CORRECTION

Page 7

For the diagram on this page substitute that on page 103.
CORRECTION

Page 103

For the diagram on this page substitute that on page 7.
and The Rt. Hon. KENNETH ROBINSON, M.P., Minister of Health.

Gentlemen,

INTRODUCTION

1. We were appointed by your predecessors in July, 1963, with the following terms of reference:—

“To advise on the senior nursing staff structure in the hospital service (ward sister and above), the administrative functions of the respective grades and the methods of preparing staff to occupy them.”

Nursing procedures and pay and conditions of service are outside our terms of reference.

2. The letters appointing us explained that there existed no definition of the administrative and managerial responsibilities of the various grades of senior nurse from ward sister up to matron and no generally recognised system of selection and training for whatever posts might be required; and that our principal purpose would he to consider whether the present structure of senior nursing staff and the scope of their administrative and managerial work needed modification in the light of modern hospital methods. Accordingly we have taken account of the hospital services, not only as they are at present, but also as they seem likely to develop under the Hospital Plans first published in 1962*. The conclusions we have reached extend to the organisation of the nursing services in hospital management groups as well as to the senior nurse staffing structure.

3. It was necessary for us to decide on the meaning of the expression, “administrative functions”. The Bradbeer Committee had gone over this ground before us and had drawn up a “list of the administrative duties ordinarily proper to senior nursing staff”†. This provided a description of the field we were to survey, but we thought it desirable to have an analytical definition also, for use in exploring it. “Administrative” seemed to us to have much the same meaning as “managerial”. We therefore took “administrative functions” to mean the work of ordering and co-ordinating jobs and the people who do them. We have seen no reason to revise this definition, on the understanding that in top posts managerial work includes a policy-forming function. The word “nursing” in our terms of reference we understood in a comprehensive sense, to include midwifery and the training of nurses and midwives for their work.

4. The ambiguity of some terms used in discussing nursing administration caused us difficulty. We have therefore drawn up, in Appendix 1, a short

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London, H.M.S.O.
Scottish Home and Health Department, 1962. A hospital plan for Scotland (Cmnd. 1602). Edinburgh, H.M.S.O.

glossary, giving the sense in which we have used them and defining others we have introduced.

5. We held our first meeting on 18th September, 1963, and issued a press notice inviting submission of memoranda of evidence. In December, 1963, we invited a number of organisations to give written evidence. For this purpose we circulated the list of questions given in Appendix 2. Later we invited some organisations and individuals to give oral evidence. A list of those who gave evidence is given in Appendix 3. We are most appreciative of their co-operation which enabled us to make an extensive survey of informed opinion.

6. We supplemented our survey of opinion with some fact finding. This included visits to the hospitals listed in Appendix 4. Through these visits we gained useful knowledge of administrative practice in different hospital groups and also had an opportunity for discussion with senior nurses of most grades, with members of governing bodies and with medical and administrative staff. We found this part of our work particularly stimulating and informative. We considered the desirability of enquiring into how nursing administration was conducted in other countries; be we concluded that, since their hospital systems were usually so different from ours, the value of any ideas we might get would be far outweighed by the time and effort involved in such a survey.

7. At an early stage we realized that the available statistics gave little information about the scope of the present senior nursing posts or about the people in them. We therefore arranged for the Statistics Division of the Ministry of Health to conduct a census on our behalf, covering all senior nursing staff above the grade of ward sister and about one in three ward sisters, charge nurses and midwifery sisters. The response was excellent and we are very grateful to all concerned in preparing, distributing, completing and analysing the questionnaire forms. The resultant material, which is surveyed summarily in Appendix 5, is valuable in itself, apart from its relevance to our own report. We have therefore arranged for a fuller account to be produced in a statistical appendix to be submitted separately.

8. Much factual material derived from past work study was made available to us by the National Health Services Central Organisation and Methods Unit of the Ministry of Health, which also undertook at our request a number of studies, including one of administrative arrangements for nurse training. We also wish to acknowledge the co-operation of the Minister of Health’s Standing Nursing Advisory Committee, who made available to us material collected by their sub-committee on post-certificate training and education of nurses and a recently completed first report relating to registered nurses in general hospitals up to and including the grade of ward sister. This supplements, from the point of view of further training for clinical work, our own report which concentrates on the managerial aspects of the work of senior nurses.

9. We have held 27 meetings, each usually extended over two successive days. One was held in Edinburgh and was attended by officers of the Scottish Home and Health Department. We are most grateful to all in the two Health Departments who assisted us, and in particular to Miss Kathleen A. Raven, Chief Nursing Officer, and Mr. L. G. S. Mason, O.B.E., Assistant Secretary of the Ministry of Health, who attended our meetings; and also to Dr. E. R. Bransby and his staff for their work on the statistical enquiry.
10. As a Committee we have been exceptionally fortunate in our Secretary, Mr. F. D. K. Williams, whose services in guiding us through the procedural pitfalls, tactfully pointing out the issues before us and recording our discussions with concision and lucidity, have been invaluable. We wish to express our very warm thanks to him for all the energetic help which he has given us: his contribution to our work has been a notable one. We also wish to record our appreciation of the services of Mr. N. R. Warner who has assisted our Secretary so ably.

11. In Chapter 1 of our report we outline our views and proposals. In Chapters 2 and 3 we describe the scope and structure of nursing administration in the past, the present position and the pattern we propose for the future. In Chapters 4 to 8 we explain the jobs of senior nurses in the various grades under the proposed staffing structure, and indicate the roles of committees and conferences in relation to nursing. In Chapter 9 we make recommendations for the selection and preparation of nurses for administrative work. Finally, in Chapter 10 we suggest how our proposals can be carried into effect.
CHAPTER 1

Outline of the Report

1.1 Despite the Bradbeer Committee's remarks* on the partnership of nursing with medical and lay administration, nursing appears to occupy a secondary position. This stems from the incoherence of the nursing administration itself and a seeming inability on the part of nurses to assert the rights of their emergent profession. The profession is not represented officially and with the same status at meetings of all governing bodies as are the medical staff and the hospital administration. It seems to us that the assertion of the professional status of nurses could best be achieved by assuming the right of the profession to be heard (sapiential authority, as it is called) on all matters concerning nursing that are controlled by governing bodies; to present to those governing bodies the profession's concept of nursing policy; and, so far as possible (that is, where co-ordination with the other administrations is not involved) to decide the policy. This will require elevation of the status of the most senior nurse administrator in each hospital group.

Staffing Structure and Grades

(i) The present position

1.2 Confusion arises from the indiscriminate and imprecise use of the title "Matron". It is applied equally to the nursing heads of large hospitals of over a thousand beds and of small hospitals of as few as ten. The Matron of a small hospital is recognised as having the same duties and so the same rights as the Matron of a large hospital within the same group, rights such as attending the Management Committee or Board of Governors to which all matrons are directly responsible. The only recognition of difference lies in the Whitley salary grading which is based upon number of beds, not upon the importance of the decisions taken. The Assistant or Deputy Matron in a large hospital may well have as onerous tasks as the Matron of a small hospital but is accorded neither the status nor the prestige.

1.3 There is also confusion about the functions of nurse administrators in the hospital organisation, least for the Ward Sister, more for the Matron and most for nurses in the intermediate grades. As in industry and commerce where the belief survives that ability to manage is not learned but innate, nursing administration is still in the process of development. Matrons tend, for example, to hold on to tasks in which they are interested, tasks which could be carried out by other nurses or even a well-trained clerk. Few matrons appear to practise the technique of delegation. Nor do they seem to aim at decentralisation, that is, arranging that decisions of the appropriate level are taken as near as possible to the scene of the activities where these decisions are required. The Assistant Matron is often treated exactly like an assistant, not as a person between the Matron and the Ward Sister, and to whom the right to command the Ward Sister (structural authority) is delegated by the Matron. The Ward Sister feels she is responsible to the Matron, a remote person in a big hospital, and not to the Assistant or Deputy. The result is that Ward Sisters regard Assistant

Matron and such “administrative posts” as of no great importance or consequence and merely as tiresome stepping stones in advancement to the desirable post of Matron.

1.4 The confusion is further complicated by difficulties stemming from traditional and widely differing beliefs on the relative status of administrative nurses in general nursing and of those in teaching and midwifery; as well as a feeling that psychiatric nurses and midwives are of a nursing world apart.

(ii) The proposed structure

1.5 We distinguish the decision to establish a nursing policy from the decision concerning the programming of the policy, that is setting the limits within which those who execute the policy, may decide to act. For example, a nursing policy decision may be the specification of a procedure for carrying out a nursing technique. The relevant programming decision may be concerned with the ordering of new equipment and the withdrawal from ward stocks of items no longer required, the communication of the new procedure to all concerned and the organisation of any necessary instruction for nursing staff and nurses in training. The executive decision, the act of bringing the new procedure into operation, will be undertaken by the ward staff under the control of the Ward Sister. Those who decide policy, the most senior officers, we propose to call top management, those who programme policy middle management, and those who control the execution first-line management.

1.6 At present, in a small hospital, the Matron may carry out both top and middle management functions, whereas in a larger hospital she may (or should) delegate to the Deputy and Assistant Matrons the tasks of middle management together with the right to give orders for the programme to be executed. If the small hospital is properly integrated within a group, or is satellite to a large hospital, the policy decisions should be made by the controlling or co-ordinating head nursing officer, and the Matron of the small hospital should be delegated only the tasks of middle management. She is then of status equivalent to that of the nurses in middle management in the large hospital. Status is established by the kinds of decision that are made not by numbers of beds controlled.

1.7 In large hospitals, and especially in the larger district general hospitals proposed in the Hospital Plans, the organisation of necessity becomes more complicated. The number of nurses executing the programme is large (the Staff Nurses). Their tasks and they themselves are organised and co-ordinated by the Ward Sister or Charge Nurse who is then in control of what may he called a section. (This may be an operating theatre section, a teaching section or out-patient section with no beds as well as a ward.) A logical grouping of such sections (three to six) constitutes a unit, the sphere of authority of a nurse in middle management; and again, a grouping of units constitutes an area, co-ordinated by a more senior middle manager. (We use the term area since very often the units to be co-ordinated are in physical proximity). Areas and units are brought together as a division, the sphere of authority of a nursing officer in top management.

1.8 There are three possible kinds of division—nursing, teaching and midwifery—for, wherever possible, a single school of nursing should be formed.
for the hospitals of a management group, and midwifery has peculiarities, statutory and otherwise, which distinguish it from general nursing. Where there is more than one division a more senior nursing officer in top management should co-ordinate the work of heads of divisions and be the nursing representative to present matters of nursing policy to the governing body of the hospital management group.

1.9 The organisation of nursing posts in a group can then be set out fairly simply and numbered in grades from 10, for the most senior nurse in top management, to 5 for the Staff Nurse who executes the programme (the lower numbers, 4 to 1, are applicable to grades below Staff Nurse).

<table>
<thead>
<tr>
<th>Level</th>
<th>Number and general title of grade</th>
<th>Local titles of posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top management:</td>
<td>10 Chief Nursing Officer</td>
<td>C.N.O. Chief Nursing Officer.</td>
</tr>
<tr>
<td></td>
<td>9 Principal Nursing Officer</td>
<td>P.N.O. Principal Matron, Principal Tutor.</td>
</tr>
<tr>
<td>Middle management:</td>
<td>8 Senior Nursing Officer</td>
<td>S.N.O. Senior Matron, Senior Tutor, Senior Midwife Teacher.</td>
</tr>
<tr>
<td></td>
<td>7 Nursing Officer</td>
<td>N.O. Matron, Tutor, Midwife Teacher.</td>
</tr>
<tr>
<td>First-line management:</td>
<td>6 Charge Nurse</td>
<td>C.N. Ward Sister, Section Sister, Midwifery Sister, Charge Nurse.</td>
</tr>
<tr>
<td></td>
<td>5 Staff Nurse</td>
<td>S.N. Staff Nurse, Staff Midwife.</td>
</tr>
</tbody>
</table>

1.10 The general titles can be used in any system for either sex, but they need not be applied rigidly in all hospital groups. Other local titles can be used, of which examples are given above, provided the grade is clearly specified. There is good reason for retaining the title of "Matron" for women. It has a long and honoured tradition and has profound significance to the general public. In general we recommend the use of "nursing officer" (which can be applied to male as well as female nurses) with appropriate adjectives to indicate the grade of management. We think the prefixes "assistant" and "deputy" should be abolished since they are confusing and do not indicate the nature of a job. An even number grade indicates a co-ordinating function in each of the three management levels, this co-ordination being exercised either by full control (the juniors being responsible to the superior) or by actual control (the juniors being responsible to a nurse in the level next above but reporting to the immediate superior). In the top-management level the Chief Nursing Officer (Grade 10) may have either full or actual control—the heads of divisions being responsible to the governing body in the latter case—or may co-ordinate by the use of her greater knowledge of the total nursing situation (sapiential authority), that is, by the use of direction as distinct from control.

1.11 This use of sapiential authority is also the essence of the process of secondment by which nurses can co-ordinate the activities of persons under the control of the hospital administrator, persons who can carry out many of the tasks now performed by nurses that are not properly nursing. We recommend that, wherever possible, nurses and nursing officers be relieved of all such tasks.

**Implications for Nursing Careers**

1.12 The proposed structure is diagrammatically, but not completely, represented in Figure 1. This shows the pyramidal nature of the structure which is of great concern in the matter of promotion. At present the pyramid is very
narrow and insufficiently extended in the upper portions, that is to say there is limited scope for promotion. There is little incentive on this account for highly competent nurses to stay in the profession and it is disheartening for those who do. The addition at the top to the rungs in the promotion ladder, as well as the widening of the lower ones, will permit of more frequent, and evident, progression upwards in status—reward for work well done. The uniform grading, too, will remove many present anomalies in relative status and will reduce the discontent that is a consequence.

<table>
<thead>
<tr>
<th>Grade</th>
<th>I</th>
<th>II</th>
<th>III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Nurse</td>
<td>School of Nursing training leading to registration</td>
<td>University course leading to degree and registration</td>
<td>School of Nursing training leading to registration</td>
</tr>
<tr>
<td>Staff Nurse (5)</td>
<td></td>
<td>Preparatory course for first-line management</td>
<td></td>
</tr>
<tr>
<td>Charge Nurse (6)</td>
<td></td>
<td>Preparatory course for middle management</td>
<td></td>
</tr>
<tr>
<td>Nursing Officer (7)</td>
<td></td>
<td>University certificate or diploma course</td>
<td></td>
</tr>
<tr>
<td>Senior Nursing Officer (8)</td>
<td></td>
<td>Preparatory course for top management</td>
<td></td>
</tr>
<tr>
<td>Principal Nursing Officer (9)</td>
<td></td>
<td>Chief Nursing Officer (Grade 10)</td>
<td></td>
</tr>
</tbody>
</table>

1.13 The recommended structure may also answer a need that was often expressed in evidence, a desire to remain "close to the patient". This attitude, wholly admirable and indicative of the professional sense of service, is also a contributory cause of some of the defects in the working of the present structure. Senior nurses tend to interfere in ward matters more than they ought to, and, however laudable it may seem for the administrative nurse to "roll up her sleeves" in the wards, it is often really a satisfying of her own needs and not a service to patients or Ward Sisters. If the senior managerial positions are clearly seen to be of greater importance, in service to more patients rather than "to the patient", these positions become desirable to the nurse with a developed sense of vocation.
1.14 Nevertheless many nurses do not wish to exchange practical nursing for managerial posts and it must be admitted that some highly skilled nurses do not have the managerial capacities that are necessary for the most senior positions. Their particular skills must be recognised and used to the full. There can be promotion to Nursing Officer (Grade 7) in control of a specialised unit, or area even in some cases. A Nursing Officer in such a post can use her accumulated specialised skill in developing her unit; and the title of Matron then becomes a mark of that nursing skill. Similarly, by the institution of teaching divisions, a promotional ladder is provided for nurses who have a proved aptitude for teaching and who wish to remain in that field. The structure we recommend is suitable for advancement of nurses in three different ways, according to the manner in which they wish to serve in their profession—in specialised nursing, in nursing administration and in teaching.

1.15 Nurses in top management need, most of all, well developed managerial skills. They should not be required to have a basic qualification in each kind of nursing represented within their sphere of authority. We see no reason at all why the head of a midwifery, or a psychiatric or a teaching division should not become a Chief Nursing Officer of a group of hospitals. Provided he or she has shown the proper managerial ability it does not matter the route taken to the top. The Chief Nursing Officer can adequately represent all divisions of nursing to the governing body and its committees by proper managerial consultation with the Principal Nursing Officers controlling the various divisions. Depending upon the composition of the group of hospitals the Chief Nursing Officer may have full control of all the hospitals, or may control only some and co-ordinate them with the others, either by actual control or direction.

**JOB DESCRIPTIONS**

1.16 Because of the confusion that already exists and would be likely to follow re-organisation should our recommendations be accepted we have believed it necessary to provide job descriptions for posts in all grades from Staff Nurse to Chief Nursing Officer including the post of Regional Hospital Board Nursing Officer. The descriptions illustrate the principles of delegation and decentralisation. The tasks are specified as “professional”, those which are dependent almost wholly upon knowledge of nursing; as “administrative”, those concerning the ordering and co-ordinating of jobs and people (our conception of the word management); and as “personnel”, those concerned with the welfare and morale of staff.

1.17 These job descriptions are to be regarded as guides. They are not complete for every job in every hospital—but they can be used as models by nursing officers in analysing the jobs of their juniors. Frequently it will be discovered that some are too much occupied with tasks of lower grade (as a Ward Sister involved in a flood of clerical work) or, in default of proper delegation at higher levels, occasionally having to make decisions of higher grades. The present job of Matron in particular will be found to have many such anomalies. The governing bodies should have jobs analysed and eventually specified according to uniform, national standards. This in itself will go far towards the required reorganisation. It will also be helpful in establishing a more rational method of determining salaries than in the present system, based upon numbers of beds and whether training is involved or not, a system which tends to stifle both
incentive and motive towards greater efficiency of the nursing service. Job specifications, if properly executed and leading to better organisation, will also encourage better communications, and there is some evidence to show that the result is likely to be improvement in patient recovery.

The Role of Committees in Nursing Administration

1.18 Communications and organisations are affected by the existing "committee" structure which has contributed to the confusion already mentioned. There are wide differences in the numbers and kinds of committees, membership and function, set up by governing bodies. It appears to us that there are too many "nursing committees"; much of their work, bedevilled by cumbersome procedures, could be carried out by officers—nurses and others—using informal consultative techniques. We recommend that meetings be properly defined, and their purposes clearly specified, whether for consultation or decision. We regard as most important the use of organised conferences through which all grades of nursing staff can contribute of their personal knowledge towards better nursing decisions. This itself is part of the movement away from the rigid and authoritarian system of command that has survived from the 19th century—it is more democratic, it leads to better communications, it is beneficial to the patients.

Preparation and Selection for Senior Posts

1.19 We are aware that these changes we recommend cannot be implemented unless nurses are educated to the jobs we describe. Accordingly we have proposed a broad scheme of systematic education and training for promotion upwards through first-line to top management, with accent upon progressively increasing managerial skills. But it should never be forgotten that complete reliance upon external "courses" is not the solution to the problem of developing administrative talent. The best education and training is "on-the-job", a constant process which is a prime task of every superior, and a duty which is owed to the junior. Again, a good job description provides the basis for this teaching.

1.20 With reorganisation into a logical scheme of grading and its attendant educative process, it is possible to establish a system of selection. We recommend the establishment in each region of a regional nursing staff committee with the functions of ensuring that appropriate courses for first-line and middle management education are available and of providing a panel of assessors for appointments to posts in Grade 8 and above. Two national nursing staff committees would have functions of setting standards for centres of management training and of supplying a nurse assessor for posts in Grade 10. We stress particularly that general and psychiatric nurses, teachers and midwives, should undergo the same managerial education, and together; for all should have the same opportunity to demonstrate their eligibility for the most senior posts where managerial ability and not nursing is the important criterion. Moreover, this joint education for the top posts will tend to weld all nursing, naturally separated in the lower grades, into one nursing profession which is coherent and felt to be coherent.
APPLICATION OF THE PROPOSALS

1.21 Lastly we recognise that the changes we recommend will not be easy to carry out. We therefore suggest a scheme of progressive implementation, locally, regionally and nationally, with a programme of five stages, from organised presentation of our ideas to review of existing organisation and re-constitution of jobs according to the job descriptions, education and preparation of officers for the highest posts, pilot schemes in one or two groups in each region, and then extension throughout the region.
CHAPTER 2

Historical Review of Nursing Administration

2.1 Against a background of social change and medical progress over the last hundred years, there have been changes of emphasis in the purposes of hospitals. They have not been simultaneous for all types of hospital but the trend has been uniform—from custody of the infirm or insane, to their care, and, finally, to their treatment and cure. There have also been changes in the functions of nurses, their preparation and their organisation in a staffing structure.

BEFORE REFORM*

2.2 Before the time of Florence Nightingale, except in some religious orders, nursing staff were given no formal training, either before or after appointment. Each grade—Matron, Sister, Nurse—was separately recruited. Suitability for employment was thought to be given by social background and previous employment.

