to take all the major ops, but that backlogs into intensive care, which backlogs into the wards. It just means that nurses have to work twice as hard. It's supposed to be one to one in intensive care: now each nurse looks after two ventilated patients at once. I think that's when morale gets very low. Nurses work tremendously hard when they have to—they'll give you everything they've got. But we're spread so thin at the moment that when we do get a busy spell you just can't give that extra boost.

SISTER

When the public thinks of nurses' grievances it thinks of money. In newspaper stories about nurses leaving the health service the subjects are leaving—for Saudi or Sydney—for salaries at least twice what they earn here. Salary is the easiest grievance to quantify and the easiest for those outside nursing to make sense of. And yet pay does not consistently rank highest in nurses' own assessment of why their morale has declined or why they are considering leaving (article I). What nurses quote are the consequences to them of the much vaunted recent successes of the National Health Service: its increased productivity and programmes of "cost improvement."

Between 1979-80 and 1986-7 numbers of inpatients, day cases, and outpatients have all increased¹—faster than government spending on hospital services, which has increased hardly at all in real terms,^{2,3} and faster than the increase in numbers of nurses^{4,5} (figs 1 and 2). These figures are used to prove past inefficiency in the service and to fuel hopes for even more improvements in the future. Cost improvement programmes made by hospital managers at the government's behest have included rationalising patient services, competitive tendering, other reductions in labour costs, and "Rayner scrutiny" savings, which have "freed" resources putatively tied up by inefficiency. Competitive tendering has been so successful that the Secretary of State for Social Services has suggested that other services—for example, portering and pathology—may soon follow domestic, laundry, and catering services.

A ward sister's reasons for her resignation (see box) give some idea of who is paying for these savings. Not only are nurses working harder as nurses but they are also trying to make up for reduced ancillary services and for "rationalised" patient services. It is clear to anybody who has spent much time with nurses (or in hospitals) recently that they are not coping with these extra demands.

Why nurses leave . . .

"It's pay, but it's job satisfaction now too. It's cutting back on back up staff, it's no equipment and pushing more patients into overworked wards. We can't give the nursing care that's required and that's the stress the nurses are feeling—it's the stress of not doing the job properly. Medical records staff was cut from seven to three. The nurses were expected to ring for notes, fetch and carry. They halved the number of porters. Who did the portering? The nurses. The nurses were always going to pharmacy. They cut down on domestic staff and the hours they were on the ward and the wards were always looking filthy. Because equipment was so short it was continually borrowed from ward to ward. Nurses had to walk up to six wards to find some vital piece of equipment, like bed elevators or space blankets for patients with shock. Sometimes CSSD would run out of stock.

Every day we had too many patients for the empty beds available, so the routine admissions would be sent home—sometimes up to three times. Doctors discharged patients too early in order to get empty beds, but patients would come back again and have to be readmitted. The administration decided we could do without agency nurses so if we were short staffed we could get no one. So the nurses, who were exhausted, went off sick more often—which made for even more stress for the other nurses. Nurses were always off duty late.

Sometimes we would have three patients in one bed within a shift. Our miscarriage in the night would go home at 8 am. Then an extra day case patient would be put into the bed. The waiting list patient who came to the ward at 10 am would wait until 5 pm. (And if the day case patient bled the waiting list patient went home and came back next morning starved for a major operation.) It was like a factory. The nurses were literally running at times we used to be so busy. So we had no satisfaction of the job being well done. Patients didn't dare talk to us because we were so busy. There was very little time for counselling.

District administrators are getting bonuses for cutting costs, bonuses for getting waiting lists shorter—they have no idea of the problem. And that made me feel even worse when I thought why we're discharging them early."

SISTER

Paying the price of success

RATIONALISATION OF PATIENT SERVICES

Take things like linen—you're hard pushed to be able to change patients' sheets as often as you need. Linen is now washed somewhere else—Hillingdon, I think—so it doesn't come back to the hospital on time. Our supplies have got to come from Twickenham: if you want something as an emergency, forget it. You're constantly phoning up for things—I spend half my life on the phone whingeing at people. If something breaks down, like the bedpan washer, they can't fix it straight away. There are not enough electricians. All sorts of things, which just build up and build up. You're there to look after people, and you spend your whole time hassling for things that should be there.

SISTER

FIG 1—Hospital activity and number of nurses (whole time equivalents, adjusted for the reduction in nurses' working hours in 1980), England.

FIG 2—Spending on NHS hospital and community health services at input volume prices, England.