2.3 The title of Matron can be traced back to the 16th century. In the voluntary hospitals she was normally a married woman, a widow of respectable background. Her duties were of those of a housekeeper; they did not extend to teaching and hardly to supervision of the nurses, and she had little opportunity to understand their work. Next to the Matron were the Sisters, a title of religious origin; they were of a higher social class than Nurses, who were rarely promoted. In addition to domestic supervision the Sisters were responsible for seeing that the doctors' orders were carried out, particularly in regard to the issue of medicines. Finally, there were the Nurses, of the domestic servant class, ill-paid and largely illiterate. They worked closely with the doctors, from whom they received their orders and in the course of their work derived some practical instruction.

2.4 In the Poor Law Infirmaries, nursing featured even less in the Matron's duties. Most had no paid nurses, but employed the inmates to nurse the sick.

FLORENCE NIGHTINGALE AND REFORM

2.5 Florence Nightingale's knowledge of nursing as practised by religious orders on the Continent led her to conclude that patients' recovery depended very greatly on the quality of the nursing and that this in turn depended on the training and organisation of the nurses. She used the peculiarly English "voluntary" hospital, as a practical instrument for translating her ideas into action and in 1860 founded the Nightingale Training School at St. Thomas' Hospital. The discipline in the training came from the religious systems of the Continent and was perhaps influenced by the Army, but it had its justification in the conventions of the age: if educated women, that is, gentlewomen, were to be attracted to nursing, strict tutelage was necessary. For the lady-pupils especially, the Nightingale Training School for Nurses became, in effect, a training ground of future matrons. The revolutionary features of her system were, first, that nurses should be trained to master their subject as men were trained to master


Much of the material in this chapter comes from this study.
their, and, second, that the entire control of the nursing staff as to discipline and training should be taken out of the hands of men and lodged in those of a woman—the Matron, responsible only to the governing body of the hospital and not to a hospital director.* This second feature was not entirely acceptable in Scotland; but in England the Matron was already an established figure, opposition was gradually overcome and it became the generally accepted pattern, the Matron taking over some functions which, if discharged at all, had belonged to the hospital administration or the doctors.

**AFTER REFORM**

2.6 The new pattern is illustrated by the following extract from a memorandum drawn up in 1879, with oversight from Florence Nightingale, by the Matron of St. Mary's Hospital, which at that time contained 190 beds:

"The matron, night superintendent, sisters (with a few exceptions) and day and night nurses have all been qualified as 'Trained hospital nurses' before entering upon their present duties: the night superintendent is a lady of education and the sisters as a rule are selected from the class of gentlewoman. As to the respective duties and qualification of the staff—

The Matron is essentially the active head of the nursing staff besides having charge of the kitchen and nursing arrangements. As such she is held responsible to the Governors for the due performance by the nurses of their duties as well as for the conduct and general discipline of the whole female staff. She is empowered (subject to the control of the Governors) to engage and dismiss nurses and female servants.

Night Superintendent. A lady of education qualified as a trained nurse ranking next to and responsible to the matron whose duties in case of absence she performs. She has the direction and control of the night nurses during the hours of night duty, and assists the matron in other matters so far as her night work will allow.

Sister. The head of the ward, responsible directly to the matron, a gentlewoman qualified as a trained nurse. Upon her rests the management of the ward and direction of the ward staff. It is her especial duty to receive, and by herself or her assistants to carry out the orders of the medical officers. She trains the probationer nurses in their ward work both by direct instruction and by working with them".†

2.7 This system was being adopted generally in voluntary hospitals in England and Wales by 1880, both general and special, including maternity hospitals. Attempts to extend it to Poor Law infirmaries and fever hospitals established under the Public Health Acts were less successful. By 1900, only some of the richer and more progressive authorities had appointed trained Matrons to hospitals with training schools. It was not until after 1929 that the process became intensified. Then the administration of the Poor Law institutions passed from the Boards of Guardians to the County and County Borough Councils, many of whom energetically exercised the powers given to them to take over the workhouse wards and run them as hospitals. There was a difference however—the hospitals were administered through the office of the Medical Officer of Health and it was usual for his representative, the Medical Superintendent, to be responsible for the administration of the whole hospital and for the Matron

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to be subordinate to him. In Scotland the traditional practice in all hospitals was for the Matron to be regarded as a member of the Medical Superintendent’s staff.

2.8 In midwifery the need for organised training of women achieved rapid recognition. This culminated in 1902 with the first Midwives Act and the inception of Central Midwives Boards to regulate their practice. Hospital midwifery remained largely a Poor Law provision until the establishment in 1919 of the Ministry of Health, on whose advice local authorities provided maternity homes, in self-contained units of from 15 to 20 beds, administered by the Medical Officer of Health. The proportion of births which took place in institutions increased rapidly.*

2.9 The asylums had been administered since the middle of the 19th century under legislation separate from the Poor Law, and the Nightingale system at first made less impact on them. There were often married couples under various titles, including master and matron, who looked after the male and female sides respectively. Training was already being instituted by the medical superintendents. The Royal Medico-Psychological Association’s certificate, first instituted in 1891, remained the generally recognised mental nursing qualification until after 1951 when it was superseded by those of the General Nursing Councils. After about 1900, women nurses, trained in general hospitals, began to be brought in to become Matrons of asylums. They introduced some features from general hospitals into the nursing organization and this was accentuated during the first world war when female nurses came to nurse male patients. The Matron was required to be S.R.N. (in Scotland, R.G.N.) as well as R.M.N. and was responsible for training for the Register (R.M.N.). (After 1948, head male nurses were mostly given equal status with Matrons; and some have been given nursing control of both sides of the hospital.)

**Development of the Pattern**

2.10 Under the Nightingale pattern the Matron’s functions could be arranged in three groups—as head of nurse training, as head of the nursing service and as housekeeper. Her position as head of her department, responsible directly to the Board of Governors, became part of the tradition of the voluntary hospitals, but there were changes of function. The changes were associated with the recognition of nursing as a profession (with a statutorily recognised qualification), the elaboration of medical treatments, and the increasing complexity of housekeeping in the larger hospitals. In consequence there was partial delegation by the Matron of some functions to a staff of administrative nurses and tutors.

2.11 *Nurse training.* Originally each Matron at a hospital with a training school trained her own probationers and awarded certificates to those who proved satisfactory. After 1919, however, the title of “registered nurse” became reserved for those trained in training schools approved by the General Nursing Councils and admitted to the Register by examination. Specialists were therefore brought in to teach: the need had in fact already been felt and the first appointment of a Nurse Tutor was made in 1914. The Matron remained the head of

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*In England and Wales, the proportions increased from 15% of live births in 1927, to 24% in 1933, 35% in 1937 and 54% in 1946.*
the training school and selected the student nurses, but, in co-operation with
the tutors, she had to meet the training requirements of the General Nursing
Council.

2.12. Nursing service. In the 20th century the techniques at the disposal of
government doctors increased rapidly. Their requirement of skilled assistance in
applying them was met in part by nurses; but they came also to rely on others,
many of them women, who were not nurses—dietitians, laboratory technicians,
occupational therapists, physiotherapists, radiographers, etc. Such staff were
not always controlled by the Matron (though she might have administrative
charge of a training school for radiographers, for example), and their place
in the hospital was often not at all clear. This added to the complexity of the
Matron’s work, though not to her authority.

2.13 Housekeeping. Under the original pattern, cleaning, catering, laundry
and care of the linen were carried out by subordinate domestic staff, and often by
nurses, under the control of the Matron and her senior nursing staff. With the
need to conserve nursing skills people came to be appointed to supervise these
services, who were not themselves nurses, though responsible to the Matron. In
some hospitals the domestic superintendents, etc., became heads of departments:
some were responsible to the Matron, some to the Secretary or Steward, and
occasionally responsibility was uncertain. Whatever the arrangement, the general
trend in the larger hospitals was for the Matron to discard the housekeeping
duties which had originally been her most important function.

2.14 The shortage of trained nurses led to concern with their salaries and
conditions of service and to the constitution for England and Wales of the
Rushcliffe Committee and of a similar committee for Scotland under Professor
Taylor. The definitions of grades instituted by these committees were the basis
of the work of the Nurses and Midwives Whitley Council established with the
National Health Service.

Development After 1948

2.15 When the National Health Service came into being in 1948, hospitals
were grouped for administration in England and Wales under Hospital Manage-
ment Committees or Boards of Governors (for teaching hospitals, that is,
hospitals associated with medical schools) and in Scotland under Boards of
Management. Since most groups were formed on a geographical basis, former
voluntary hospitals were joined with hospitals previously administered by local
authorities.

2.16 An important effect of such grouping on nursing administration was the
further extension from the English voluntary hospitals of the Nightingale
pattern—that is, one Matron for each hospital, working in partnership with the
principal administrative officer and representatives of the medical staff in the
day-to-day management of the hospital. In England and Wales, as posts of
medical superintendent were discontinued in the former local authority hospitals,
the Matrons came to be regarded as directly responsible for professional nursing
matters to the governing body of the hospital group: and this arrangement
was eventually accepted in Scotland.

2.17 While the status of Matrons in former local authority hospitals generally
improved, in many voluntary hospitals it declined. The intimate relation of the
Matron with governors who were concerned with a single hospital could not be
maintained in a group of hospitals—perhaps fifteen or more, each with its own Matron, with access in some groups only to a House Committee. In some groups the position of the Matron compared unfavourably with that of the Group Secretary and of the medical staff, whose influence was exercised at the level of the governing body. Advice given to hospital authorities by Health Ministers on the relation of nursing heads to the governing body is reviewed in the following paragraphs.

2.18 Hospital authorities in England and Wales were advised at the outset that the Matron “should report directly to the appropriate Committees on the matters for which she is responsible and should have direct access to the Management Committee (or in an emergency to the Chairman) when necessary”;* also that “the Matron of any hospital in a group should be present” at meetings of the governing body “when nursing questions affecting her hospital are discussed.”† This advice was rephrased in 1954 and again in 1959 when the following extracts from the Bradbeer Report were commended in circular H.M.(59)21:

"(i) (Para. 245(26)). ‘The matron should be regarded in her capacity as head of the nursing services as directly responsible to the governing body of the group and should have the right of direct access to it.’

(ii) (Para. 342(3)). ‘The chairman of the group nursing advisory committee or some other matron chosen by the matrons of the group to represent them should also be present at meetings [of the governing body].’"

In 1961 the policy was re-stated in circular H.M. (61) 79:

“The Minister considers that a matron should have the right to attend all meetings of the House Committee in her own hospital and to attend meetings of the Hospital Management Committee or Board of Governors when matters directly or indirectly affecting her own department are being discussed.”

“In addition one matron should attend all meetings of the Board of Governors or Hospital Management Committee to represent all the matrons in the Group. Chief male nurses should attend and be represented in the same way.”

2.19 In Scotland similar advice was given in circular S.H.M.(55)32 on attendance by Matrons at meetings:

“... If however the matron is to be able to carry out her duties effectively, she must be fully aware of all matters affecting her sphere of responsibility which may be before the Board or its committees, and must have an opportunity of tendering advice before decisions are taken. At least one matron from a hospital in a group should . . . attend meetings of the Board of Management (or of any committee at which the general business of the Board is mainly carried on).”

But a different view was taken on her responsibility:

“The matron’s responsibilities lie, not directly to her Board of Management, but to the medical superintendent or in certain matters to the group secretary. Questions which arise in the ordinary course of day-to-day work will normally be settled with these officers, as appropriate, within the framework of general decisions of the Board of Management.”

†R.H.B.(49)25/H.M.C.(49)17/B.G.(49)19.
This advice was modified in 1958 in the light of a recommendation in the Henderson Report:* 

"As the Report says, the matron should be directly responsible to the Board for nursing matters but should work in partnership with the medical administrator in view of his concern with nursing questions".†

†S.H.M.58/45, confirmed in S.H.M.34/1964.
CHAPTER 3

The Future Pattern of Nursing Administration

3.1 In this chapter, before outlining our proposals for a new staffing structure, we review the present arrangements for nursing administration and consider the factors which should influence its development. Since nursing administration cannot usefully be considered in isolation from the rest of hospital management, we first describe the characteristics of hospital groups, the general arrangements for their management at present, and the changes in their managerial organisation likely to be brought about as a consequence of the Hospital Plans.

HOSPITAL MANAGEMENT

(i) Characteristics of hospital and hospital groups

3.2 Hospital groups vary greatly in size, from under 50 beds (in the Northern Region of Scotland especially) to over 3,000. Hospitals exclusively for dental purposes generally have no beds, only clinics. The extent to which the activities of the constituent hospitals are co-ordinated varies from one group to another.

3.3 In England and Wales each of the 36 teaching hospital groups is deemed "to be a single hospital" for the purpose of the National Health Service Act; and their administration does tend in fact to be more closely integrated than in most non-teaching hospital groups. In the regions there were, at the end of 1963, 2,399 hospitals in 366 groups. Rather more than half the groups were in the bed-range, 500 to 1,499: 1,920 (nearly 80%) of all the hospitals had only 200 beds or less and of these 960 (over 40% of all the hospitals) had only 50 beds. Mental illness hospitals tend to be larger: only 17% have less than 200 beds, while 65% have over 600 beds. Hospitals for the mentally sub-normal are smaller and more numerous than those for mental illness: only about 15% of them have over 600 beds.

3.4 Table I shows the average distribution of hospitals, by size, in groups of different sizes in England and Wales in 1963.

**Table I**

Distribution of hospitals by size: England and Wales

<table>
<thead>
<tr>
<th>Size of group</th>
<th>Numbers of hospitals by size</th>
<th>Average total number of hospitals per group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50 beds and under</td>
<td>51 to 200 beds</td>
</tr>
<tr>
<td>Under 500 beds ...</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>500 to 999 beds ...</td>
<td>3</td>
<td>2—3</td>
</tr>
<tr>
<td>1,000 to 1,499 beds</td>
<td>2—3</td>
<td>3</td>
</tr>
<tr>
<td>1,500 to 2,000 beds</td>
<td>2—3</td>
<td>3</td>
</tr>
<tr>
<td>Over 2,000 beds ...</td>
<td>1—2</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Ministry of Health statistics.

Notes: (1) In a few groups only.
(2) In about half the groups.
There is great variety, both between different regions and within each region itself. Thus the average number of hospitals in a group varies from 4.2 in the South West Metropolitan Region (which nevertheless has groups of 12 or more) to 9.8 in Wales (which however has one group consisting of a single hospital). There is equal variety in the extent to which groups contain hospitals of different types. Some groups consist entirely of hospitals for mental illness or for mental subnormality; in others, psychiatric hospitals are grouped with hospitals of other types—general and specialised.

3.5 In Scotland at the end of 1963 there were 381 hospitals in 82 groups. Two-thirds of the groups have less than 1,000 beds; but—if the sparsely populated Northern and North Eastern Regions are excluded—the picture presented is much the same as in England and Wales, with over half the groups in the bed-range, 500–1,499.

3.6 In many groups the hospitals have little in common except the same governing body and the fact that they provide a hospital service in a particular geographical area or of a particular kind, for mental illness, for example; and coordination may be limited to what the Group Secretary needs to do in arranging the business of standing committees. In some groups, the hospitals may be organised for administrative purposes in sub-groups, with the same Hospital Secretary and perhaps the same House Committee. They may also be associated for operational purposes, but not necessarily in the same sub-groups, for example, a large acute hospital takes the more difficult cases from smaller hospitals and in turn passes on to them the convalescent cases.

(ii) Management of individual hospitals

3.7 In small hospitals a common pattern of management is an equal partnership of the Matron and Hospital Secretary (who may serve more than one hospital) in which managerial decisions are often taken jointly, under the supervision of the governing body and in consultation with the medical staff: but—and particularly in Scotland—there are many small hospitals to which no Hospital Secretary is appointed, and more managerial functions have to be undertaken then by the Matron with such support as can be given from headquarters by the Group Secretary or the Medical Superintendent.

3.8 At the other extreme are the larger hospitals, often at the headquarters of a group, where the supporting services are organised each under a head of department—catering, cleaning, building maintenance, engineering, pharmacy, physiotherapy and others—and to co-ordinate them the functions of Hospital Secretary are often assumed by the Group Secretary himself, or by his deputy. Some of the heads of departments may have no functions outside the main hospital, except sometimes to give advice.

(iii) Management of hospital groups

3.9 For hospital groups the general arrangements are described concisely in the Henderson Report:

"While in Scotland we have in the large general hospital groups two officers of (in theory at least) equal status, there is in England one chief administrative officer of the Board—the Secretary. Although English hospital groups are organised on the tripartite conception of hospital administration—medical, nursing
and lay, each operating within its own sphere—the Secretary has a general co-
ordinating function over the whole range of the group’s activities”.*

The report endorses the traditional Scottish practice of having an administrative
medical superintendent as “co-ordinator of all activities within the hospital” and a “lay administrator . . . responsible (to the Board not the medical superin-
tendent) for those departments of the hospital in which the lay interest pre-
dominates”, and recommends that the Matron should in future be the officer
responsible to the Board for nursing matters.†

THE HOSPITAL PLANS

3.10 If changes are to be made in the organisation of hospital services, there
will need to be adjustment of the arrangements for their administration, in-
cluding the administration of the nursing services.

3.11 The Hospital Plans published in 1962 indicated great changes in the
character of the typical hospital and of the hospital group. These plans are not
in themselves revolutionary for they seek only to accommodate changes in the
techniques of medical practice which are already taking place. The changes are
in accord with the scientific and technological advances which have been made
during the first sixty years of the 20th century, exceeding the total of all such
advances during the previous nineteen centuries. There is no reason to sup-
pose that the explosive character of developments will not continue in the second
half of the century and inevitably further influence medicine. The new tech-
niques are usually expensive and expert management will be needed, in which
nurses should play their part, if costs are to be held in check.

3.12 The hospital pattern outlined in A Hospital Plan for England and Wales is
based on the concept of the district general hospital, located at or near the centre
or one of the centres of the population which it serves, and placing at the dis-
posal of patients the full range of hospital facilities. Mental illness hospitals
for long-stay patients are to be smaller than at present and in less isolated
positions: short-stay patients are to be treated in units attached to district
general hospitals. Sub-normal patients are to be cared for separately from the
severely sub-normal and in small units of up to 200 beds. A maternity unit
will normally be a part of the district general hospital. A large number of the
existing small hospitals will cease to be needed, but many will be retained—as
maternity units for districts remote from the district general hospitals, as long-
stay geriatric units and to provide out-patient services.‡

3.13 In Scotland, the new hospitals to be built are likely to replace hospitals
which already have the functions of district general hospitals, though some may
take over the functions of small acute hospitals which may become geriatric
units associated with the communities they serve. Mental illness hospitals in
Scotland are not isolated and will not have to be replaced on that account.

3.14 It will be many years before all the new buildings are provided under the

†Op. cit., paragraphs 33 and 34.
‡Op. cit., paragraphs 19 to 30. It was expected that district general hospitals would
“normally be of 600–800 beds”, but many are being planned to have 1,000 beds or
more.
Plans, but new buildings may not always be a prerequisite to the adoption of the pattern. On the contrary, if they are to be operated effectively, the principles underlying the pattern should be anticipated, in the use made of existing buildings and of staff and equipment. This can be done, if what are now regarded as separate hospitals are organised as units of a single hospital. This process will be helped if hospital management groupings are revised to accord with the catchment areas of the district hospitals of the future.

3.15 Some Regional Hospital Boards are already amending the management grouping of hospitals in accordance with the new pattern, by amalgamating psychiatric and general hospital groups and by other regrouping which results, generally, in fewer but larger groups. Since the publication of the plans at the beginning of 1962, the numbers of hospital management groups have decreased in England and Wales, from 381 to 350 (July, 1964), and, in Scotland, from 88 to 79 (April, 1964). There is also a trend towards concentrating the training of student nurses in fewer schools; and there are indications that this is being complemented by integration of the training of students (for different parts of the Register and for the Roll) in training schools under a single administration.

3.16 On these facts and assumptions we think it reasonable to use the new hospital pattern as the framework of reference, and to found our proposals for a senior nursing staff structure on the concept of integrated hospital management groups. In the new conditions, a strong common purpose will not, of itself, suffice for co-ordinating what will be an increasingly complex organisation. Clear lines of control must be laid out. Professional administration will be indispensable, under a governing body whose role will be to prescribe policies adapted to the interests of the people served by the hospitals rather than, through their members, to participate in management. The need for reviewing the arrangements for managing hospitals has already engaged attention.*

**Administrative Nursing Links Between Hospitals**

(i) The present position

3.17 The need for co-ordinating nursing over an area wider than that of the individual hospital has long been felt and, despite difficulties presented by the existing staffing structure, some progress has been made towards effecting it. The administrative nursing links already established are of two kinds—for nurse education and training and for nursing service. The former is the more common.

3.18 Area Nurse Training Committees (in Scotland, Regional Nurse Training Committees) advise on and assist with nurse training arrangements in regions. Hospitals have been encouraged to become associated for nurse training

*In England and Wales the roles of Hospital Management Committees and of senior officers in relation to them are included within the scope of four studies of hospital management being undertaken by research teams from Manchester University, the Institute for Operational Research and Lancaster University. In Scotland the Farquharson Lang Committee has been set up by the Scottish Health Services Council, "to study the administrative practice of hospital boards, including the allocation of business to committees and the delegation of responsibilities to officers; and to consider whether, taking account of practice in other fields, any changes are desirable." They have drawn attention in their report to the desirability of establishing for the management in each group "one source of nursing advice" in relation not only to problems in particular hospitals, but also to those of nursing administration affecting the group as a whole.
purposes. Thus in England and Wales, for training for the general part of the Register, approval is given by the General Nursing Council only if there are 300 or more beds available, with an average daily occupancy of at least 240. Since comparatively few general hospitals of themselves have this number, hospitals, formerly “complete training schools”, have either combined to form “group” training schools, or alternatively (sometimes additionally) second their student nurses for part of the time to hospitals which are approved for secondment, but not as training schools. There may be a combined training school in a management group, providing training for the different parts of the Register and for the Roll, or there may be separate training schools for each, and there may be links for nurse education between hospitals in different management groups. As a nurse, throughout her career, will retain the badge of the nurse training school in which she was trained, the bond formed between hospitals by linked nurse training arrangements is a strong one. Hospitals which train for the mental or mental subnormality parts of the Register, being large, are generally complete training schools in themselves. Occasionally in the past, two hospitals have been approved by a Central Midwives Board as a single midwifery training institution for Part I midwifery training.

3.19 In a “group” training school one Matron is recognised as head of the school and has authority to visit the other hospitals to satisfy herself as to the standard of training given, but sometimes a qualified tutor, not holding a post of Matron or Chief Male Nurse, has been made directly responsible to the governing body, under a title such as “director of nurse training”. Only in a few cases has a person other than a Matron or a Chief Male Nurse been recognised as head by either of the General Nursing Councils: in Scotland, up to January, 1965, five such posts had been so recognised—in one case, the earliest, the holder being responsible to the Northern Regional Hospital Board; and only one post in England and Wales.

3.20 Posts for controlling the nursing services of a number of hospitals have usually taken one of two forms; either a “group” Matron, usually controlling a hospital of her own, is appointed with authority to co-ordinate the work of the other Matrons, usually with particular reference to nurse training; or a number of hospitals is regarded for the purposes of nursing administration as a single hospital to which one Matron is appointed. In the second case the organisation is not readily distinguishable from that where the nursing administration of a single large hospital, comprising units at a distance from each other, has been decentralised. There is a third case, of less importance, where one Matron is appointed in charge at two or more hospitals, each with its separate nursing staff.

3.21 Association of hospitals under a single nursing administration, except for purposes of nurse training, has not been encouraged. In 1954 the Minister of Health advised hospital authorities against appointing principal or group Matrons and suggested that “instances where a single Matron can suitably be appointed for two or more hospitals . . . will be exceptional and, as a general rule, each hospital should have its own Matron; a hospital with a bed complement of 200 or more almost always would require its own Matron”; a hospital devoted entirely to maternity work, “of whatever size, should have its own Matron”; and it would be “particularly undesirable to associate a mental hospital or a mental deficiency institution with other types of hospital under
the same Matron".* Difficulties over salary scales also may have checked the combination of hospitals as units of a single large hospital for the purpose of nursing administration. In practice, the salary of an Assistant Matron in charge of such a unit is often related to the number of beds under her charge, unless she is shown to have functions extending over the other units as well; so that the salary compares unfavourably with that of an Assistant Matron holding a staff post in a large hospital as well as with that of Matron of a small hospital.

3.22 In psychiatric hospitals, particularly those for mental illness, the trend towards unifying nursing administration has taken a different form. The need to have two nursing heads, Matron and Chief Male Nurse, is being questioned and in some hospitals, they have been replaced by one post of Principal Nursing Officer. Proposals have also been made for providing a single Chief Nursing Officer for a group which has consisted of a number of mental illness hospitals, each divided into male and female sides.

(ii) Future development

3.23 We agree with the Farquharson Lang Committee on the need to establish an authoritative source of advice on nursing to the management in each group.† Equally, there is need for co-ordination of nursing administration. The aim in all groups must be to organize the nursing administration in such a way as to reconcile the need for strength, through unity of control, with the need for a degree of local autonomy, to allow scope for initiative. The form of organisation should be adapted to the circumstances of the case: there can be a minimum of central control, as in a confederation, or a tighter control, as in a federation. In groups which are functionally close-knit, the solution will lie in the appointment of a group nursing head, to control the nursing services of the group; in others, to appoint one with a co-ordinating function only. In devising the nursing structure, it will be necessary to ensure that it can be fitted to the requirements of the existing and transitional situations and to exceptional situations, such as in the north of Scotland where geographical factors are decisive in determining the organisational pattern of hospitals. Some hospital groups however are unnecessarily small and effective administration of the nursing services would be easier to arrange if the groups were larger.

3.24 It is not only the traditional staffing structure which so far has held back the development of group administration for nursing, in contrast to other hospital departments. There are two other important factors. First, there has been difficulty over demarcating the sphere of authority of the nurse administrator from that of the hospital administrator. Strict definition may be unnecessary in the kind of partnership that often is found between Matron and Hospital Secretary in an individual hospital; but it is essential if a group nursing head is to be appointed. Second, there is apprehension that institution of a post of group nursing head must detract from the initiative of Matrons of hospitals, which is a most valued feature of the hospital services in Great Britain.

3.25 We believe these objections to be groundless in properly organised hospital services. Before outlining our proposals for a new senior nursing staff structure, therefore, we state the principles which we think should govern the solution of these two problems.

*H.M.(54)4.
†See the footnote to paragraph 3.16,
3.26 The starting point is the patient, whose cure or care is the object of the enterprise and to this end many functions are discharged by very many people working together. There should be managers of each major function—nursing, teaching, engineering, accounting and so on—and their duty is to control their subordinates, that is to give them orders and to co-ordinate their jobs. The right to do so we term \textit{structural authority} and it belongs to the office or the post to which a person is appointed. We see the nursing function in hospitals as caring for patients, and carrying out treatment under the direction of doctors and in co-operation with other professional and technical staff. The primary function of the nurse administrator then is ordering and co-ordinating nursing jobs and the people who do them, and these constitute her \textit{sphere of authority}. This may include conducting training schools and institutions in accordance with the requirements of the General Nursing Councils, Central Midwives Boards and other external bodies. It will always include the in-service training and welfare of staff, in their own interest as well as that of the service, for concern with the individual employee as a person is an essential part of management. In the second place, the nurse administrator may have additional duties, according to the way in which the supporting services are ordered.

3.27 The right decisions can be taken by managers, however, only if they take proper account of all the circumstances. For this they need information and advice from those who have expert knowledge in their own field. No one is obliged to act upon the advice of an expert hut, if to ignore it is likely to frustrate the object, such conduct would be irresponsible. This authority of the expert we have called \textit{"sapiential authority"}. It comes, not from an office or post, but from the qualities of the individual. In the conduct of a complex enterprise such as a hospital or a hospital management group it is essential, if good decisions are to be made in any sphere by those whose duty it is to make them (structural authority), that those who can contribute to making them good through expertness (sapiential authority) should have an opportunity to be heard.

3.28 Under the Nightingale pattern catering, domestic cleaning, linen and laundry, and staff residences were usually placed in the Matron’s sphere of authority. The current trend, rightly, is to relieve her of responsibility for them. This is not to imply that nurses have no interest in their efficient functioning. On the contrary, on them depends the quality of the care that can be given by nurses to patients, as indeed on all the services that serve the purpose of the enterprise, such as building maintenance, engineering and others, which have not by tradition been placed under the Matron’s control.

3.29 In the ordering of all the things which go towards the well-being of the patients nurses have a duty to make their requirements known and a right to be heard. This constitutes their \textit{field of influence}. Their views must be taken into account, because of their knowledge (sapiential authority) of the needs of patients, which they necessarily acquire; but the responsibility for the decisions will rest with the officers to whom the functions have been given under the arrangements approved by the governing body. The fact that it may have fallen to nurses to make good shortcomings in the services provided must not be allowed to draw Matrons into assuming \textit{control} of services extraneous to nursing, so that their proper work suffers.
3.30 In some smaller hospitals, so situated that supporting services cannot easily be controlled by appropriate heads of departments from the group headquarters, some, such as catering and cleaning, are operated most effectively if they are placed in her sphere of authority. This can be done by transfer of the staff. Or, in a large hospital, although the head nurse administrator is not responsible, for instance, for the cleaning services, nevertheless the tasks of domestic assistants must be co-ordinated with those of others in wards by the Ward Sister: this also can be arranged by means of secondment.

DELEGATION

3.31 Divesting the nurse administrator of control of services for the management of which nursing expertness is not necessary is one way of making the job of the senior nurse administrator less burdensome. The other is delegation. If a business is small the person at the top can run it single-handed. If it grows beyond a certain size, other people are appointed under him to take control of parts of the work and he retains a guiding, but not a detailed control. In nursing administration effective delegation is rarely seen. This is not surprising in view of the structure and traditions of the service. The structure is not conducive to effective delegation: the Matron of a sizeable hospital may head an array of deputy, assistants and administrative sisters to whom she assigns duties, but she does not find the relief that the top person in a business seems to find. She often retains detailed control of work she purports to delegate and deliberately retains work which she could well hand over to assistants.

3.32 There are a number of contributory causes:

(i) **On the part of Matrons.** In general Matrons are over-conscientious and not good at delegating. They have not been trained in management and their training as nurses—meticulous in details on which the life of a patient depends—leads in a contrary direction. Because they can do things better than their subordinates, they may retain duties which ought to be delegated; and when approached direct on a matter within the competence of a subordinate they may deal with it personally thereby undermining the authority of the subordinate.

(ii) **On the part of subordinates.** Ward Sisters on the whole are self-reliant people, but when, on promotion to posts in Matron's Office they venture on to "administration", many seem unable to take decisions: this is attributable to the absence of a tradition of effective delegation of authority to these posts as well as to lack of preparation or suitability for administrative work.

(iii) **On the part of others.** In members of the governing body, medical staff and others in the hospital service there is an unreasonable expectation that the Matron will have a detailed knowledge of all matters traditionally within her sphere of authority. A Matron of a sizeable hospital who seeks to better her arrangements for delegation is often brought to a halt by requirements founded in the association of the word, "Matron", rather than in reflection on the proper function of the head nurse administrator in a hospital. Hence, the Matron is often over-burdened, while other administrative nurses find their work dissatisfying, being removed from the care of the patient and without true managerial functions.
3.33 At the root of the matter is the confusion caused by applying the same title, Matron, to posts which are at different levels of management. The job of a Matron of a 1,000-bedded general hospital and of the Matron of a cottage hospital of, say, 30 beds have or should have about as much in common as those of a sales director of a fair-sized manufacturing firm and the manager of a small business: they have a common interest in selling, but will do very different things in pursuance of it. The true job of the head nurse administrator of a large hospital is one of specialist top management, in setting standards of nursing care and in reconciling nurse-training requirements with the provision of a competent nursing service. The job of the Matron of the cottage hospital is regarded as proper to middle management. The confusion extends to other grades. The level of the managerial functions of an Assistant Matron or a Departmental Sister cannot be inferred from the title of her grade. The post may be in a line relationship to that of the Matron and, where the nursing administration has been decentralised, it may carry authority in a section of the hospital; or alternatively it may be in a staff relationship and virtually without a sphere of structural authority. The failure to delegate to holders of posts in these middle grades has unhappy consequences, both in the degree of job satisfaction and in the efficiency of the organisation.

The New Staffing Structure

3.34 It is natural that nurses should feel dissatisfied with any role in which their contribution to nursing care seems diminished. The patient himself should be seen however as fighting in the front line of the battle against illness—with the nursing, medical and other staff together providing the forward support, the intelligence and weapons, and the supplies. Thus conceived, the role of senior nurses could be recognised as vital: jobs would be reorganised and reassigned, delegation would be properly practised and the contribution to be made by middle management to the common purpose would be seen to be more effective even than that of the Staff Nurse and Ward Sister, by reason of the importance of the decisions taken.

3.35 We propose therefore that the jobs of senior nursing staff should be graded according to the quality or type of the decisions to be taken, that is, whether they are appropriate to top management, middle management or first-line management. The function of top management is assisting in the formation of policy and applying it to the sphere controlled (division). The function of middle management is “programming”, that is, formulating procedures for applying the policy in a particular sphere (area or unit). The function of first-line management is executive, that is, seeing that the work programme is carried out (in sections of units, usually wards). Nursing policy should be formulated by nurses in top management who would control or co-ordinate its implementation throughout the hospital group; but the decisions on its detailed application should be made by nurses in middle management and those on its execution by nurses in first-line management. The aim should be to bring together work in which the decisions are appropriate to a given level of management and to constitute jobs accordingly. All jobs should also be constituted so that specialist professional skills are applied economically. The resultant “pyramid” gives at once an efficient organisation and an attractive career structure.
3.36 For accommodating all nursing posts (jobs) in the three levels of management six grades (or ranks) are sufficient. These are given below. They are numbered for ease of reference in descending order, from 10 down. The fact that the numbers 1 to 4 are not allocated indicates that there are other subordinate grades. Each grade has been given a descriptive name, without specific masculine or feminine associations, applicable to all holders of posts with equivalent functions, whatever the form of specialisation—general, paediatric or psychiatric nursing, midwifery, teaching.

<table>
<thead>
<tr>
<th>Level</th>
<th>Title of grade</th>
<th>Grade No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top Management (Policy)</td>
<td>Chief Nursing Officer</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Principal Nursing Officer</td>
<td>9</td>
</tr>
<tr>
<td>Middle Management (Programming)</td>
<td>Senior Nursing Officer</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Nursing Officer</td>
<td>7</td>
</tr>
<tr>
<td>First-line Management (Executive)</td>
<td>Charge Nurse</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Staff Nurse</td>
<td>5</td>
</tr>
</tbody>
</table>

3.37 The titles given to posts within the grades should not be such as to imply that a post has no proper functions of its own; so the prefixes "assistant" and "deputy" should be avoided. There is reason for retaining the title of "Matron" which is well established in tradition, but not, as now, for applying it to a post held by a man, nor on the other hand to emphasise the sex of the holder as in "Chief Male Nurse": the initial letters of the words making up the title of the grade could be used instead. There need not be uniformity in all hospitals in the titles applied to posts, as distinct from grades. The following are some suggestions:—

**Top Management:**
- Grade 10: Chief Nursing Officer, Director of Nursing, C.N.O.
- Grade 9: Principal Matron, Principal Tutor, P.N.O.

**Middle Management:**
- Grade 8: Senior Matron, Senior Night Superintendent, Senior Midwife Teacher, Senior Tutor, S.N.O.
- Grade 7: Matron, Night Superintendent, Midwife Teacher, Tutor, N.O.

**First-line Management:**
- Grade 6: Ward Sister, Midwifery Sister, Section Sister, Charge Nurse, C.N.
- Grade 5: Staff Nurse, Staff Midwife, S.N.

3.38 In Appendix 6 Chart A shows the organisation where the group consists of both a large district general hospital and a mental illness hospital of similar size. In Appendix 7 there are specimen job descriptions of posts in each grade down to Charge Nurse, related to Chart A. The chart does no more than illustrate the principles of organisation which are outlined in this chapter. There are unlikely to be many groups closely resembling it, but as the hospital plans take shape management groups should tend more to fall into such patterns. Other charts in Appendix 6 show how the principles could be applied in some typical situations. The job descriptions, which also illustrate the principle of delegation, are likely to be fairly readily applicable.

3.39 In each job description although the functions are specified under three headings—professional, administrative and personnel—they are essentially interdependent. The last two headings comprehend the functions with which this report is specifically concerned. Under "administrative" are functions
of ordering and co-ordinating jobs; under "personnel" are functions of ordering and co-ordinating people; both sets together constitute management. The "professional" functions have been added to show that the jobs of necessity require nurses to do them, to explain more clearly the kind of staffing structure envisaged and to facilitate its application. In the larger hospitals units controlled by Matrons in the grade of Nursing Officer (Grade 7) will for the most part tend to be specialised and will present opportunities for nurses who have acquired specialist professional skills as Ward Sisters to deploy them more widely on promotion. The sphere of authority of Senior Matrons (Senior Nursing Officer, Grade 8) will tend to be determined more by the physical position of the units to be co-ordinated: the administrative content of the job will therefore be comparatively greater and the professional content smaller. In smaller hospitals, the extent to which middle-management functions are specialised will depend on the type of hospital.

**JOB DESCRIPTION AND JOB ANALYSIS**

3.40 In order to grade posts correctly, there should be a *job description* of each job or kind of job in a hospital. This should be done in consultation with the person holding the post in whose immediate sphere of authority (control) the job to be described lies. For the Staff Nurse (Grade 5) this will be the Charge Nurse (Grade 6); for the Ward Sister it will be the Matron in charge of the *unit* (Grade 7) and so on. It may be found that a Ward Sister is spending time on sub-clerical or clerical work, which is well below her proper grade, or—in default of other arrangements—undertaking *programming* functions (such as devising her own record systems) which belong to grades above hers. Such anomalies will be disclosed by *job analysis* and should be rectified by reallocation functions (*job specification*). Uniform national standards should be promulgated by the Health Departments and their application by Hospital Management Committees and Boards of Management should be co-ordinated by Regional Hospital Boards.

3.41 Application of this process will confirm—what is obvious—that often posts to which the same title, Matron, is applied belong to different levels of management, a feature at present imperfectly recognised in differentiating them for salary purposes by counting numbers of beds and taking into account responsibility for nurse training. It will also show that individual jobs of Matron are badly constituted, with functions belonging to more than one level of management, and thereby demonstrate the need for reorganisation.

**NOTE ON THE GRADES**

3.42 Clearly the grading of a post has financial implications, but the primary use of the grades described in this report is the determination of the correct nursing staff structure, not the determination of salaries. For salaries the grades are no more than the material out of which a salary structure can be fashioned. While the quality of the decisions to be taken should be the primary element in determining the remuneration attaching to a post, another is the relative difficulty of jobs falling within the same grade. For the more senior posts at the present time numbers of beds in a hospital and whether it is a training school are used for differentiating the remuneration for posts which otherwise are graded the same. These are unreliable as sole criteria and their use can put obstacles in the way of bettering the organisation. Numbers of beds
in themselves do not make a job more difficult and the need to co-ordinate the requirements of nurse training and nursing service is only one factor among many: others are the complexities of nursing administration in a teaching hospital, the different kinds of nurse training courses administered, the numbers of students and pupils, the business of wards and clinics as measured by turnover and attendances, and the kinds of specialist unit. The new grading structure we propose is related, though not directly, to numbers of staff controlled and we think it will be well suited to distinguishing degrees of difficulty. Nevertheless we think it should be unnecessary to distinguish more than three categories within any grade.

3.43 The grades have been devised for posts in hospital management groups, but they would also be suitable for senior nurses employed by Regional Hospital Boards.
CHAPTER 4

Staffing Structure and Grades: First-Line Management

4.1 In first-line management nurses order and co-ordinate others in caring for patients, and also nurse patients personally. There are two grades of job, exemplified in those of the Staff Nurse and the Ward Sister:

(1) The job of the Staff Nurse (as of the Senior Enrolled Nurse) is to provide nursing care for a group of patients. She is qualified by her professional training to understand each patient’s special needs and so to direct unqualified nursing staff. These assistants report to her, though they are responsible—as she is herself—to the Ward Sister. If there is no Staff Nurse (or Senior Enrolled Nurse) or if she is away, her management functions will be carried out by an enrolled nurse or senior student nurse, nominated by the Ward Sister.

(2) The job of the Ward Sister is essentially one of organisation—to assign jobs to the team under her control and enable them to be done. She controls the work of others, and herself does work requiring the skill of

<table>
<thead>
<tr>
<th>Table II</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Type of hospital(2)</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
<th>W.T.E.(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. ENGLAND AND WALES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>494</td>
<td>23,898 (2,131)</td>
<td>24,392</td>
<td>19,598 (1,725)</td>
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<tr>
<td>Maternity</td>
<td>—</td>
<td>1,840 (1,428)</td>
<td>1,840</td>
<td>1,419 (1,156)</td>
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<tr>
<td>Mental illness</td>
<td>3,385</td>
<td>1,197 (—)</td>
<td>5,302</td>
<td>4,702 (—)</td>
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<tr>
<td>Mental subnormality</td>
<td>633</td>
<td>429 (—)</td>
<td>1,062</td>
<td>937 (—)</td>
</tr>
<tr>
<td>Long-stay</td>
<td>132</td>
<td>1,686 (140)</td>
<td>1,818</td>
<td>1,367 (109)</td>
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<tr>
<td>Other</td>
<td>204</td>
<td>3,672 (198)</td>
<td>3,876</td>
<td>3,152 (169)</td>
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<tr>
<td><strong>Total</strong></td>
<td>4,848</td>
<td>33,442 (3,897)</td>
<td>38,290</td>
<td>31,175 (3,159)</td>
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<td><strong>B. SCOTLAND</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>98</td>
<td>2,791 (258)</td>
<td>2,889</td>
<td>2,367 (217)</td>
</tr>
<tr>
<td>Maternity</td>
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<td>509</td>
<td>435 (368)</td>
</tr>
<tr>
<td>Mental illness</td>
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<td>543 (—)</td>
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<td>1,258 (—)</td>
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<tr>
<td>Mental deficiency</td>
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<td>75 (—)</td>
<td>183</td>
<td>176 (—)</td>
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<tr>
<td>Long-stay</td>
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<td>257 (—)</td>
<td>262</td>
<td>196 (1)</td>
</tr>
<tr>
<td>Other</td>
<td>32</td>
<td>902 (44)</td>
<td>934</td>
<td>705 (38)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,018</td>
<td>5,077 (732)</td>
<td>6,095</td>
<td>5,137 (624)</td>
</tr>
</tbody>
</table>

**Source:** Health Department statistics as at 30.9.1964.

**Notes:**

(1) Including Staff Midwives (figures shown in brackets).
(2) The relation of the classification of types of hospital, in this and other tables in the report, to the classification ordinarily used in the Health Departments’ statistics is explained in Appendix 5.
(3) “Whole-time equivalent.”
the registered nurse. She is under the control of the Matron (structural authority) but, in matters of medical treatment, acts in accordance with the directions of the medical staff (sapiential authority).