COMPETITIVE TENDERING

In 1983 health authorities were instructed to put domestic, catering, and laundry services out to tender. The Fair Wages Resolution was rescinded the same year, meaning that private contractors no longer had to pay the same wages or observe the hours and conditions previously established. By the end of 1986 "competitive tendering" was saving £86m a year, arising mainly from "the rationalisation of existing operations (in domestic services), less favourable conditions of employment, greater use of part time staff, changes in working practices and increased productivity."⁶

Translated, this means fewer staff employed for fewer hours for the same workload. Cheapness seems to have ousted quality as the main criterion of a contract's acceptability, and the most successful way of cutting costs adopted by contractors has been to use more part time staff. According to one report, very few contractors' employees now work more than 16 hours a week, jeopardising their statutory rights to claim unfair dismissal, redundancy pay, maternity pay, or pay when laid off, which are based on minimum hours of work. Virtually none are paid enough each week to take them above the national insurance contribution threshold of £39.00, and so they are ineligible for statutory sick pay, state pension, unemployment benefit, and other contributory benefits.⁷

It would be surprising if these part time workers, whose conditions of employment are more reminiscent of the early nineteenth than the late twentieth century, performed as well as if they were in secure full time employment. Dossiers of evidence collected since 1983 suggest that their performance has been much worse.⁸ In many cases nurses have been "carrying the can"—washing, cleaning, and apologising as meals and laundry have failed to materialise. If competitive tendering is to be extended to portering services as successfully as it has been to other services nurses are unlikely to be able to take up the slack: hospitals really might grind to a halt.

ACCOMMODATION—"REALISTIC" PRICING AND RAYNER SCRUTINY

Because of the cutbacks the nurses' home now dictates what electrical appliances you can have. Young girls are coming in for three years—it's supposed to be their home. And yet they're not allowed to have a cake mixer or a toaster because they say the electricity bills are too high and must be cut. That's all you get being a nurse, accommodation.

STUDENT NURSE

Or, all you got—subsidised accommodation for nurses may be an idea whose time has gone. In 1982 "realistic" charges for nursing

FIG 3—Lodging charge as percentage of basic pay for staff nurse 1979-87.

accommodation were introduced (fig 3), at a time when real pay was stationary and direct taxation was high (article II). One year later a Rayner scrutiny examined residential accommodation provided by the NHS (total value over £1000 million) and its report concluded that stock surplus to "essential need" should be sold off.⁹ In the authors' judgment only first year learners could claim an essential need for accommodation. Since then the sales have begun, those in the more affluent south east raising most money. The cost of renting or buying has increased there too, much faster than nurses' salaries. In the larger cities nurses, no longer able to live in nurses' homes, can afford only to live further and further away from where they work. Travel costs constitute an increasingly large proportion of their salaries: eventually nurses try to find work closer to where they live, exacerbating the nursing shortages of inner cities.

Away from inner cities the deregulation of bus services has meant fewer services outside peak hours (when most nursing shifts begin and end), increasing inconvenience. Travelling long distances at night (for example, after late shifts) almost anywhere in the country puts nurses at a greater risk of violence.

Selling off nursing homes has been a success only when measured in terms of its contribution to "cost improvements." For recruiting and retaining nurses it has been a disaster. There are suggestions that the government has recognised this and may be taking action to reverse its policy of closing nursing homes.^{10 11} In addition, the NHS Management Board has been negotiating with building societies and housing associations on ways of providing low cost housing for nurses to rent and buy¹²; last month the first of these schemes was announced.¹³ Forgotten are the reservations of the Rayner scrutineers who regarded some of the arguments used in support of subsidised accommodation for nurses as "patronising." Perhaps all

Many nurses express dissatisfaction with the level of responsibility they now have to bear. One of the consequences of staff shortages is that nurses have to "act up." A recent study showed that 18% of nursing auxiliaries, 40% of student nurses, and 77% of enrolled nurses were participating in the administration and supervision of wards—responsibilities formerly designated to staff nurses and above. Almost half the student nurses had been left in charge of wards on occasion.¹⁶ (Photograph courtesy of Royal College of Nursing and Still Price Court Twivy D'Souza.)

concerned would benefit from looking at how the police are kept happy: by either rent free accommodation or an annual rent allowance, worth £1861-3722 in London (in addition to London weighting).

Devotion to the patient: nursing's strength and weakness

If you look back at nursing it seems that nurses will shoulder any burden they've been given, because in the end it's going to be the patient who suffers if I don't do more. So I do more.

SISTER

Nursing's credo puts patients' interests first. Because nurses spend so much of their time so close to patients their patients' needs are usually obvious to them. ("At the end of the day if they don't bring the food down from the kitchen and you've got the patient there starving for dinner, what do you do?") Nurses try to satisfy these needs and feel badly when they can't; when the strain of endlessly falling below their standards becomes too much they leave.

Resigning because of persistent stress or low morale may be the right response for nurses to preserve their mental health. Many more absent themselves through "sickness"¹⁴ as a way of coping with the problem. Disruptive this undoubtedly is, although less so than leaving, for which absenteeism should be seen as the dress rehearsal. Some commentators choose to see nurses' high rates of absenteeism not as an index of poor morale but as evidence of their fecklessness, as they do the high prevalence of cigarette smoking among nurses,¹⁵ similarly castigated with scant regard to the context in which it occurs or the reasons why such a behaviour pattern is adopted.