4.2 The job of the Staff Midwife is equivalent to that of the Staff Nurse. Both are placed in Grade 5 (Staff Nurse). Numbers of posts and staff in the grade are indicated in Table II.

**EXISTING GRADES EQUIVALENT TO GRADE 6 (CHARGE NURSE)**

4.3 The other principal Whitley grades to be regarded as equivalent to that of Ward Sister/Charge Nurse are Midwifery Sister, Night Sister/Night Charge Nurse and Departmental Sister/Departmental Charge Nurse, category (c). The generic title proposed for the grade in which all such posts fall is Charge Nurse (Grade 6). Table III gives an indication of the present members and disposition of such posts.

**Table III**

<table>
<thead>
<tr>
<th>Staff in Grade 6 (Charge Nurse) (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of hospital</strong></td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td><strong>A. ENGLAND AND WALES</strong></td>
</tr>
<tr>
<td>General...</td>
</tr>
<tr>
<td>Maternity...</td>
</tr>
<tr>
<td>Mental illness...</td>
</tr>
<tr>
<td>Mental subnormality...</td>
</tr>
<tr>
<td>Long-stay...</td>
</tr>
<tr>
<td>Other...</td>
</tr>
<tr>
<td>Total...</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>B. SCOTLAND</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>General...</td>
</tr>
<tr>
<td>Maternity...</td>
</tr>
<tr>
<td>Mental illness...</td>
</tr>
<tr>
<td>Mental deficiency...</td>
</tr>
<tr>
<td>Long-stay...</td>
</tr>
<tr>
<td>Other...</td>
</tr>
<tr>
<td>Total...</td>
</tr>
</tbody>
</table>

**Source:** Health Department statistics as at 30.9.1964.

**Notes:**
1. Including Midwifery sisters (figures shown in brackets).
2. "Whole-time equivalent".
3. Approximate ratio based on whole-time equivalent.

(i) **Use of the grade**

4.4 In England and Wales the total number of staff (whole-time equivalent) in Grade 6 (Table III) is about equal to the total number in Grade 5 (Table II), though for men, the number is greater. This balance is not found, however, in each of the different types of hospital: while there are more nurses in Grade 5 (Staff Nurse) than in Grade 6 (Charge Nurse) in general, maternity and "other" hospitals there are less in psychiatric and long-stay hospitals. Factors underlying this contrast are the employment in long-stay hospitals of Enrolled Nurses instead of Staff (i.e. Registered) Nurses; and, in psychiatric hospitals, the
appointment under a shift system, of two Charge Nurses or Ward Sisters to a ward.

4.5 In Scotland there are overall more nurses in Grade 5 (Staff Nurse) than in Grade 6 (Charge Nurse), which position holds, to a greater or lesser degree, in all the types of hospitals, except mental deficiency. The more satisfactory ratio results from more generous staffing in Grade 5 (Staff Nurse) which makes possible a more economical use of Grade 6 (Charge Nurse). The more sparing provision of posts in grades equivalent to Grade 6 (Charge Nurse) is seen by comparing the ratios of nurses (whole-time equivalent) in Grade 6 to staffed beds (see last column of Table III): it is lower in Scotland than in England and Wales.

4.6 As between the various types of hospitals in both the hospital services there are marked differences between the ratios of nurses in Grade 6 (whole-time equivalent) to staffed beds (and so to in-patients)—highest in maternity hospitals, lowest in psychiatric hospitals. This reflects the fact that in psychiatric hospitals a relatively higher proportion of the nurses are employed in wards, as distinct from departments, the wards being on average larger than in other kinds of hospitals. The extremely low ratio of sisters to staffed beds in maternity hospitals shows how much they are engaged in clinical work in delivery suites, etc., either exclusively or in combination with control of wards.

(ii) Characteristics of nurses in the grade

4.7 Age. There are more women in Grade 6 aged 25-29 than in any other 5-year age group. The men in Grade 6 (Charge Nurse) tend to be older than the women; there are more men in the age group 50 to 54 than in any other and very few indeed under 30. A high proportion of the men were not appointed to the grade until age 40 or over.

4.8 Period in the grade. Nearly a third of all Charge Nurses and Ward Sisters have spent 10 or more years in the grade, there being very little variation according to type of hospital. The annual turnover in posts of Ward Sister and Charge Nurse seems to be about 12%, this being the proportion of nurses who had been less than one year in the grade at the time of our statistical enquiry.

4.9 Marriage. The proportion of Ward Sisters who are married is higher than that of Midwifery Sisters; and in either case the proportion who are married is higher in England and Wales (41% and 27%) than in Scotland (24% and 16%). Few men in the grade of Charge Nurse are unmarried.

4.10 Part-time working. In England and Wales about 12% of Ward Sisters and 13% of Midwifery Sisters work part-time as compared with about 5% in both cases in Scotland. Although about half of the part-time Ward Sisters work in general hospitals, the proportion of part-time to whole-time Ward Sisters is much higher in long-stay hospitals (1 : 4) than in hospitals generally (1 : 7).

*Our statistical enquiry showed the proportion of nurses in Grade 6 (Charge Nurse) working by day in wards to be generally higher in Scotland than in England and Wales. In both countries the proportion was highest in psychiatric hospitals (well over 90%) and lowest in general hospitals and maternity hospitals.
There are proportionately more part-time Midwifery Sisters in maternity hospitals than in general hospitals. Alike in England and Wales and in Scotland, part-time working among men in Grade 6 (Charge Nurse) is insignificant.

4.11 Place of birth. About 17% of nurses in Grade 6 in England and Wales and about 5% in Scotland were born outside Great Britain. These percentages include nurses of British parentage but born overseas.

The Present Job of the Ward Sister

4.12 Despite increased nursing activity in other clinical areas of the hospital, such as out-patient departments and operating theatres, the wards remain the principal and usual field of employment of nurses in first-line management. We therefore use the present job of the Ward Sister to illustrate the present managerial functions at this level.

4.13 A principal factor determining the job is the number of patients whose nursing care a Ward Sister can effectively control. The more intense the treatment and the shorter the turn-over interval, the fewer she can be expected to manage. Numbers of beds in a ward (often in more than one room) vary from as few as 10 to over 100, the larger wards being the less active ones in psychiatric hospitals. Each Ward Sister’s separate sphere of authority is readily recognised since one ward is physically separate from another.

4.14 The tradition in general nursing has been that a Ward Sister is considered to be in control of her ward, whether or not she is temporarily absent; and there are well recognised arrangements for her representation when off duty. By day, it is normal practice for the Staff Nurse to deputise, sometimes with support from the Ward Sister of a neighbouring ward. By night, the desirable arrangement for deputising is for Staff Nurses co-ordinated by a Night Sister, to take over and to report to the Ward Sisters or their deputies when they resume duty in the morning, but often only student nurses are available. In psychiatric hospitals the arrangements at night are similar to those for general nursing. By day, where day duty is covered by a single shift a Deputy Ward Sister takes the place of the Ward Sister; but where there are two shifts by day, there is a Ward Sister or Charge Nurse in charge of each, with no Deputy, an arrangement which reflects the separate traditions of psychiatric nursing. A practice is growing in some general hospitals to appoint two Sisters to the same ward for day duty, the junior generally reporting to and deputising for the senior.

4.15 On the whole Ward Sisters seem to find their job satisfying. This we attribute largely to the fact that each exercises decentralised control and substantial delegated authority. Apart from their authority (structural) over their own staffs their personal (sapiential) authority is recognised by all with whom they have dealings. There is human interest and full scope for the exercise of professional and managerial skills. These features often make it the height of a nurse’s ambition. Nevertheless, while the Ward Sister’s job is, in principle, sound, there are some defects which are becoming increasingly apparent in the larger and busier hospitals.

4.16 First, there may be too much for her to do. Each year the number of patients treated per staffed bed is increasing. This implies not only more intensive nursing, but more work on paper and at the telephone: and, with the
reduction in nursing hours, there are fewer qualified nurses on duty. Unpublished studies, conducted in 1962 by the N.H.S. Central Organisation and Methods Unit, showed that on average, in typical acute hospitals, only a quarter of the Ward Sister's time was spent on nursing duties. In this situation many Ward Sisters have been supported in giving practical instruction to student nurses by Clinical Instructors.

4.17 Second, ward administration can be unduly difficult. There are two parts to the work of the Ward Sister as a co-ordinator—co-ordinating the ward team and co-ordinating at ward level, on the patient's behalf, other services that contribute to the patient's treatment and welfare and which are carried on outside the ward. Each has become more complex. On the one hand, the ward team is less homogeneous. Once consisting of Staff Nurses, Student Nurses and Ward Maids, there have been added additional grades—enrolled nurses, pupil nurses, nursing auxiliaries, ward clerks, ward orderlies, domestic assistants. All work shorter hours, so that there is more co-ordination of jobs and personnel to be done; and in large hospitals, where administration of services has become departmentalised, with Domestic Superintendents and Catering Officers, for example, lines of control and communication may have become uncertain. On the other hand, as diagnostic procedures and techniques of treatment have become more numerous and more extensively applied, a corresponding burden falls upon the Ward Sister on whose administrative ability largely depends their effective application to the individual patient. Again, if there are several consultants, each with his own patients in the same ward, this adds to the Ward Sister's difficulties.

4.18 Third, the job may have functions which belong to a higher level of management and for which the Ward Sister may not have been prepared. Ward routines, nursing procedures and organisation of office work in large hospitals often cannot be effectively prescribed from the level of the nursing head of the whole hospital, because the requirements vary in different specialties and the Matron may have so many nurses directly responsible to her, that a sure grasp of the problems of each is impossible. Established Ward Sisters tend to become wedded to traditional practices, lacking the time or inclination or knowledge to change them, while those more newly appointed may lack the necessary experience.

THE JOB OF THE CHARGE NURSE (GRADE 6)

4.19 We believe that with the introduction of a new staffing structure it should be possible to remedy the present defects of the Ward Sister's job and to extend its desirable features to other nursing jobs in Grade 6.

(i) Functions

4.20 The Charge Nurse (Grade 6) in a ward (section) can be enabled to concentrate on the proper functions of first-line management in nursing by three means:

(1) Affording relief from some tasks, especially non-nursing duties;*
(2) Clarifying lines of control and communication; and
(3) Providing the support of effective middle management.

*See also Chapter 5, paragraphs 5.22 to 5.32.
4.21 The third of these means is elaborated in Chapter 5. Here a beneficial side-effect only is noted. The job of the Ward Sister is physically strenuous and, with advancing age, it is difficult to stand the pace. She may then either retire (on a very small pension) or, perhaps reluctantly take up a job in “administration” or become a Home Sister, so that a fund of specialised professional experience is largely wasted. As a unit Matron (Nursing Officer, Grade 7) with control, for instance, of a group of wards in a specialty, she could, if properly prepared for it, do a more valuable job and one which, with recognised status attached to it, would become sought after as that of Ward Sister is now. This could prolong the career of the experienced nurse in the hospital service.

4.22 There are a number of tasks of which many Ward Sisters could well be relieved and so enabled to give more direct care to the patient. No more time should be spent on administrative work than is really necessary. Job analysis has shown that much of the time of the Ward Sister is taken up by tasks which are neither professional (viz. nursing and teaching) nor managerial (viz. organising work and managing people) and by activities, incidental to her proper job of management, but unduly time-consuming. There are three ways in which relief can be given:

(a) by supplying her with services;

(b) by saving her time through improved methods;

(c) by providing lay assistance under her direction.

4.23 Among services supplied to wards in some larger hospitals are the automatic “topping-up”, by means of an imprest system, of ward supplies of dressings, linen, crockery and cutlery; preventive maintenance of buildings and equipment; messenger services; and centrally controlled domestic services. These could with advantage be provided more generally and not only in the main hospitals of a group. In these ways the Ward Sister could be relieved, not just of the clerical work in making requisitions, but also of tasks of supervision inseparable from exercise of control. Only drugs and special diets should have to be ordered, for control of these cannot be shed by the Ward Sister.

4.24 It is argued that domestic staff work better in wards if they are under the control (structural authority) of the Ward Sister. This need not be so. A service can be given with complete satisfaction by staff under the control of a Domestic Superintendent, who engages them, instructs them on cleaning methods and allocates them to wards. While working in the wards, however, they form part of the ward team and the Ward Sister co-ordinates them with others of the team. In directing them she exercises personal (sapiential) authority by virtue of her knowledge of hygienic requirements. If she is dissatisfied with the methods of their work, she will take the matter up with the Domestic Superintendent, who controls the cleaners and prescribes the cleaning methods, or the Supervisor assigned to a particular group of wards. Under this system cleaning staff are under the control (structural authority) of the Domestic Superintendent, but work within the field of influence (sapiential authority) of the Ward Sister: it is called secondment. In order to illustrate the principle, the relative responsibilities in this case are set out in Appendix 8.

4.25 Significant saving of the Ward Sister’s time can be achieved by introducing efficient clerical methods. Printed forms requiring a minimum of writing
should be used. In some hospitals time is still spent by nurses on ruling columns in record books. There should be constant review by nurses in middle management of clerical and other ward procedures in order to save Ward Sisters’ time.

4.26 The kind of assistance most obviously useful to the Ward Sister in wards where there are frequent admissions and discharges is that of a clerk/receptionist or ward aide. Studies have shown that in wards of from 28 to 30 beds there are about 14 hours’ work a week of this kind to be done. Difficulty arises therefore in devising a job for such a ward aide. Alternatives are:

(1) employment part time in a single ward on mainly clerical duties;
(2) employment whole time in two or more wards on mainly clerical duties;
(3) employment whole time in a single ward on mixed duties, part clerical but mainly of a kind assigned to a ward orderly.

If units comprising several wards, under a Nursing Officer (Grade 7, a Matron) are instituted, the deployment of ward assistants in the most economical manner could more easily be arranged than at present.

4.27 The second way of making the job of the Ward Sister easier is clarifying lines of control and communication. A significant statistical correlation has been noted between the efficiency of acute hospitals (as indicated by “the rapidity with which general medical and surgical cases are discharged”) and the relationship between the Ward Sisters and “the whole array of central services, from the doctors, the matron and the secretary to the physiotherapist, the engineer and the barber”. Where communications are poor, morale in the ward is bad and efficiency of the hospital low. One line of approach to a solution is to try to change attitudes, and “sensitivity training”, preferably conducted within the framework of the hospital, could be a means of acquiring management techniques and social skill in communicating with people. This could be tried as a remedial method but, in our view, at the root of the matter is organisation.

4.28 If there is a proper structure, with lines of control and communication well laid out and properly understood, the relationship between the Ward Sister and those in authority or with whom she co-operates is likely to be satisfactory. If the distinction between structural and sapiential authority is clearly recognised by the Ward Sister and those with whom she has to deal, both her job and her relations with others will be easier. She must know to whom she can give orders and on what matters, and from whom she herself can receive orders and on what matters. She must recognise that in other matters she can only give or be given directions; in these she has no right by reason of her office to require compliance or be required to comply, but she should know to whom she should report failure to comply with reasonable requirements in order that in future difficulties may be resolved by decisions taken by those authorised to take them.

4.29 The duty and the right of the Ward Sister to contribute ideas for improving nursing procedures and the nursing programme in general must also be recognised and the requisite machinery provided. Sometimes at meetings of

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† The object in “sensitivity training” is to train a person in appreciation of the motives and attitudes of himself and others.
Ward Sisters with the Matron communications tend to be all one way and to take the form of instructions. This frustrates the purpose. Communication should be two ways. All, whatever their grade, should be heard according to their knowledge of the subjects discussed (sapiential authority). Nurses in first-line management have a more immediate knowledge of some current problems and may well be better able to indicate lines of solution than those in more senior positions. The information and ideas they contribute will make it easier for those whose duty it is to provide solutions to make the right decisions.

(ii) Deputising

4.30 The reduction in nursing hours to 84 a fortnight means that a Ward Sister will on average be on duty in her ward for only half the day-time hours, that is, six hours daily. During annual leave (six weeks), sick leave and other special leave she will be away entirely. She may either do "split-duty" working in the morning and the late afternoon, the times when the ward is busiest, or she may do shift duty as is common in psychiatric hospitals. The question arises whether a Ward Sister can be expected to control the ward when not physically present. In psychiatric hospitals which operate a shift system each of two Charge Nurses is regarded as in control during his own shift: in general hospitals and in some psychiatric hospitals the Ward Sister remains in control, being represented, when off duty, by her deputy.

4.31 We think it best to have one person in the grade of Charge Nurse (Grade 6) in control of the ward. We realise, however, that this system depends on there being sufficient Staff Nurses (Grade 5) to deputise in addition to carrying out their own work. If, under a shift system, there are to be more than one nurse to a ward in the grade of Charge Nurse (Grade 6), the junior should report to the senior, both being responsible to the Nursing Officer (Grade 7). At present in psychiatric hospitals where there are two Ward Sisters or Charge Nurses to a ward, each with equal authority, neither may be able to exercise the control which the job requires: one may be "played off" against the other, which is bad for the patients and for the junior staff. Some psychiatric hospitals have tried to overcome this by having one Ward Sister or Charge Nurse in control, and a Deputy Charge Nurse on each shift. We regard such a post of Deputy as being in Grade 5 (Staff Nurse), but distinguished by special remuneration in recognition of its difficulty. We see no objection to this if the difficulty of the job justifies it. Having one Charge Nurse (Grade 6) to a ward should not reduce the number of promotion posts for men if, as is proposed under the Hospital Plans, the wards in psychiatric hospitals are made smaller and if posts of Charge Nurse are provided in departments outside wards wherever needed.

4.32 During the prolonged absence of the Ward Sister on leave, or acting in a higher post, as distinct from temporary daily or weekly absence off duty, it is often the practice for a "relief sister" to take over. This is because in many hospitals there are insufficient Staff Nurses even to do duty in their own capacity, let alone to act for the Ward Sister. Posts of Relief Sister, where instituted, should be in the grade of Charge Nurse (Grade 6). They could be interchangeable with posts of Night Sister and used as first promotion posts for Staff Nurses before appointment to control a ward as Ward Sister, and for part-time staff.
(iii) Other types of post

4.33 Apart from Ward Sister, Relief Sister and Night Sister and their male equivalents, there are other posts appropriate to the grade of Charge Nurse. These are of three kinds:

First, posts in which nursing is also undertaken personally in combination with control or co-ordination of qualified nurses and other staff (paragraphs 4.34 to 4.36).

Second, some teaching posts (paragraph 4.37).

Third, posts assisting officers making programming decisions, that is, staff posts (paragraphs 4.38 to 4.40).

4.34 Included in the first kind are posts in clinical areas other than wards, such as, operating theatres, accident and emergency departments, out-patient departments, delivery suites, ante-natal clinics, psychiatric day hospitals and occupational therapy groups. In each case the job should carry with it co-ordination of qualified nurses in Grade 5 (Staff Nurse) and the aim should be to constitute a definite sphere of authority (section). Thus, in a large out-patient department a Charge Nurse's section could comprise a number of clinics. Some she would take herself, others would be taken by Staff Nurses under her control. The Charge Nurse's sphere of authority would not necessarily, as in a ward, be associated with exclusive occupation of a particular part of the department, for at different times it would be used for different clinics. Accordingly control of drugs, for example, might better be exercised centrally, but, so far as possible, there should be decentralisation and delegation to the Charge Nurses, each of whom would control her own team.

4.35 Other posts of the first kind are those of Sisters in charge of small maternity homes and of out-patient clinics in premises away from the main hospital: in these the care of patients is combined with co-ordinating functions and control of staff in the same way as is that of the Ward Sister. The sphere of authority may include non-nursing staff which in a larger hospital would be controlled by the hospital administrator: they should be regarded as transferred to the control of the Sister in charge unless a service can be provided, in which case they would be seconded.

4.36 Examples of titles suitable for posts outside wards in the grade of Charge Nurse are Out-patient Sister, Theatre Sister, Section Sister, Sister in Charge. The titles, "Departmental Sister" and "Departmental Charge Nurse" are not recommended since the term "department" can connote a sphere of authority larger than a section.

4.37 Of the second kind are the teaching posts of Clinical Instructor and Teacher of pupil nurses. These are considered together with other teaching posts in Chapter 7.

4.38 Of the third kind are posts in which nurses help in carrying out programming functions, but in a staff relationship, so that they do not control the nurses whose work they assist in co-ordinating. Many administrative nursing posts at the present time are of this kind: some are posts of "administrative sister" in the grade of Departmental Sister (one who "is below the rank of Assistant Matron and assists the Matron in the supervision of the nursing services of the
hospital"), others may be in the grades of Assistant Matron, Home Sister and Housekeeping Sister. Additional uses of such posts now are:

(1) for leave relief of a Matron or Assistant Matron;
(2) for work in a Matron's office;
(3) for control of domestic and other non-nursing staff;
(4) for training in administration.

4.39 These posts are usually unattractive except as a means, sometimes illusory, to promotion. Their advantage is flexibility, in that a miscellany of functions can be attached to them and the number of posts related economically to the work of hospitals of different sizes. It is, however, impossible to justify the employment of people with the comparatively scarce and costly skills of the registered nurse on clerical work or the deployment of non-nursing staff. The function of deputising for the Matron (Nursing Officer, Grade 7) of a small hospital, as in a unit of a larger hospital, could usually be carried out, with clerical assistance, by a Charge Nurse (Grade 6) selected from those working in wards and other sections. The post of Housekeeping Sister is clearly obsolete. That of Home Sister is no longer necessary, since residential accommodation can be administered by wardens and the counselling functions can be carried out by Nursing Officers (Grade 7) and others in line management.

4.40 There remains the use as training posts for administration. In Chapter 9 we propose a new system of training. The only such training posts we envisage is for Charge Nurses with administrative aptitude, who could profit from working for a short time on the staff of the Chief Nursing Officer. Administrative Sister is a suitable title for a woman in such a post.

4.41 Job descriptions for various posts of Charge Nurse (Grade 6) are given in Appendix 7.

Future Developments

4.42 Our general conclusion has been that those characteristics of the job of the Ward Sister which make it satisfying ought to be continued and the underlying principles applied to other jobs in Grade 6 (Charge Nurse). Before reaching this conclusion we considered whether any radical change in the job was necessitated by current developments in the organisation of nursing care (in particular, progressive patient care and increased use of out-patient departments) and in the personal circumstances of senior nurses (especially early marriage and part-time working among women).

(i) Developments in the organisation of nursing care

4.43 "Progressive patient care is the systematic grouping of patients according to the degree of illness and dependence on the nurse rather than by classification of disease and sex".* The system contrasts with the traditional pattern under which the patient remains in the same ward, the degree of nursing care, including the positioning of the bed for ease of surveillance, being adjusted to the requirements of the patient's condition. Experiment has concentrated intensive care units which accommodate critically ill patients only for as long

as they need the additional facilities. An advantage is thought to be the maintenance of a steadier level of work in the general wards by the removal of critically ill patients. A further development could be the removal from the general wards to self care units of patients largely able to fend for themselves. To a greater or less degree this is already done in some general hospitals, convalescent patients being transferred from the acute wards to smaller satellite hospitals. Their removal helps to simplify the staffing of the general ward by keeping the work load at a more constant level. We see nothing in this system which radically alters the job of the Ward Sister.

4.44 The extent to which nursing is now undertaken in departments, as distinct from wards has been referred to earlier (in paragraph 4.6). The trend seems likely to develop further under the Hospital Plans. This is taken into account in our proposal (in paragraph 4.34) that jobs for Charge Nurses (Grade 6) should be constituted in the departments on lines which have proved satisfactory in the wards. We think also that this kind of job is particularly suited to part-time working.

(ii) Part-time working

4.45 Part-time working is increasing. Between 1948 and 1964 the proportion of registered nurses working part time in England and Wales increased from 13% to 26% and in Scotland from 18% to 24%. Among midwives, the proportion increased from 16% to 22% in England and Wales, and from 7% to 21% in Scotland. These are substantially higher proportions than those (given in paragraph 4.10 above) of Ward Sisters and Midwifery Sisters who work part time. The main incidence of part-time working, due to marriage, is in Grade 5 (Staff Nurse), where it can most easily be absorbed. The question arises whether marriage will lead to many fewer women registered nurses being available in the future to work whole time as Ward Sisters in Grade 6 (Charge Nurse). An authoritative answer cannot yet be given. It may be noted however, that the proportion of Ward Sisters who are married greatly exceeds the proportion who work only part time, which suggests that marriage and nursing whole time are not incompatible.

4.46 As our statistical enquiry has shown part-time working in Grade 6 (Charge Nurse) is already well established. It raises no difficulties in posts of Relief Sister and Night Sister; and it is well suited outside wards, where working is confined to set hours except in emergency. It is also apparent that posts of Ward Sister in long-stay hospitals, where the pace is slower, can to a great extent be held part time. The situation as it affects the busier wards of hospitals will need to be watched carefully. If women able to work whole time in Grade 6 (Charge Nurse) are not forthcoming in sufficient numbers, it is possible that men will increasingly enter what has traditionally been a field for women. This will be facilitated by the proposed new staffing structure which makes no distinctions of sex. Alternatively, or additionally, the job of the Ward Sister could be amended to accommodate part-time working on a shift system. In this case some of the management functions could be passed to the Nursing Officer (Grade 7). We would not wish the proposed new staffing structure to be perpetuated when conditions necessitate change.
Definition of Grade 6

4.47 The following definition is offered as a summary description of Charge Nurse (Grade 6):—

A registered nurse (in a maternity department, a state certified midwife)
(a) who controls a ward or other section of a unit;
or (b) who has functions of the same level in a teaching post;
or (c) who, in a staff post, assists a nursing officer of Grade 8 or above.
5.1 In middle management nurses order and co-ordinate other nursing staff in caring for patients, but do not normally give direct nursing care. The nature of the jobs can be described (by analogy with computers) as "programming": that is, working out nursing plans by determining the nursing procedures and jobs and the staff required to do them.

5.2 There is a tendency for systematic programming of nursing by "administrative nursing staff" to be restricted to personnel functions, that is, obtaining, training and allocating staff. How to make the best use of the staff does not always receive its due share of attention: routines may remain fixed in patterns conceived in different circumstances. Failure to review and amend them may be attributable, partly, to lack of preparation for administrative functions, partly,

<table>
<thead>
<tr>
<th>Type of hospital</th>
<th>Number of staff</th>
<th>Number of qualified tutorial staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>A. ENGLAND AND WALES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General ... ... ...</td>
<td>354</td>
<td>6,196 (565)</td>
</tr>
<tr>
<td>Maternity ... ... ...</td>
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<td>657 (642)</td>
</tr>
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<td>931</td>
<td>823 (—)</td>
</tr>
<tr>
<td>Mental Subnormality ... ... ...</td>
<td>422</td>
<td>400 (—)</td>
</tr>
<tr>
<td>Long-stay ... ... ...</td>
<td>112</td>
<td>1,102 (45)</td>
</tr>
<tr>
<td>Other ... ... ...</td>
<td>107</td>
<td>1,483 (59)</td>
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<td>Total ... ... ...</td>
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<td>10,661 (1,311)</td>
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<table>
<thead>
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<th>Number of qualified tutorial staff</th>
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<td></td>
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<td>Women</td>
</tr>
<tr>
<td>B. SCOTLAND</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General ... ... ...</td>
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<tr>
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</tr>
<tr>
<td>Mental Deficiency ... ... ...</td>
<td>30</td>
<td>39 (—)</td>
</tr>
<tr>
<td>Long-stay ... ... ...</td>
<td>4</td>
<td>55 (—)</td>
</tr>
<tr>
<td>Other ... ... ...</td>
<td>5</td>
<td>197 (13)</td>
</tr>
<tr>
<td>Total ... ... ...</td>
<td>206</td>
<td>1,360 (201)</td>
</tr>
</tbody>
</table>

Source: Health Department statistics as at 30.9.1964, except those for qualified tutorial staff in Scotland which come from the statistical enquiry.

Notes: (1) Including however Home Sisters and Housekeeping Sisters who are to be regarded as in Grade 6 (525 in England and Wales and 47 in Scotland, as shown in the statistical enquiry).

(2) "Whole-time equivalent", including tutorial staff.

(3) Including figures for midwifery staff, shown in brackets.
to defects in the staffing structure. In this chapter we suggest ways in which the staffing structure can be improved.

5.3 The present numbers of middle management posts are not easily determined, since the grades in which posts are held do not reliably indicate the functions carried out. Table IV therefore includes all nursing staff above the grade of Ward Sister/Charge Nurse (Grade 6).

5.4 The present ratio of posts above Grade 6 to posts in Grade 6 (Charge Nurse) is approximately 1 to 2.5 in England and Wales, and 1 to 2.3 in Scotland. The ratio for men is 1 to 3.2 in England and Wales, and 1 to 3.3 in Scotland.

Existing Grades Approximating to Middle Management

5.5 Table V gives particulars of some more numerous, non-tutorial grades above Ward Sister or equivalent (Grade 6).

5.6 About 1% only of nurses in grades above Grade 6 (Charge Nurse) work part time. The annual turnover of posts in the grade of Departmental Sister/Departmental Charge Nurse seems to be about 10%, this being the proportion of nurses who had been less than one year in the grade at the time of our statistical enquiry. For the grade of Assistant Matron/Assistant Chief Male Nurse the comparable proportion is 10% in England and Wales and 12% in Scotland. The ‘department’ in which the most Departmental Sisters/Departmental Charge Nurses work is the Matron’s office: 27% in England and Wales.

Table V

Staff in selected intermediate grades above Grade 6(1)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number(2) of staff</th>
<th>Main age group</th>
<th>% (3) in grade for 10 years or more</th>
<th>% (3) who have taken selected administrative courses(4)</th>
<th>% (3) with higher educational qualifications (5)</th>
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</thead>
<tbody>
<tr>
<td>Deputy Matron/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deputy C.M.N.:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>non-psychiatric</td>
<td>136</td>
<td>50–54</td>
<td>22</td>
<td>28</td>
<td>13</td>
</tr>
<tr>
<td>psychiatric</td>
<td>356</td>
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<td>24</td>
<td>4</td>
<td>8</td>
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<td>Superintendent Midwife</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>non-psychiatric</td>
<td>132</td>
<td>40–59</td>
<td>40</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>psychiatric</td>
<td>527</td>
<td>45–49</td>
<td>16</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Night Superintendent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>non-psychiatric</td>
<td>228</td>
<td>50–54</td>
<td>11</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>psychiatric</td>
<td>1,719</td>
<td>50–54</td>
<td>26</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Senior Assistant Matron/</td>
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<td></td>
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</tr>
<tr>
<td>Senior Assistant C.M.N.</td>
<td>271</td>
<td>50–54</td>
<td>15</td>
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<td>6</td>
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<tr>
<td>Assistant Matron/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>non-psychiatric</td>
<td>891</td>
<td>50–54</td>
<td>14</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>psychiatric</td>
<td>2,344</td>
<td>40–44</td>
<td>31</td>
<td>4</td>
<td>11</td>
</tr>
</tbody>
</table>

A. England and Wales

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number(2) of staff</th>
<th>Main age group</th>
<th>% (3) in grade for 10 years or more</th>
<th>% (3) who have taken selected administrative courses(4)</th>
<th>% (3) with higher educational qualifications (5)</th>
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<tbody>
<tr>
<td>Deputy Matron/</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Deputy C.M.N.:</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>non-psychiatric</td>
<td>136</td>
<td>50–54</td>
<td>22</td>
<td>28</td>
<td>13</td>
</tr>
<tr>
<td>psychiatric</td>
<td>356</td>
<td>50–54</td>
<td>24</td>
<td>4</td>
<td>8</td>
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<tr>
<td>Superintendent Midwife</td>
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</tr>
<tr>
<td>non-psychiatric</td>
<td>132</td>
<td>40–59</td>
<td>40</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>psychiatric</td>
<td>527</td>
<td>45–49</td>
<td>16</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Night Superintendent</td>
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<td></td>
</tr>
<tr>
<td>non-psychiatric</td>
<td>228</td>
<td>50–54</td>
<td>11</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>psychiatric</td>
<td>1,719</td>
<td>50–54</td>
<td>26</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Senior Assistant Matron/</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Senior Assistant C.M.N.</td>
<td>271</td>
<td>50–54</td>
<td>15</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Assistant Matron/</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>non-psychiatric</td>
<td>891</td>
<td>50–54</td>
<td>14</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>psychiatric</td>
<td>2,344</td>
<td>40–44</td>
<td>31</td>
<td>4</td>
<td>11</td>
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</table>
### Table V—continued.

Staff in selected immediate grades above Grade 6—continued.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number(3) of staff</th>
<th>Main age group</th>
<th>(%) (3) in grade for 10 years or more</th>
<th>(%) (3) who have taken selected administrative courses(4)</th>
<th>(%) (3) with higher educational qualification (9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. SCOTLAND</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Deputy Matron/</td>
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</tr>
<tr>
<td>Deputy C.M.N.:</td>
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<td></td>
</tr>
<tr>
<td>non-psychiatric</td>
<td>16</td>
<td>50—54</td>
<td>3*</td>
<td>6*</td>
<td>2*</td>
</tr>
<tr>
<td>psychiatric</td>
<td>48</td>
<td>50—54</td>
<td>10*</td>
<td>2*</td>
<td>5*</td>
</tr>
<tr>
<td>Superintendent Midwife</td>
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<td>4*</td>
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<td>4*</td>
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<td>Night Superintendent:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>non-psychiatric</td>
<td>42</td>
<td></td>
<td>8*</td>
<td>1*</td>
<td>12*</td>
</tr>
<tr>
<td>psychiatric</td>
<td>28</td>
<td>50—54</td>
<td>6*</td>
<td></td>
<td>5*</td>
</tr>
<tr>
<td>Senior Assistant Matron/</td>
<td>9</td>
<td>50—54</td>
<td></td>
<td></td>
<td>2*</td>
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<tr>
<td>Senior Assistant C.M.N.</td>
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<td></td>
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<tr>
<td>Assistant Matron/</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Assistant C.M.N.:</td>
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<td></td>
</tr>
<tr>
<td>non-psychiatric</td>
<td>183</td>
<td>55—59</td>
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<td>15</td>
<td>24</td>
</tr>
<tr>
<td>psychiatric</td>
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<td>45—49</td>
<td>17</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Departmental Sister/</td>
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<td>45—49</td>
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<td>6</td>
<td>24</td>
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<tr>
<td>Departmental Charge Nurse</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Statistical enquiry.

**Notes:**

1. But including Departmental Sister/Departmental Charge Nurse, category (c), which is equivalent to Grade 6 (Charge Nurse):—
   - England and Wales: 486
   - Scotland: 31

2. Those who replied to the questionnaire.

3. Actual numbers, asterisked(*) are given instead where the numbers are small.

4. Diploma in nursing administration (University of Edinburgh); administrative certificate of R.C.N.; one-year administrative course at King Edward’s Fund Staff College; Ward Sister’s certificate of R.C.N.; three-months Ward Sister’s course at King Edward’s Fund Staff College; Diploma in nursing.

5. University degree, or higher school certificate or its equivalent.

Wales and 35% in Scotland. The other main departments in which Departmental Sisters/Departmental Charge Nurses are employed are theatres and out-patients, of which each employ about a quarter of those in the grade.

5.7 There are a number of men holding posts with female titles: Deputy Matron—21 in England and Wales and 4 in Scotland; Senior Assistant Matron—11, all in England and Wales; Assistant Matron—98 in England and Wales and 4 in Scotland. Nearly all these posts of Deputy Matron and about half those of Assistant Matron are in psychiatric hospitals.

5.8 Of nurses in the grades included in Table V, about 14% in England and Wales and about 5% in Scotland were born outside Great Britain, about the same as the comparable percentages for nurses in Grade 6 (Charge Nurse), given in paragraph 4.11.
PRESENT USE OF SOME INTERMEDIATE GRADES

(i) Deputy Matron/Deputy Chief Male Nurse

5.9 The Whitley definition of Deputy Matron/Deputy Chief Male Nurse is now virtually the same for psychiatric and other hospitals (one "who assists the Matron/Chief Male Nurse and deputises for her/him over the whole range of her/his duties"). In non-psychiatric hospitals however the post of Deputy Matron exists only in those with 500 or more beds which are training schools; while in psychiatric hospitals there are, for salary purposes, two categories of Deputy Chief Male Nurse according to the extent to which training functions are undertaken by the Chief Male Nurse.

5.10 In a large hospital, which is a training school, where the Matron has numerous outside commitments, the post of Deputy Matron (as that of Principal Tutor) may belong to top management rather than to middle management. In some hospitals, despite the Whitley definition, the Deputy Matron does not, in the Matron's absence, deputise for her over the whole range of her duties: the Superintendent Midwife may deputise in respect of the maternity department and the Principal Tutor in respect of the teaching department; this can be a very satisfactory arrangement. A normal duty of the post of Deputy Matron is control of the Matron's office.

(ii) Night Superintendent

5.11 A post which in many hospitals exemplifies the true characteristics of middle management is that of Night Superintendent. The Whitley definition of the grade in general hospitals is:

"A State Registered Nurse with two or more Night Sisters/Night Charge Nurses working under her who is responsible at night for the nursing of the patients in the hospital, for the control of the nursing staff and for other appropriate duties".*

The post has a sphere of authority defined in time and place. Yet, although it clearly makes a valuable contribution to the quality of nursing care, one of the conclusions of a survey conducted in 1959 by the Royal College of Nursing was that Night Superintendent was one of two administrative nursing posts most difficult to fill (the other being Administrative Sister).†

(iii) Assistant Matron

5.12 The grade of Assistant Matron in non-psychiatric hospitals is particularly illustrative of vagueness of function in the intermediate grades. The definition

*For maternity hospitals the definition is similar, but relates to midwifery staff. In psychiatric hospitals Night Superintendents on either side need only have one Night Sister/Night Charge Nurse working under them. In a general hospital instead of having a post of Night Superintendent, the hospital authority may pay as Senior Night Sister, each Night Sister who has sole charge in a different section or building within the same hospital; for large psychiatric and maternity units in a general hospital separate Night Superintendents may be appointed.

†Royal College of Nursing. 1965. Administering the hospital service: a review. p.37.
(one "who assists the Matron and... may deputise for her"), is loose, and the functions of the post vary greatly:—

(1) There may be line responsibility; the Ward Sister being responsible to the Assistant Matron, who is in turn responsible to the Matron irrespective of whether there is a Deputy Matron. Line responsibility is rare and, where it exists (when an Assistant Matron is "in charge of" a unit or wing), it is not always clear what authority or power she may exercise in that function.

(2) There may be a "triadic" system in which both Assistant Matron and Sister are responsible to the Matron but the Ward Sister reports to the Assistant Matron: the Assistant Matron feels that she has little authority over the Sister and her position is made difficult if the Matron gives orders directly to the Sister, thereby undermining what authority the Assistant Matron may have.

(3) There may be a "dual triadic" system in which the Deputy Matron as well as the Matron gives orders to the Sister, and when a decision is needed the Assistant Matron does not know whether to refer the matter to the Deputy Matron or to the Matron.

(4) The Assistant Matron may be literally "assistant", one who passes on orders and directions, who cannot give orders or directions, because she is not authorised to make the necessary decisions. She is doing a job part of which, in some ways, could be done by a clerk.

(5) The Assistant Matron may be doing a job which could be done by someone who is not a nurse at all.

About one Assistant Matron in six has day-to-day charge of a hospital, or unit, being answerable to a Matron based elsewhere. Such jobs are akin to true middle management. The functions of the remainder are more likely to be staff.

5.13 The grade in psychiatric hospital equivalent to that of Assistant Matron in non-psychiatric hospitals is Senior Assistant Matron/Senior Assistant Chief Male Nurse ("a qualified mental nurse who, in a psychiatric hospital with 500 or more female/male beds, assists the Matron/Chief Male Nurse by taking charge of a unit of the hospital or field of work requiring the constant supervision of a nurse more senior than an Assistant Matron/Assistant Chief Male Nurse"). Though the definition is more explicit, the sphere of authority and functions are often equally indefinite.

(iv) Departmental Sister/Departmental Charge Nurse

5.14 There are three categories of Departmental Sister/Departmental Charge Nurse in non-psychiatric hospitals—(a), (b) and (c)—according to the number of registered nurses supervised, whether more than ten or less than four. (In the lowest category the salary is the same as that of Ward Sister/Charge Nurse and the posts belong to first-line management). The corresponding grade in psychiatric hospitals is Assistant Matron/Assistant Chief Male Nurse. In both
5.15 Insofar as Departmental Sisters/Departmental Charge Nurses (and their equivalent in psychiatric hospitals) have a defined sphere of authority their jobs are likely to be more satisfying than those of some Assistant Matrons in non-psychiatric hospitals and Senior Assistant Matrons/Senior Assistant Chief Male Nurses in psychiatric hospitals. However:

(1) the titles of the grades do not properly indicate the level of management to which posts belong;

(2) in non-psychiatric hospitals the relation of Departmental Sisters/Departmental Charge Nurses and Assistant Matrons is uncertain and the differentiation of the two higher categories according to the number of registered nurses supervised is unsatisfactory in omitting, for instance, to take into account control of enrolled nurses.

DEFECTS OF THE PRESENT SYSTEM

5.16 Unpublished studies by the N.H.S. Central O. and M. Unit indicate that among hospitals there is no consistent allocation of duties to nurses in the administrative nursing grades. The same tasks, in different hospitals, may be undertaken by Matrons, Deputy Matrons, Assistant Matrons and even Administrative Sisters indiscriminately. An Assistant Matron may have no proper nursing function of her own. Originally the post may have carried with it housekeeping duties, such as control of domestic staff or the linen room, which provide a sphere of at least partial authority; but, as these pass to non-nursing specialists, Assistant Matrons are left personnel functions only, in which the tasks are often largely clerical.