Born a woman: remembering and forgetting

Nursing is regarded as the female occupation par excellence, an extension of woman's "natural" role as carer. Given this it is not surprising that the characteristics of the ideal nurse resemble those of the ideal woman (article V). The figures support this close association between nursing and womanhood—in this country nearly nine out of 10 nurses are women; the National Health Service is this country's largest employer of women. Yet with this all pervasive (and, to many nurses, oppressive) identification of nurses with women goes some curious selective forgetting. The most prominent forgotten fact is that if these nine out of 10 nurses experience the same fertility rate as other women then they will have about 16 children among them.¹⁷ At present few employers of large numbers of women make less provision for nurses to manage family responsibilities than does the NHS.

It starts with maternity leave. Nobody replaces a nurse absent on maternity leave; she is included in the staff complement, and the reduced total have to stretch themselves further until her return or resignation. Few hospitals provide crèches, preschool playgroups, or child care facilities for older children after school or in school holidays. (The problems in doing so are not insurmountable: Kingston Hospital provides 25 crèche places, for 10 hours a day, at a cost to parents of 65p an hour. The health authority's annual subsidy approximates to one staff nurse's salary.)

There is insufficient flexibility in taking account of the domestic responsibilities of working parents, and better arrangements for part time working could be made. Job sharing should have happened a long time ago: the concept of dividing the day up into shifts and transferring responsibility to maintain 24 hour care is hardly a revolutionary one for nurses, and yet a recent evaluation of a shared ward sister's post could find no previous examples.¹⁸

With the rapid technological changes affecting medicine (and therefore nursing) many nurses who have been away for a few years are anxious about returning. "Back to nursing" courses helping them update their skills would improve return and would certainly cost less than training a new nurse from scratch, which is what mostly happens now.

What is to be done?

If asked nurses can describe very precisely how their jobs have changed during the past few years and why morale is low. Shouldering an increased workload of nursing and non-nursing tasks in an environment of diminishing resources would be an accurate summary of what nurses have told me. The root of the problem is that although plans to increase productivity and to reduce "inefficiency" have been imposed with the best of intentions, no consideration of their effect on nurses has been taken into account. Nurses' voices have been ignored. Part of this may

be attributed to nurses' traditionally low place in the hospital hierarchy. Recently, however, management restructuring has further reduced their participation in decision making. Nurses realise this better than anyone else and are taking steps to improve matters. My next article examines some of their proposed solutions.

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Research Policy

Is research to be privatised?

RICHARD SMITH

Many of the researchers that I spoke to thought that the perceived crises in research—the inability to support some top graded projects, the difficulty in attracting people into a career in research, and the emigration of good scientists—were all caused by lack of government money and could be resolved by more money. Professor George McNicol, principal and vice chancellor of Aberdeen University, was confident when I spoke to him that this was the case, and Sir Peter Swinnerton-Dyer, chairman of the University Grants Committee told the House of Lords Select Committee on Science and Technology that the problem with the dual support system was entirely one of funding.¹ Others that I spoke to thought that British research had many other problems apart from lack of money, but most felt that relative poverty was a central difficulty. They were particularly concerned that Britain is increasingly lagging behind its "competitors."²

Government expenditure on research: going down

Those who have been bemused by the arguments over how much is being spent on the National Health Service will not be surprised to learn that the arguments over real spending on research are just as complex. In fact, they are more complex because the money for research comes from various sources, some of which are not easily measured; and even government money reaches research workers through more than one route.

Table I is taken from the *Annual Review of Government Funded R&D 1987*, a review that is now published each year, and shows the planned changes in constant terms of government expenditure on research.³ Overall expenditure on research and expenditure on civil research will in real terms stay almost static between 1984-5 and 1989-90, and so will expenditure through the research councils and

the University Grants Committee. This is an improvement from the figures given in the *Annual Review of Government Funded R & D 1986*, when overall expenditure was planned to fall in real terms by about 5% between 1984-5 and 1989-90 and expenditure on civil research was planned to fall by 9% between 1983-4 and 1988-9.⁴ The

FIG 1—Expenditure on research and development, UK 1972-83 (reproduced with permission of Office of Health Economics¹¹).

change in government thinking is not, however, as dramatic as it might seem for reasons that are explained below. Fig 1 shows overall expenditure on a longer timescale, and it can be seen that it increased in real terms until 1981, although much of this increase was on defence research.

The Advisory Board for the Research Councils, which has the job of advising the government each year on the amount it should spend through the research councils, argues that the fall in expenditure on research will be worse than these figures show.⁵ The constant prices