5.17 It is common to blame the "system" for the dissatisfaction often expressed by Assistant Matrons in staff posts. The basic assumption apparently is that, if a 24-hour service is to be provided, there must be continuous administrative cover for the nursing services at one focal point of the hospital, the Matron's Office (in which the Matron, if not present herself, must be personally represented), from which ward rounds are conducted by the Matron or her

*"A Departmental Sister/Departmental Charge Nurse" (in general hospitals) "is:

Group (1) a State Registered Nurse who is in charge of a department in which other State Registered Nurses are employed; or is responsible for supervising a group of wards and the work of the Ward Sisters/Charge Nurses concerned; or is below the rank of Assistant Matron and assists the Matron in the supervision of the nursing services of the hospital;

Group (2) a qualified mental nurse who is in charge of one or more psychiatric units or wards in which other qualified mental nurses and/or State Registered Nurses are employed".

"An Assistant Matron/Assistant Chief Male Nurse" (in psychiatric hospitals) "is a qualified Mental Nurse who either

(i) is in charge of a department, or supervises a group of wards and the work of the Ward Sisters/Charge Nurses concerned, being a department or a group of wards in which the establishment provides for four or more qualified mental nurses, not being Post-registration Student Nurses, to be on duty simultaneously at any time as well as the Assistant Matron/Assistant Chief Male Nurse; or

(ii) carries other responsibilities of equal weight".

**
deputy or her assistants. But under the proposed staffing structure, if functions have been properly assigned and staff allocated, there is no need for a central nursing office to be manned continually. Contingencies arising outside office hours will be referred to a "duty" officer who will in addition remain in control of her unit or area.

5.18 It is also difficult to fill senior posts in line management in many large hospitals, including posts of Matron and particularly those of Superintendent Midwife. Many women seem to prefer to obtain posts of Matron in small hospitals. The reasons may be that they avoid, on the one hand, the burden of administering a large nursing service with inadequate support, and, on the other, they have greater scope for initiative than in subordinate posts in large hospitals. There are disadvantages however—the lack of scope for influencing the decisions taken by the governing body on nursing policy; the almost inevitable consequence of becoming out of touch with modern developments in nursing techniques; and the need to contend, in isolation, with staffing crises.

5.19 There is a real danger of many administrative nursing posts remaining unfilled in the large district general hospitals to be provided under the Hospital Plans owing to the unwillingness of many able nurses to take up posts in nursing administration.

THE NEW STRUCTURE

5.20 We consider that the jobs of nurses in middle management should be recast from a staff to a line relationship, so as to reproduce in them the desirable features that come from delegation and decentralisation.

5.21 The new structure proposed is a formalisation of arrangements already put into effect in some hospitals and hospital groups, where the nursing heads have, with such success as the present structure allows, energetically tackled the problems of organisation. They have applied the principles of decentralisation and delegation and have assigned their own spheres of authority to nurses in the middle grades, such as Departmental Sister and Assistant Matron.

RELIEF FROM NON-NURSING DUTIES

5.22 The aim is that the senior nurse in middle management should concentrate on work which only a nurse is qualified to undertake. There are many tasks done by senior nurses which could be done by others. This is justifiable only if they are insufficient to constitute the job of a person of suitable calibre who is not a nurse. With the development of larger district general hospitals and of the idea of group nursing administration, there should be reappraisal of all such work, for the change of scale may make its reallocation practicable.

5.23 There are three ways in which nurses in middle management can be relieved from non-nursing work:

(1) if services are provided under the control of the hospital administration;

(2) if suitable people, other than nurses, are appointed to undertake middle-management functions under the control of nurse administrators;

(3) if adequate clerical help is provided.
(i) Services under the control of the administration

5.24 The aim should be to provide all hospitals, grouped if necessary for the purpose, with the services of a Hospital Secretary. There are still many hospitals, more particularly in Scotland, where Matrons and their supporting staff undertake work which ought to be undertaken by Hospital Secretaries and their staff; and, even where such staff are available, nurses are required to undertake these non-nursing duties. Where it is impracticable to provide a Hospital Secretary, clerks should be appointed, responsible to the Group Secretary, though reporting to the Matron (Nursing Officer, Grade 7).

5.25 In the larger hospitals control of cleaning, catering, supply of linen, laundry, messenger and portering services and administration of residential accommodation can readily be exercised by people who are not nurses, including Domestic Supervisors and Wardens. We are satisfied that the function of providing for the welfare of student and pupil nurses and of nursing staff in residence can be discharged by nurses without retaining control of the residential accommodation. Non-nurses placed in control of these services should be made responsible to the hospital administrator (structural authority), while required to provide services in accordance with standards prescribed by the governing body with advice from nurse administrators (using sapiential authority).

5.26 These services should, so far as possible, be extended to all hospitals of the group so that the executive functions of Catering Officers, Group Domestic Superintendents and other specialist officers are not confined, as often at present, to the main hospital of the group. In the outlying hospitals their subordinates will report to the Hospital Secretary, at the hospital where he is based; elsewhere in smaller hospitals, they can be seconded to the Matron (Nursing Officer, Grade 7) or transferred to her sphere of authority.

(ii) Non-nurses in middle management

5.27 If it is unavoidable that services of the kind indicated should remain under the control of the nursing administration, then at least it should be delegated to lay supervisors, except in some small, remote hospitals where this is impracticable.

5.28 We consider that a Chief Nursing Officer (Grade 10) who controls nursing in a group should have the assistance of a general administrative grade officer, either seconded from the Group Secretary’s staff for a period of at least two years, or a permanent appointment, filled perhaps by promotion from the clerical staff of a nursing office. The duties could include liaison with the Finance Office over the salaries and letters of appointment of newly appointed nursing staff, the organisation of record keeping and other clerical work for all nursing offices of the group, serving the Nurse Education Committee and assisting with nursing publicity, nurse recruitment and nurse allocation. He or she would act in nursing matters under the direction of the Senior Nursing Officer (Administration).

(iii) Clerical staff and methods

5.29 Where the arrangement of the premises allow, in a district general hospital or other large hospital with a Teaching Division, the aim should be to provide
a single central nursing office to serve the Chief Nursing Officer (Grade 10), the Principal Nursing Officer (Grade 9) in charge of the Nursing Division and the Principal Tutor (Principal Nursing Officer, Grade 9) in charge of the Teaching Division. The number of staff required will depend on the number of student and pupil nurses. For the central nursing office of an average district general hospital, with 1,000 beds and 250 student nurses, it is estimated that the following staff would be required: a general administrative grade officer, a personal secretary, a clerical officer and a shorthand typist. If the Principal Tutor’s office is separate, the staff would need to be allocated according to the work load. If the number of student nurses were greater, extra clerical staff would be needed. In a Midwifery Division, with about 100 beds, two personal secretaries or the equivalent may be needed.

5.30 Much of the work now done by administrative nursing staff on preparing change lists is clerical and could be delegated to the control of the general administrative grade officer. Experiments are being conducted into the use of computers to carry out this work. Senior nurses could confine their part to adjustments to the change lists necessitated by unforeseen contingencies and individual requirements.

5.31 In many existing hospitals, mostly smaller than that instanced above, the clerical assistance given to Matrons is inadequate in number and quality and it is often for this reason that senior nurses spend so much time on clerical work. If the new nursing structure is accepted, the opportunity should be taken to draw up job specifications for the clerical staff required and grade them accordingly.

5.32 In the larger hospitals consisting of a number of units under Nursing Officers (Grade 7—Matrons) it is estimated that, on the average, the work which could be done by a clerk would amount to about 10 hours a week for each unit. There is little clerical-type work (about 4 hours a week) arising from the duties of a Senior Matron (Senior Nursing Officer, Grade 8) which could be delegated. We suggest that there should be one clerk allocated to each area to assist the senior Nursing Officer (Grade 8) and the Nursing Officers (Grade 7).

**The Job of the Nursing Officer (Grade 7)**

1. **Sphere of authority**

5.33 In a large or medium-sized hospital of any type, wards in related specialties should be grouped together to form a unit, under the control of a Nursing Officer (Grade 7) to whom the Charge Nurses (Grade 6) will be responsible. For a woman holder of the post the title of Matron will be suitable, for her functions will be virtually the same as those which will pertain to a Matron of a separate small hospital. She will have special knowledge of the techniques of the specialties of her unit, so that she can act as consultant to the Charge Nurses, and she will also be qualified, by virtue of the training she has received in management, to “programme” the work of the unit—reviewing the procedures and controlling the staff. The functions of first-line management will be delegated to her Charge Nurses, but there will remain with her the same kind of continuing responsibility for her unit as by tradition has rested with the Matron of the hospital. In her absence off duty, one of the Charge Nurses will
deputise for her during the day, and at night this will be done by the night staff. These may be found either from within the unit, or—if preferred—centrally for the area or the division. In her absence on leave, one of her colleagues could answer for her.

5.34 Not all the units will be composed of wards. The jobs of the Theatre Superintendent and the Out-patient Superintendent, for instance, will also be carried out in the grade of Nursing Officer (Grade 7). The title, Matron, could, if preferred be used for women holders. A suite of operating theatres may well employ more staff than a small hospital. In one with ten operating theatres there may be as many as 30 registered nurses, apart from enrolled nurses, student and pupil nurses, operating theatre attendants and orderlies. Such a suite might need to be organised as two units.* The control and training of the staff and relations with the medical staff who work in the suite, perhaps as many as 40, call for expert administration on the part of the nurse in charge as well as for a thorough professional knowledge of the techniques employed. The work should be organised in sections, each under a Charge Nurse (Grade 6).

5.35 Teaching posts will also have their spheres of authority. The unit of the Tutor (Nursing Officer, Grade 7) will not in this case necessarily be identifiable with a physically separate part of the hospital: it may be a group of students whose teaching is under the control of one Tutor, or a group of subjects the teaching of which is managed by one Tutor.†

(ii) Functions

5.36 The functions of posts of Nursing Officer (Grade 7), as for the other grades, can be classified as professional, administrative and personnel. It will not be a case of being "side-tracked" into "administration". The following paragraphs refer specifically to posts in nursing service as distinct from tutorial posts.

5.37 The professional functions are such as to require a nurse of experience and seniority. The Nursing Officer will act as consultant in nursing practice, and develop new ideas and methods in the unit. She will support the Staff Nurses when Ward Sisters are off duty. She will participate personally in the training of the nursing staff and in the practical training of student and pupil nurses allocated to the unit. If relatives of patients have problems which the ward staff cannot resolve, they can arrange to see the Matron (Nursing Officer, Grade 7) of the unit.

5.38 The primary administrative function will be to organise the nursing staff of the unit, redeploying them as necessary in response to day-to-day needs and asking for support from outside the unit when necessary. The importance of the job in the system of internal communications must be emphasised, for the Nursing Officer (Grade 7) has a key role to play in "feeding back" information from below to the policy-forming officers in top management, so that all decisions can be taken with knowledge of the clinical situation.

5.39 The personnel function will be particularly important. People perform best if their individual characteristics—their weaknesses and strong points—are

*See paragraph 5.50.
†See Chapter 7, paragraph 7.46.
taken into account. From the nature of their work nurses are subjected at
times to much emotional stress, and the Matron is looked to for support and
guidance. In a large hospital the function is beyond the capacity of one person
and it tends to be shared, but unsystematically, with other senior nurses. The
function can be called “counselling” and the nursing staff of a unit will look
especially to their Nursing Officer (Grade 7)—the Matron—for such support.
She will be the leader of her staff, supervising and reporting on their progress
and responsible for developing their professional and managerial skills.

(iii) Kinds of post

5.40 Apart from teaching there will be two kinds of nursing post in Grade 7
(Nursing Officer):

(1) with control in a specialist unit, such as operating theatres or neurosurgery
or midwifery;

(2) with control in a non-specialized unit, such as the general medical wards
of a large hospital or a self-contained small general hospital.

The first kind will require specialised professional experience. So, apart
from teaching, there will be two avenues of promotion for Charge Nurses
(Grade 6). Those inclined to specialise can look to posts of Nursing Officer
(Grade 7) in which they will have full scope for employing their special clinical
abilities. Others will seek posts where general administrative ability is the
principal requirement. In both kinds experience will be gained which will help
to qualify senior nurses for top management: the dilemma of many Ward
Sisters in the past will be avoided—whether to continue with clinical nursing
and to forgo further promotion or to take up “administration” in the hope of
qualifying eventually for a top post.

5.41 A typical non-specialized post will be that of Nursing Officer (Grade 7)
in a small general hospital. If there is support from a nurse at a higher
level the nursing in most small hospitals could suitably be controlled by a
Nursing Officer (Grade 7). We explain in Chapter 6 how the top-management
functions, which belong at least nominally to their present Matrons, should be
discharged.* It will be helpful to the holders of such posts if there is occasional
temporary interchange between posts in the main hospital of a group and those
in smaller hospitals. This will serve to broaden their experience and qualify
them for further promotion. This will be easier to arrange if appointments
in the grade of Nursing Officer (Grade 7) and above are made to the hospital
group rather than for service in a particular hospital.

5.42 Among specialist posts in middle management will be the senior nursing
post in some dental hospitals. These hospitals rarely have beds and the
senior nurse is usually called Sister in Charge. Under the Hospital Plans larger
dental hospitals are to be built, some with schools for dental surgery attendants
and hygienists. These will often be of a size to justify organisation of the nurs-
ing staff as a unit under a Nursing Officer (Grade 7). A woman holder of the
post can have the title of Matron and there will be Charge Nurses (Grade 6)
responsible to her, their sections all consisting of staff serving clinics or operat-
ing theatres for dental surgery. It is usual for the senior nurse in charge of a
dental hospital also to direct dental surgery attendants, trained and in training.

*See paragraphs 6.16 and 6.17.
in nursing matters. Such staff may then be regarded as seconded. Alternatively they may come under her control, in which case they are to be regarded as transferred and there will be additional administrative and personnel functions for the Nursing Officer (Grade 7). In this case she must be given the necessary secretarial assistance. Top-management functions can be discharged as explained in Chapter 6.

5.43 Another, usually non-specialized, post of Nursing Officer (Grade 7) will be that of Night Superintendent, one for each area, to co-ordinate and support the Night Sisters (Charge Nurses, Grade 6) who will generally be provided one for each unit so that each deputises for a unit Matron (Nursing Officer, Grade 7). In the same way the Night Superintendent could represent the Senior Matron (Grade 8) who controls a medium sized hospital or an area of a large hospital (see paragraph 5.51 below). The programming functions of this post will be minor and mostly limited to the re-deployment of nursing staff to meet emergencies, for the procedures in the unit will be laid down by the unit Matron (Nursing Officer, Grade 7). The Night Superintendent's role mainly will be to support the sometimes young and inexperienced Charge Nurses (Grade 6) on duty at night. The post is likely to be suitable for a newly promoted Nursing Officer (Grade 7). It will often be unnecessary to centralise nursing supervision at night for the whole of a large district general hospital, though when a Night Superintendent in one area is off duty, another could act in a supportive role. Posts of Night Superintendent should usually be of temporary tenure and, in large hospital, they could be held in rotation by Nursing Officers (Grade 7) for periods of not more than a year at a time. Supervision at night for psychiatric and maternity departments could be provided separately, in the appropriate grade, according to the size and level of activity at night—Grade 6 (Charge Nurse) or Grade 7 (Nursing Officer). Arrangements in a large mental illness hospital will depend on the general form of organisation.

5.44 Job descriptions for various posts of Nursing Officer (Grade 7), are given in Appendix 7.

Criteria for Instituting Posts in Grade 7

5.45 The essential criterion for instituting posts of Nursing Officer (Grade 7) is that the job specification should include programming functions as well as co-ordinating sections under Charge Nurses (Grade 6). However, since a principle of good organisation is that there should be economy in grading, some suggestions are made for the use of the grade.

5.46 Where there are only two sections under Charge Nurses (Grade 6) to be co-ordinated, this can be done by the senior. An example of this in the present grading system is the Senior Night Sister/Senior Night Charge Nurse in a non-psychiatric hospital (one "with no or only one Night Sister/Charge Nurse under her . . . ") as compared with the Night Superintendent (one "with two or more Night Sisters/Charge Nurses under her . . . "). Except in a teaching department therefore, a post of Nursing Officer (Grade 7) should not be instituted where there are less than three sections under Charge Nurses (Grade 6), unless there is co-ordination of teaching and nursing service to be effected in an isolated unit, as in a small maternity hospital which is itself a training institution. This gives a lower limit to the institution of posts in Grade 7.
5.47 For the upper limit we suggest that a unit should not usually consist of more than six sections under Charge Nurses (Grade 6), or the equivalent.

5.48 A Nursing Officer (Grade 7) will normally control the nursing services of about four or five sections with 100 to 150 beds if the unit consists of wards with 25 to 30 beds to a ward; in other areas, such as operating theatres and outpatient clinics there will be an equivalent sphere of authority in terms of staff controlled. The number of beds in a unit in which specialist—for instance, neurosurgical—nursing is undertaken may be less, though the number of nursing staff will remain about the same for the ratio of qualified nursing staff to patients will usually be higher.

5.49 In a small general hospital, physically separate and without any close functional link with any other hospital, a Nursing Officer (Grade 7) will be needed if there are at least three sections under Charge Nurses to be co-ordinated, or two only, if there are also non-nursing staff transferred to her control. This is the situation of the Matrons of many small hospitals at the present time, as distinguished from that of a Sister in Charge, whose post can be in Grade 6.

The Senior Nursing Officer (Grade 8)

(i) Sphere of authority and functions

5.50 Where it is necessary for two or more units, under their Nursing Officers (Grade 7), in teaching or in nursing service, to be co-ordinated at a level below top management, this will be the function of a Senior Nursing Officer (Grade 8). It could be combined with staff functions in respect of particular subjects, for example welfare of part-time nursing staff and organisation of in-service training, in which there is special need of co-ordination of the work of all Nursing Officers (Grade 7) in the group. Similarly, at night, in a large hospital, if there are two or more areas each with Night Superintendents (Nursing Officer, Grade 7), it may be necessary to have a co-ordinating post of Senior Night Superintendent (Senior Nursing Officer, Grade 8).

5.51 In a nursing service post the sphere of authority (area) of a Senior Nursing Officer (Grade 8) will be the whole of a separate medium-sized hospital; or a part of a single large hospital; or a group of small hospitals. In each case the principal factor in grouping units will be physical proximity rather than relationship of specialties. The professional element of the job will be less than in Grade 7, the emphasis being on deployment of staff and on personnel work.

5.52 In a large general hospital not all the units will need to be grouped under a Senior Nursing Officer (Grade 8). The Nursing Officer (Grade 7) in charge of a psychiatric unit will not usually need to be co-ordinated at a level below top management (Grade 9), for the unit will be largely self-contained in regard to personnel and procedures; but the organisation should be flexible so that a capable specialist Nursing Officer (Grade 7) may gain promotion to Senior Nursing Officer (Grade 8) while retaining responsibility for the specialty in question together with other units.

5.53 A special use for the grade will be in the post of Senior Nursing Officer (Administration) to assist a Chief Nursing Officer (Grade 10), who controls the nursing services in a large management group. This should be a post of temporary tenure for a nurse who is in view for promotion to Grade 9. She
will also be available to relieve a Principal Nursing Officer (Grade 9) and, if necessary, other Senior Nursing Officers (Grade 8) in charge of areas (groups of units). In a Nursing Division co-ordinated, but not controlled by a Chief Nursing Officer (Grade 10), a post of Senior Nursing Officer (Administration) may be needed to assist the Principal Nursing Officer (Grade 9) in control of it if there is nurse training. In such a case—for instance, in a large mental illness hospital of a mixed group which includes both psychiatric and non-psychiatric hospitals—the Senior Nursing Officer (Administration) will provide continuity for the central nursing administration of the hospital and co-ordinate the placing of student and pupil nurses for practical experience.

(ii) Kinds of post

5.54 In a general hospital approved as a midwifery training school the head midwife will ordinarily be in the grade of Senior Nursing Officer (Grade 8), unless the post qualifies for placing in Grade 9 as Principal Matron in charge of the Midwifery Department.† She will have responsible to her at least two Nursing Officers (Grade 7) whose work she will co-ordinate—that is, a Midwife Teacher and a Matron. Where midwifery is on a smaller scale, there can be one unit under a head midwife in Grade 7 (Nursing Officer) who will herself be the "approved teacher".‡

5.55 In a teaching post the function of a Senior Tutor (Senior Nursing Officer, Grade 8) will be to organise the teaching of certain subjects and to co-ordinate the work of other Tutors (Nursing Officer, Grade 7) who teach them. Normally a Senior Tutor (Grade 8) will be responsible to the Principal Tutor (Principal Nursing Officer, Grade 9) who controls the Teaching Division of the hospital management group. In groups where nurse training is not undertaken on a scale warranting the appointment of a Principal Tutor (Grade 9) or there are obstacles to centralising nurse training for the group as a whole, the chief teaching post or posts will be in the grade of Senior Nursing Officer (Senior Tutor, Grade 8)—or even, in the case of a very small training school, Nursing Officer (Tutor, Grade 7). The aim however should be to organise nurse training on a group basis and to have a central school. The Tutors would then have specialist support, at present lacking in some smaller training schools.

5.56 Posts in the service of Regional Hospital Boards at present graded as Assistant Nursing Officer would also properly be placed in middle management (Grades 7 and 8).

5.57 Job descriptions of various posts of Senior Nursing Officer (Grade 8) are given in Appendix 7.

CRITERIA FOR INSTITUTING POSTS IN GRADE 8

5.58 The occasion for instituting posts of Senior Nursing Officer (Grade 8) is the need to co-ordinate the work of Nursing Officers (Grade 7) at a level below top management (Grades 9 and 10). A useful by-product is the creation of promotion posts in which senior nurses can obtain experience which will qualify them for promotion to top management. To prevent the secondary aspect

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*See Chapter 6, paragraph 6.42.
†See Chapter 6, paragraph 6.34.
‡See also Chapter 7, paragraph 7.14.
becoming dominant we suggest that within the regions control should be exercised by Regional Hospital Boards over the establishment of posts in grades above Grade 7. For teaching hospitals in England and Wales this control could be exercised by the Ministry of Health. Factors to be taken into account are the number and kind of units to be co-ordinated and the layout of the buildings in which they are accommodated; generally speaking, the more compact the premises, the less the difficulty of co-ordination. The number of units co-ordinated will usually be from three to six.

5.59 In a large district general hospital accommodated on a single site, with good internal communications, we estimate that there will be a proper job for a Senior Nursing Officer (Grade 8) controlling an area of three units; if these consisted entirely of general medical or surgical wards, the post could carry with it control of nursing services for from 300 to 450 beds. Where specialist nursing is undertaken the group of units will tend to be smaller in terms of beds, though not in terms of staff controlled; so also where the sphere of authority includes units without beds, such as operating theatres.

5.60 In a psychiatric hospital with 750 to 1,000 beds, there might be one Senior Nursing Officer (Grade 8) in control of each of the two sides, male and female, and a third, the Senior Night Superintendent, in charge of the whole hospital at night, co-ordinating the work of two Night Superintendents (Grade 7), one for each side. This pattern would be adjusted if the traditional organisation on the basis of male and female sides were discontinued*. In addition there will be a post of a Senior Nursing Officer (Administration) referred to in paragraph 5.53.

5.61 In groups in which the units are scattered, the sphere of authority of a Senior Nursing Officer (Grade 8) in terms of beds will tend to be smaller. For the units to be co-ordinated will themselves usually be smaller and, if they are at a distance from each other, co-ordination will be more difficult. In a busy acute hospital, about 250 beds and supporting departments may be as much as can be controlled by a Senior Nursing Officer (Grade 8). The limit could be raised in a long-stay hospital. For midwifery the limit in terms of beds would be much lower.

5.62 A staff post of Senior Nursing Officer, Administration (Grade 8) may also be instituted in the circumstances described in paragraph 5.53.

5.63 The organisation charts in Appendix 6 illustrate the use of posts of Senior Nursing Officer (Grade 8).

Definitions of Grades 7 and 8

5.64 The following definitions are offered as summary descriptions of the grades in middle management:

Nursing Officer (Grade 7)

A registered nurse (in a teaching post, a qualified tutor) who

(a) controls a unit;

or (b) at night supervises and co-ordinates the nursing staff in a group of units.

*See Chapter 7, paragraphs 7.19—7.23.
Senior Nursing Officer (Grade 8)

A registered nurse (in a teaching post, qualified tutor) who

(a) controls or co-ordinates the work of Nursing Officers (Grade 7);

or (b) is the nurse who assists a Principal Nursing Officer (Grade 9)

in a large Nursing Division, or the Chief Nursing Officer (Grade 10).
CHAPTER 6

Staffing Structure and Grades: Top Management

6.1 In top management nurses formulate nursing policy and organise its implementation by others, whose functions they co-ordinate. The primary objects of nursing policy are a high quality of nursing care for patients and the training of nurses in accordance with professional requirements. A principal administrative function is reconciling the two objects in a practical plan. The personnel functions are equally important, for the whole tone of a hospital and the happiness of the patients and the people who work in it are deeply influenced by the nursing heads.

6.2 Nursing policy is formed at two levels, national and local. At the national level, senior nurses have an important influence on its formation—as members of professional organisations, of the Health Ministers’ statutory advisory committees, and of the General Nursing Councils and the Central Midwives Boards which determine standards of professional training. Locally, there is also scope for initiating nursing policy, within regions and hospital groups. In either case, the new policies have to be presented to governing bodies for acceptance and their implementation planned. The nursing posts for discharging top-management functions locally should be provided in the staffing structure.

6.3 In a fairly large hospital group, in which the wards are complemented by a wide range of supporting departments, the primary functions of organising nursing care and of organising nurse training are usually in themselves sufficiently complex for each to require the attention of a nurse in top management: their co-ordination is an additional function. The nurse staffing structure required for the two primary functions and for their co-ordination is occasionally found in a group consisting of a single large hospital, with or without outlying units, which itself forms a hospital management group: here the Matron is the chief nursing officer, and responsible to her are a Deputy Matron (who has day-to-day charge of the nursing service) and a Principal Tutor (who has equivalent functions in relation to nurse training). Such a group, where the Matron advises the governing body on nursing policy at their meetings, is well suited for the discharge of top-management functions in nursing, but the pattern is comparatively uncommon.

6.4 In taking evidence and on our visits we gave particular attention to the channels of responsibility and communication between nursing heads of hospitals and the governing bodies and to the question whether “top level” decisions should be taken independently by the nursing head of each hospital in a group.

6.5 We found a wide measure of agreement that the nursing administration of very small hospitals was often best associated with that of large hospitals, particularly those of the same type. There was also recognition of the need for more effective co-ordination of nursing administration in most hospital groups and for better means of communication between the governing body and nursing heads in hospitals. Some organisations were satisfied that these functions could be discharged through the Group Secretary or through members of Hospital Management Committees or of Boards. Others gave support for fulfilling them by the institution of posts of group nursing head, but were uncertain whether
such posts should be combined with nursing control in all the hospitals, or in a particular hospital. A special difficulty was foreseen if a group included two or more large hospitals of about equal size or hospitals of different types.

6.6 In making proposals we have been particularly aware of the need for flexibility and for suiting the means of discharging top-management functions in nursing to the different characteristics of hospital groups.

**EXISTING NURSING POSTS IN TOP MANAGEMENT**

6.7 The exercise of top-management functions in nursing often depends on the personal qualities of the holder of a post as well as the structure of the hospital group and the arrangements made by the governing body to obtain nursing

**Table VI**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number(2) of staff</th>
<th>Main age group</th>
<th>Number in grade for 10 years or more</th>
<th>Number who have taken selected administrative courses(3)</th>
<th>Number with higher educational qualifications (4)</th>
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<tr>
<td><strong>A. ENGLAND AND WALES</strong></td>
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<td>Matrons:</td>
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<td>general ... ...</td>
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<td>50—54</td>
<td>81</td>
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<td>55—59</td>
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<td>27</td>
<td>50—54</td>
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<td>Chief Male Nurses</td>
<td>77</td>
<td>45—59</td>
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<td><strong>B. SCOTLAND</strong></td>
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<td>Chief Male Nurses</td>
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</table>

**Source:** Statistical enquiry.

**Notes:**

(1) Including Matrons and Chief Male Nurses with 500 or more beds in psychiatric and long-stay hospitals; 100 or more beds in maternity hospitals; 300 or more beds in general and "other" hospitals.

(2) Those who replied to the questionnaire.

(3) Diploma in nursing administration (University of Edinburgh; Administrative certificate of the R.C.N.; one-year administrative course at King Edward’s Fund Staff College; Diploma in nursing.

(4) University degree, or higher school certificate or its equivalent.
advice. The scope for their exercise is likely to be greatest in the larger hospital which is a nurse training school. Sometimes the policy-forming functions are fulfilled in part by the Nursing Officers of Regional Hospital Boards who advise the Hospital Management Committees, or Boards of Management, on nursing staff establishments and other matters.

6.8 Table VI gives some particulars of holders of selected, non-tutorial, senior posts in larger hospitals. Some of the posts of Matron are held by men; our statistical enquiry showed 15 such posts of Matron (including 5 in psychiatric hospitals).

Present Limitations on Top Management in Nursing

6.9 Apart from lack of training for administration, two important factors which hamper the exercise of top-management functions in nursing are the traditional concept of the post of Matron as reflected in the Whitley grading structure, and the nature of some hospital management groups.

6.10 The Whitley definition of Matron in a general hospital is:—

"The State Registered Nurse who is head of the nursing service in a hospital and is responsible for the nursing of the patients and for nursing administration. In training schools she is responsible for the training. She undertakes other appropriate duties as may be prescribed by the employing authority".

The definitions of the grade of Matron in other types of hospital are similar, except that in the definition for a psychiatric hospital the Matron is referred to as "the head of the female nursing service".

6.11 Though these definitions are imprecise, for instance, in not stating to whom the Matron is to be responsible, they nevertheless clearly imply that one Matron cannot have control (structural authority) over another. This principle has, so far, with occasional reappraisal, been firmly held by the nursing profession, on the assumption that each Matron is responsible directly to the governing body, as under the Nightingale pattern. It has been reinforced by the separate origins of the different kinds of nursing—general, sick children's, fever, mental illness, mental subnormality and midwifery.

6.12 Direct responsibility of the Matron to the governing body, appropriate enough when each governing body administered one hospital, is difficult to achieve in the large multi-hospital group of the present time. The Group Secretary, or the Medical Superintendent, is necessarily interposed, and his co-ordinating function may (or may seem to) become a controlling function; so that a Matron becomes subject to the control of another officer, though not of another nurse.

6.13 In these circumstances each governing body tries to devise locally acceptable channels of communication with Matrons, and means of co-ordinating nursing and formulating nursing policy. These means may include House Committees for single hospitals or a number of hospitals. Co-ordination of nursing plans may be sought through a Nursing Committee, or its chairman, or through the Group Secretary acting on its behalf, or through one of the Matrons acting with the consent of the others or through the substitution of Assistant
Matrons in posts formerly held by Matron. The results are often unsatisfactory: in some large groups effective top management in nursing is incompatible with the separate and direct responsibility to the governing body of each of a number of Matrons: others are too small for its development.

6.14 The proposed new grading structure can make a major contribution to a solution, but it will work better in hospital management groups which are satisfactorily constituted. The Hospital Plans, with their concept of the district general hospital, should give a new impetus to the rationalisation of hospital grouping. We assume that in consequence some smaller groups may be amalgamated, and larger ones that would otherwise contain more than one district general hospital may be divided. With the adoption of the new staffing structure it will then be possible to provide the close contact between the head of the nursing service and the governing body which is essential for good management. Since re-arrangement of hospital grouping will not always be practicable and since the process would in any case take many years, we propose a number of alternative structural arrangements for nursing top management in different kinds of group.

THE NEW STRUCTURE

6.15 Our proposals for top management in the new staffing structure are modelled, as for middle management, on arrangements already adopted in some hospital groups.

6.16 Policy-forming functions for nurses in hospital groups should be carried out by nurses in top management, that is, Principal Nursing Officers (Grade 9) and Chief Nursing Officers (Grade 10). The Principal Nursing Officer’s sphere of authority (division) will consist of a number of units (each under a Nursing Officer, Grade 7), some or all being grouped into areas (under Senior Nursing Officers, Grade 8). Large hospitals will in themselves have sufficient units to form a division (sometimes more than one division). Divisions can also be formed by bringing together smaller hospitals (units or areas) for purposes of nursing administration. The scale of nursing activities will determine whether in any group there is to be one comprehensive Nursing Division, or whether a separate division should be formed for teaching, or for midwifery or for any other branch of nursing. A suitable title for the Principal Nursing Officer (Grade 9) controlling a Teaching Division will be Principal Tutor and, for a woman, in a Nursing Division or a Midwifery Division, Principal Matron.

6.17 In multi-hospital groups the linking of hospitals to form a division for nursing management should, so far as possible, be in line with medical and administrative organisation. Some existing administrative “sub-groups”, often consisting of a fairly large general hospital and neighbouring smaller hospitals and having a House Committee and a Hospital Secretary in common, may be suitable for the purpose. Alternatively it may be preferable to associate a number of specialist hospitals of the same type. For example, in a group which includes a number of small mental subnormality hospitals, these could be associated either with neighbouring hospitals of different types, or with each other, to form a Nursing Division under a Principal Nursing Officer (Grade 9): similarly with maternity hospitals and smaller mental illness hospitals.
6.18 The aim should be to form a single school of nursing for the hospitals of a management group, and in a fairly large group a Teaching Division could usually be formed, with 250 or more student and pupil nurses, under a Principal Tutor (Principal Nursing Officer, Grade 9). In smaller groups or those in which the administration of teaching cannot be centralised, a separate Teaching Division will not be formed and the Senior Tutor (Senior Nursing Officer, Grade 8) or Tutor (Nursing Officer, Grade 7) will be responsible to the Principal Nursing Officer (Grade 9) controlling the Nursing Division.

6.19 In a hospital management group with more than one division, each under a Principal Nursing Officer (Grade 9), we recommend that a post of Chief Nursing Officer (Grade 10) be provided to co-ordinate them and the nursing heads of hospitals (units or areas) which are not brought within a division, and also to provide a single channel of consultation with the governing body on policy matters. In a group which contains not more than one large hospital, together with a number of "satellite" hospitals we prefer that the Chief Nursing Officer (Grade 10) be given control, so that all the nursing staff of the group are within her sphere of authority. In other kinds of group the post can have a co-ordinating function, but with control of one or more particular divisions (including the Teaching Division). For instance, a nursing head with control in a large general or psychiatric hospital, in a group which contains both, could co-ordinate the nursing in all the other hospitals, of whatever type, within the group.

6.20 Similarly in smaller groups, where the post of group nursing head is in Grade 9 (Principal Nursing Officer), it could carry with it control in some hospitals and a co-ordinating function only in others. In the larger groups, however, which contain several divisions, co-ordinated by a Chief Nursing Officer (Grade 10), each Principal Nursing Officer (Grade 9) should invariably control all the nursing of the division.

6.21 The advice of Regional Hospital Board Nursing Officers (Chief Nursing Officer, Grade 10) will be available to all hospital management groups within each region. This will be particularly useful in groups too small for a post of Principal Nursing Officer (Grade 9).

6.22 Charts exemplifying forms of nursing organisation in different kinds of hospital management group are set out in Appendix 6.

**The Job of the Principal Nursing Officer (Grade 9)**

(i) Functions of posts

6.23 The Principal Nursing Officer (Grade 9) in any division—teaching or nursing—must have a knowledge of the principles of management and an understanding of the place of the nursing function in the whole hospital enterprise. The capacity for original and constructive thought on problems of nursing service or nurse training is not enough; it must be backed by a good knowledge of the working of other functions in the hospital (through consultation with the officers who control them) and the ability to draw (through organising good channels of consultation) on the collective knowledge (sapiential authority) of nurses, particularly those within the division. The Principal Nursing Officer (Grade 9) will not personally undertake programming functions, but will leave them to nurses in Grades 7 and 8. This is particularly important where the
Principal Nursing Officer (Grade 9) controls branches of nursing of which she has no specialist knowledge, for example, where one who is a general trained nurse controls midwifery or psychiatric nursing or teaching. This being so, it will be unnecessary to insist that the nurse in top management (Grades 9 and 10) should have a basic qualification in each kind of nursing that is represented within her sphere of authority. The qualification will be training in management, hacked by the insight that comes from professional experience. However, if a separate Teaching Division is constituted in a group, or a separate Midwifery Division, or a Nursing Division for psychiatric nursing (mental illness or mental subnormality, or both combined), then the Principal Nursing Officer (Grade 9) who is placed in control of it should have the relevant basic qualification in teaching or midwifery or psychiatric nursing.

6.24 The functions of the Principal Nursing Officer (Principal Matron, Grade 9) controlling a Nursing Division will be essentially the same whether her sphere of authority is in a single large hospital or extends over a number of separate hospitals. It will depend on the circumstances of the case whether a Principal Matron (Principal Nursing Officer, Grade 9) holds unit Matrons (Nursing Officer, Grade 7) responsible to the Senior Matron (Senior Nursing Officer, Grade 8) who then has full control, or responsible directly to herself, while reporting to the Senior Matron, who then has actual control. The former arrangement will be especially suitable in out-lying hospitals, in which the Principal Nursing Officer’s supervision will tend to be less close; and, in a district general hospital, for psychiatric nursing and for midwifery, where these are included in the Nursing Division.

6.25 Effective decentralization and delegation to nurses in middle management must be insisted on. It is one important way in which the job of the Principal Nursing Officer (Grade 9) controlling a Nursing Division will differ from that of the Matron of a large hospital under the present staffing structure: the other is in the line of demarcation between her functions and those of the Principal Tutor (Principal Nursing Officer, Grade 9). For we consider that in the new structure, the function of controlling student and pupil nurses, including their selection, should belong to the Teaching Division, in consultation with the Nursing Division under the Principal Matron (Principal Nursing Officer, Grade 9). Matrons of hospitals which are training schools now often spend a disproportionate amount of time and energy in dealing personally with student nurses. This is not a proper function of top management, although undoubtedly a Matron in present circumstances can be most effective in attracting candidates of good quality to her own hospital. If nurse training is on too small a scale to justify setting up a Teaching Division under a Principal Tutor (Principal Nursing Officer, Grade 9), and the tutorial staff belong to the Nursing Division, the Senior Tutor (Senior Nursing Officer, Grade 8) should usually interview candidates on behalf of the Principal Matron (Principal Nursing Officer, Grade 9).

6.26 Allocation of student and pupil nurses for practical training in units will be done by staff of the Teaching Division, in accordance with the plan for practical training settled by the Principal Matron of the Nursing Division, in consultation with the Principal Tutor and with the Principal Matron of the Midwifery Division, if there is one, as regards obstetric nurse training. It will be for the Senior Matrons (Senior Nursing Officer, Grade 8) and Matrons of
units (Nursing Officer, Grade 7) to arrange the assignment of student and pupil nurses within units so as to balance the staffing needs of sections (wards) and the training requirements of individuals.

6.27 Midwifery training will, as at present, be excluded from the function of the Teaching Division. Top management for midwifery, nurse training and psychiatric nursing are further considered in Chapter 7.

(ii) Types of post

6.28 In a hospital group which consists of one large district general hospital, including a training school for 250 or more student and pupil nurses and 100 or more maternity beds, there will be three divisions, each under a Principal Nursing Officer (Grade 9): a Nursing Division, a Midwifery Division and a Teaching Division. If midwifery or teaching is conducted on a smaller scale, it can be included within the Nursing Division, or alternatively, it could form an area controlled by a Senior Nursing Officer (Grade 8) responsible directly to the Chief Nursing Officer (Grade 10).

6.29 If in addition to a large district general hospital there are "satellite" hospitals in the group, they can be added to the Nursing and Midwifery Divisions of the main hospital, but if there are two large general hospitals in the same group, the better arrangement will be for each of them to form a separate division under its own Principal Matron (Principal Nursing Officer, Grade 9), each of whom might also control the nursing in smaller outlying hospitals. If there is a large psychiatric hospital, this similarly could form a separate division under a Principal Nursing Officer (Grade 9) : alternatively a number of mental illness or mental subnormality hospitals could form a separate Nursing Division within the group.

6.30 Job descriptions for various posts of Principal Nursing Officer (Grade 9) are given in Appendix 7. In a group in which nursing is organised in a single Nursing Division, its Principal Nursing Officer (Grade 9) will have additional functions, shown in the job description of the Chief Nursing Officer (Grade 10): in particular, those of attending meetings of the governing body as professional adviser on all nursing matters and recommending the nursing policy for the group.

Criteria for Instituting Posts in Grade 9

6.31 The main criterion is that the job specification of the Principal Nursing Officer (Grade 9) should include policy-forming functions, as well as co-ordination of areas and units.

6.32 In order to give proper scope to the holder of the post, and because there is a limit to the number of nurses who can be prepared for top management, a lower limit should be set to the size of a division. We suggest that this should be the same as the upper limit proposed for the sphere of authority of the Senior Nursing Officer (Grade 8), that is, six units under Nursing Officers (Grade 7), as explained, with particular reference to Nursing Divisions, in Chapter 5*.

6.33 It will be desirable also to impose an upper limit, in the region of 12 units, to the size of a division controlled by a Principal Nursing Officer (Grade 9).

*See Chapter 5, paragraph 5.58.
The extra units, if there are six or more, could be formed into a separate Nursing Division or, if less than six, they could be placed under a Senior Nursing Officer (Grade 8), responsible directly to the Chief Nursing Officer (Grade 10), which might be suitable for a large psychiatric or geriatric component of a district general hospital; or, in the case of paediatric or gynaecological units, they might be added to the Midwifery Division.

6.34 The same criteria can be applied to the institution of a separate Midwifery Division, though the upper limit is unlikely to be relevant. For this type of nursing there are wide variations in the level of activity, according to whether only normal cases are taken, and whether there is midwifery training. We consider that a separate Midwifery Division should be formed if there is a nucleus in a single centre (a midwifery training school) which has as many as six units (each with a Nursing Officer, Grade 7), and an average yearly total of 2,500 births: this will usually require at least 100 beds (including special care cots, but not other cots or labour beds). The sphere of authority of the Principal Matron (Principal Nursing Officer, Grade 9) controlling the Midwifery Division could be extended by bringing within it small maternity hospitals (area or unit) and occasionally gynaecological or paediatric departments.

6.35 For a separate Teaching Division to be formed in a group giving a district general hospital service, we suggest that there should be a total of at least 250 student and pupil nurses in training. No ratio of student nurses to tutors has yet been proposed by the General Nursing Council for Scotland, but the ratio accepted by the General Nursing Council for England and Wales is 1 to 40. On this basis, there should be not less than six Registered Tutors in a Teaching Division, that is, six units. For reckoning units, posts of Tutor filled by unqualified tutors should be included and also posts of Senior Tutor (Senior Nursing Officer, Grade 8).*

6.36 Jobs in the grade of Principal Nursing Officer (Grade 9) are likely to increase in difficulty according to the size of the division controlled. We suggest that, within the grade, categories reflecting degrees of difficulty should be recognized according to the number of units controlled. Three categories should suffice.

THE JOB OF THE CHIEF NURSING OFFICER (GRADE 10) IN HOSPITAL GROUPS

(i) Functions of posts

6.37 It will be the job of the Chief Nursing Officer (Grade 10) to obtain a clear insight into the major nursing problems of all hospitals in the group and to explore possibilities for their solution, in consultation with the senior nurses, individually and collectively, and with other officers. Among matters calling for her attention will be the recruitment, deployment, welfare and further training of nursing staff, the budgetary implications of nursing policies, means of relieving nurses of non-nursing duties and the channels of communication within the hospital group. Some matters will be within the powers of officers to decide; others will need to be referred (generally by means of a joint recommendation agreed by officers beforehand) to the governing body or a committee. The Chief

*See Chapter 7, footnote to paragraph 7.46.
Nursing Officer (Grade 10) will be the nursing spokesman at meetings of the governing body and its standing committees.*

6.38 Decisions taken by the governing body will be promulgated by the Group Secretary, whose function it is as principal administrative officer to review and co-ordinate all activities in the group: but it will be for the Chief Nursing Officer (Grade 10) to take all measures to have the approved nursing policy implemented. For her work she will be responsible directly to the governing body, but the principal administrative officer must be kept informed of action taken or proposed within the approved policy. In this limited sense therefore the Chief Nursing Officer (Grade 10) is properly described as accountable to (that is, reporting to) the principal administrative officer.

6.39 The Chief Nursing Officer (Grade 10) will not control services, such as catering and cleaning, which are conducted by non-nursing staff who in particular hospitals, are transferred to the sphere of authority of senior nurses whom she controls: the control of such services will rest with the principal administrative officer through channels (Group Catering Officer, Group Domestic Superintendent, etc.) defined by him in consultation with all concerned.

6.40 An important feature of the job of Chief Nursing Officer (Grade 10) will be the development of efficient channels of communication, both between nurses and other hospital officers, and also within the nursing service itself, so that due consideration is given to proposals to better the organisation at whatever level they originate. Success in this is associated with good personnel management and is the mark of the good administrator. It is obtained by proper organisation and by force of example among immediate subordinates rather than personal dealings with the staff whose control has been delegated to these subordinates. The kinds of committees and conferences which are useful for purposes of consultation and co-ordination are considered in Chapter 8.

(ii) Types of post

6.41 Posts of Chief Nursing Officer (Grade 10) will be suitable in large hospital management groups in which nursing is organised in more than one division. On a rough estimate, at the present time such posts would be justified in about three-fifths of the hospital groups in England and Wales and one-third of those in Scotland.

6.42 In a large hospital group, where nursing is organised in more than one division, a Chief Nursing Officer (Grade 10) can be appointed:

1) with nursing control in all hospitals; or

2) with control in some hospitals and a co-ordinating function for others.

6.43 Where the Chief Nursing Officer (Grade 10) has full control, the nursing beeds in hospitals (areas or units) will be responsible to her, either directly or through the head of their division (Principal Nursing Officer, Grade 9). Where she has a co-ordinating function only, they will be directed by her, while remaining responsible to the governing body and reporting to the Group Secretary. In this case the Chief Nursing Officer has the right to give them directions, but not orders, unless specifically so authorised by the governing body. Under

*See Chapter 8, paragraphs 8.21 and 8.22.
the second pattern, if there is one Teaching Division for the group under a Principal Tutor (Principal Nursing Officer, Grade 9), it will come under the control of the Chief Nursing Officer (Grade 10) as "head of the nurse training school".

6.44 In a group with one large district general hospital and others which are functionally linked, it will be suitable for the Chief Nursing Officer (Grade 10), to be given control, both in the main hospital and in the other hospitals (areas or units). If the other hospitals are not included in a division under a Principal Nursing Officer (Grade 9), the Chief Nursing Officer (Grade 10) will have direct control in them and undertake top-management functions for nursing in them.

6.45 In a group containing a large general hospital and a large psychiatric hospital, whether or not they are served by a single Teaching Division, hospital authorities may prefer to give the Chief Nursing Officer (Grade 10) control in one and a co-ordinating function only for the other. Similarly, in regard to other hospitals in such a group or in other kinds of multi-hospital group, the Chief Nursing Officer (Grade 10) can be either a co-ordinator or a controller. There must be no misunderstanding over functions or responsibility and the arrangements must be clearly defined and recorded and acceptable to all concerned.

6.46 Of the two arrangements the first, with a controlling post of Chief Nursing Officer (Grade 10), is especially suited to large but compact hospital groups which operate as a single organisation rather than as a collection of individual hospitals. For some large hospital groups, however, in which there are few functional links or they are only partly developed, the second arrangement may be better suited, at least as a transitional form of organisation, with the Chief Nursing Officer (Grade 10) in control of nursing in some hospitals, and with a co-ordinating function for others.

6.47 A job description for posts of Chief Nursing Officer (Grade 10) in hospital management groups is given in Appendix 7.

Criteria for Instituting Posts in Grade 10.

6.48 The main criterion is that the job specification should include co-ordination of nurses having policy-forming functions, that is, of Principal Nursing Officers (Grade 9) in control of divisions.

6.49 A Chief Nursing Officer (Grade 10) will co-ordinate at least two divisions—a Teaching Division and a Nursing Division, each under a Principal Nursing Officer (Grade 9). In a large multi-hospital group there may be in addition a Midwifery Division and perhaps another Nursing Division (for instance, a mental illness hospital), or other hospitals (areas) under Senior Nursing Officers (Grade 8) or (units) under Nursing Officers (Grade 7), not included within a division and coming directly within the sphere of authority, or co-ordination, of the Chief Nursing Officer (Grade 10).

6.50 Since there will be variations in the degree of difficulty of the job of Chief Nursing Officer (Grade 10) according to the number and size of divisions controlled or co-ordinated, categories should be recognised within the grade as in the case of Grade 9 (see paragraph 6.36 above).
Regional Hospital Board Posts in Grade 10.

6.51 While each Hospital Management Committee, Board of Management or Board of Governors controls its own separate nursing services and determines the number and functions of nurses to be employed within financial limits, this control is exercised (except for teaching hospitals in England and Wales) on behalf of the Regional Hospital Boards; and in Scotland the Regional Hospital Boards also retain the right, which is occasionally exercised, to make appointments of staff employed for purposes wider than those within the scope of a single Board of Management. The need to co-ordinate nursing policy within each region has from the beginning been recognised in the appointment of a Nursing Officer to each Regional Hospital Board, and, in regard to nurse training, by the establishment of Area Nurse Training Committees (in Scotland, Regional Nurse Training Committees).

6.52 The following guidance on the functions of these Nursing Officers was issued in 1948 by the Ministry of Health:

"The duties of Nursing Officers will no doubt be determined in the light of experience, but in the first instance it appears that their principal task should be to assist in the recruitment of staff and in the general arrangements to give effect to the Minister's interim nursing policy. The Nursing Officer should be available to visit hospitals in the Board's area to discuss with Hospital Management Committees and their officers problems of training, recruitment, accommodation, welfare, and allied matters, and to advise the Board on any steps it may be necessary for them to take".*

6.53 The functions of Regional Hospital Board Nursing Officers vary from one region to another. In general, they advise Regional Hospital Boards on nursing subjects and inform them of the Health Ministers' nursing policies. They arrange or promote courses of further training for qualified nurses, help with nursing publicity and recruitment, and assist in the work of Area (or Regional) Nurse Training Committees. They also advise Regional Hospital Boards on applications for extra allocations to finance additions to nursing staff comple-
ments. In consequence their advice is often sought on nursing establishments, and on connected subjects, by Hospital Management Committees or Boards of Management. Recently they have also been appointed as assessors to selection panels for making senior nursing appointments. In most regions posts of Assistant Nursing Officers have been instituted, and some Nursing Officers have been able to extend their activities to research on such matters as nursing staff wastage and staffing requirements in different specialities and to advising on plans for new hospital buildings. Since the Nursing Officers keep in close touch with the Nursing Divisions of the Health Departments they are well placed to inform Matrons in their regions of developments in national policy, so that their influence can be important. In some regions however the experience of Nursing Officers and their staffs is largely confined to general nursing. This should be remedied.

6.54 As constituted in the past the job of the Regional Hospital Board Nursing Officer has compared unfavourably in status with that of Matron of a large hospital with a training school, as well as with posts of other heads of services at the headquarters of Regional Hospital Boards. The job has been unattractive,

not merely on account of incidental factors such as the need for constant travelling, but because the functions have been indeterminate. In our view the job is of the highest importance for its formative influence on nursing policy and staffing structure in the regions and it ought to be made attractive to experienced and senior nurses of high administrative calibre. The grade should be no lower than that of the Chief Nursing Officers (Grade 10) in hospital management groups whom they advise.

6.55 Accordingly we recommend that in the new structure, except in the smaller Scottish regions where Grade 9 (Principal Nursing Officer) may be appropriate, Nursing Officers of Regional Hospital Boards should be graded Chief Nursing Officer (Grade 10).

6.56 A job description for the post of Regional Hospital Board Nursing Officer (Chief Nursing Officer, Grade 10) is given in Appendix 7.

**Definitions of Grades 9 and 10**

6.57 The following definitions are offered as summary descriptions of the grades in top management in hospital management groups:

**Principal Nursing Officer** (Grade 9)

A registered nurse (in a Midwifery Division, a qualified midwife and, in a Teaching Division, a qualified tutor) who *controls* a *division*, or, in a hospital management group in which there is no post of Chief Nursing Officer (Grade 10), *controls or controls* and *co-ordinates* the work of *areas* and *units*.

**Chief Nursing Officer** (Grade 10)

A registered nurse who *controls or controls* and *co-ordinates* the work of *divisions* together with that of any *areas* and *units* which are not included within a *division*.
CHAPTER 7

Application of the New Structure to Midwifery, Psychiatric Nursing and Nurse Education

7.1 The new staffing structure described has been devised to accommodate posts in all branches of nursing and so to be applicable to midwifery, psychiatric nursing and teaching. It has been suggested to us in evidence that each of these has special characteristics which make it advisable for it to be administered separately from the rest of nursing. We do not think this to be necessary; but their control must be decentralised and delegated. In this chapter we consider their special organisational needs.

Midwifery

(i) Relation of midwifery to other nursing

7.2 Those who hold that midwifery should be administered separately from other nursing argue that it works better this way, the necessary co-ordination between midwifery and general nursing being effected by co-operation of the two Matrons as equals, rather than through control by the Matron of a general hospital. This view is supported by the argument that midwifery is a profession distinct from that of nursing: for the qualifications are prescribed by different statutory bodies and the midwife, unlike the nurse, is a practitioner in her own right who is concerned primarily, not with the sick, but with healthy people. The inference is drawn that maternity departments should therefore be excluded from the control of a Matron of a general hospital (certainly of one who is not herself a midwife)—either invariably, or when midwifery training is conducted, or if the department is above a certain size or accommodated in premises physically separate from the rest of the general hospital.

7.3 Those who take the opposite view argue that midwifery is in fact a branch of nursing and point out that the great majority of practising midwives are also qualified nurses. They believe that the connection in the future will be even stronger—with even more births taking place in the hospital; a greater proportion or maternity beds being provided in general hospitals; closer association of obstetrics with gynaecology and paediatrics; more nursing staff being used to supplement midwives; and obstetric training being included in the training of the student nurse.

7.4 Our own conclusions are that, with the present staffing structure, there are sometimes practical advantages in the control of midwifery being separate from that of general nursing, but that, with the proposed new staffing structure, co-ordination will best be attained by integrated control.

(ii) Advantages of the new structure

7.5 The new structure will extend to all branches of nursing two features which the midwifery profession have rightly insisted on for midwifery in general hospitals: first, decentralised line management of maternity departments and, second, association of clinical work with administration in jobs above the level of Sister. They are reflected in advice given by the Minister of Health in 1954 on the position of the Superintendent Midwife:—
"In any maternity department (within a general hospital) which is a training school for pupil midwives, the superintendent midwife should be responsible for the administration of her department directly to the matron of the hospital and not to one of her subordinates. All midwifery staff and pupils appointed to the maternity department should be selected by the matron only after consultation and in agreement with the superintendent midwife".*

7.6 In the new staffing structure the position of the Superintendent Midwife will in many respects become the prototype of middle management for the rest of nursing. Since posts of senior nurses will be graded in a uniform staffing structure, irksome questions of the relative precedence of Assistant Matrons and Superintendent Midwives will cease to arise. Head midwives will not find themselves deprived of any voice in the selection of staff, for their personnel functions will be defined in their job descriptions according to their grade. There need be no outside interference with midwifery practice, for the programming functions belong to middle management. For those who aim at posts in top management, without abandoning midwifery, there will be posts of Principal Matron (Grade 9) in Midwifery Divisions of district general hospitals as well as in large separate maternity hospitals.

7.7 Characteristics which now give midwifery administration its strength are also to some extent a source of weakness. The recognition that administration is incidental to midwifery practice rather than a separate function sometimes prevents a proper appreciation of the need to prepare for it. Thus midwives deepen their clinical knowledge by studying for the Midwife Teachers' Diploma, but in the past they have rarely taken courses in nursing administration. Like those in other specialties, nurses engaged in midwifery must be encouraged consciously to develop their skills in management at all levels. Our proposals for such preparations are given in Chapter 9.

7.8 In addition, the aim of preserving "autonomy" for head midwives in professional matters has brought with it a tendency towards isolation and consequently they have often not benefited from new trends in nursing. Our proposals for the constitution of large maternity departments as Midwifery Divisions and the inclusion of peripheral maternity hospitals within the sphere of authority of their Principal Matrons (Principal Nursing Officer, Grade 9) should help to remedy these defects. Where, in appropriate cases, gynaecological or paediatric units are included in Midwifery Divisions, this also should counteract isolationism on the part of midwives.

(iii) Special characteristics of maternity departments

7.9 In some respects midwifery in general hospitals will continue to be differently organised from most general nursing:—

(1) The midwife has statutory functions in respect of the care of the mother and baby.

(2) Midwifery training is conducted as an integral part of the work of the department under the control of the head midwife.

(3) Activity is more evenly spread over the whole 24 hours of the day than in most other specialties.

*H.M. (54) 4.
7.10 Shorter working hours make it difficult for one midwife exclusively to care for a mother during her confinement. Moreover, facilities can be used more intensively if delivery suites are staffed and controlled separately from lying-in wards. Nevertheless, in the interests of patients and to make the work of midwives of all grades satisfying, the aim should be to provide for as much continuity of care and control as the circumstances allow. The following suggestions for organisation are made with these objects in view, but the details will need to be adjusted in the light of research being undertaken into the staffing of maternity departments.

7.11 In a Midwifery Division controlled by a Principal Nursing Officer (Grade 9)* the maternity services (area) under the Senior Matron (Senior Nursing Officer, Grade 8) might be organised in three units, each controlled by a Matron (Nursing Officer, Grade 7)—lying-in and ante-natal beds and clinics; delivery suites; and special care cots and nurseries, if any. Alternatively, if the delivery suites are dispersed, there might be two units of wards, each with its delivery suites, and a third unit comprising special care cots and clinics. There would also be a post of Night Superintendent held in rotation by the Nursing Officers (Grade 7).

7.12 A unit consisting of lying-in and ante-natal beds would consist of wards, each controlled by a Midwifery Sister (Charge Nurse, Grade 6).

7.13 In a unit comprising delivery suites two teams (sections), or three in a very large unit, could be formed under Midwifery Sisters (Grade 6). Midwives for night duty could be provided—except for the Night Superintendent (Grade 7)—from within the unit. For each section there could be two Midwifery Sisters (Grade 6) for duty by day (the junior reporting to the senior, as explained in paragraph 4.31 in relation to Ward Sisters) and a third by night. Because the work is strenuous and to give variety of experience, the Midwifery Sisters (Grade 6) and the Staff Midwives (Grade 5) should be interchanged from time to time with those in other units.

7.14 In hospitals which are midwifery training schools our proposals involve no change in the present arrangements for the conduct of training. It is the practice of the Central Midwives Boards to address correspondence on matters of policy to the Group Secretary and on routine matters to a designated “official correspondent”, who is usually, for a separate maternity hospital, the Matron, or, for a department in a district general hospital, either the Superintendent Midwife or the Approved Teacher. With the new staffing structure, we would expect the Group Secretary to receive communications on policy and refer them to the nurse administrator who discharges top-management functions for midwifery. In the case of a large training institution which forms a Midwifery Division this will be the Principal Matron (Principal Nursing Officer, Grade 9). Otherwise it will be the Principal Matron (Principal Nursing Officer, Grade 9) who controls the Nursing Division, if midwifery is included within it; or, in a large group, for a midwifery training school which does not form part of a division, it will be the Chief Nursing Officer (Grade 10). Correspondence on routine matters should continue to be addressed to an “official correspondent” —generally the Approved Teacher.

*See Chapter 6, paragraph 6.34.
7.15 For dealing with correspondence in the Midwifery Division two Personal Secretaries, or the equivalent in other grades, should be provided to assist the Principal Matron (Principal Nursing Officer, Grade 9) and the Senior Matron and the Senior Midwife Teacher (Senior Nursing Officer, Grade 8).

7.16 In Appendix 6 Chart A shows the organisation of a Midwifery Division in a group consisting of a large district general hospital and a large psychiatric hospital. Other charts show how the hospital maternity services might be organised in other kinds of group. Job descriptions related to Chart A are given in Appendix 7 for posts in Grades 6 (Charge Nurse) to 9 (Principal Nursing Officer).

Psychiatric Nursing

7.17 We have given particular attention to two matters; first, the trend towards unifying the male and female nursing services under one nursing head in each psychiatric hospital and, second, the feasibility of posts of Chief Nursing Officer (Grade 10) to co-ordinate nursing services in "mixed" hospital groups, containing both psychiatric and non-psychiatric hospitals. We have considered both matters in the context of the Hospital Plans.

7.18 The purpose of psychiatric hospitals, both for mental illness and for mental subnormality, has been changing: the emphasis has been passing from custody and care of the patients to treatment. The change, which is not occurring uniformly in all hospitals or for all kinds of patient, has its implications for nursing organisation.

(i) Unification of male and female nursing services

7.19 The traditional division of the nursing service into two, male and female, has corresponded with the segregation of male and female patients in separate parts of the hospital. The move towards unifying them has two sources, first, the needs of psychiatry, and second, considerations of administrative efficiency.

7.20 Some of the needs of psychiatry are stated in guidance recently issued by the Ministry of Health, which suggests that large hospitals for the mentally ill can be made more effective by division into self-contained sections, each under a consultant and related to a geographical area.* This implies discontinuance of two separate male and female sides and the integration of the male and female nursing services. This has been effected in a number of hospitals, as well as in short-stay psychiatric units in general hospitals. There being no division into male and female sides, men and women of the nursing staff are in many ways interchangeable in all grades and there is unified control by a single nursing head.

7.21 When undertaken for administrative reasons, unification is usually limited to the top administrative nursing posts. Below them, at least from the grades of Assistant Matron/Assistant Chief Male Nurse down, the nursing staff continue to be divided into two services, male and female. Unification under a single nursing head has obvious advantages, not only for the nursing services, but also for the administration of nurse training. When Matron and Chief Male Nurse are

*H.M.(64)45, para. 30.
equally heads of a training school, the Principal Tutor is in the difficult position of being responsible for both.*

7.22 In taking evidence we found the principle of having one nursing head in a psychiatric hospital entirely acceptable. Any misgivings related to possible difficulties foreseen in its application and to its effect on promotion prospects. Some hospitals were thought to be too large for control by a single nursing head and it was suggested that male nurses should not be required, contrary to their terms of appointment, to look after female patients.

7.23 Our conclusion is that, with the new staffing structure, there should be one nursing head in each hospital to control the nursing staff. The administrative advantages are indisputable. The fact that a hospital is large need not present undue difficulty of control, since under our proposals there will be decentralisation and delegation. This recommendation does not imply that men and women nurses should be entirely interchangeable. The extent will depend on a number of factors including the availability of nursing staff and the suitability of the patients: these must be taken into account when the medical plan of care and treatment is formulated in consultation with the nurses. In many hospitals the practice of separating the patients into male and female sides may continue for some time.

*The following are the Whitley definitions, as given in the Nurses and Midwives Council Handbook of Pay and Conditions of Service (1965):

51. A Matron is the qualified mental nurse who is the head of the female nursing service in a hospital and is responsible for the nursing of the patients and for nursing administration. In training schools she is responsible for the training; she may also undertake such other appropriate duties as may be prescribed by her employing authority.

52. A Chief Male Nurse is the qualified mental nurse who is the head of the male nursing service in a hospital and is responsible for the nursing of the male patients and for nursing administration on the male side of the hospital and undertakes such other appropriate duties as may be prescribed by his employing authority. (For salary categories see Note 4 to Table IID Part III)."

The Note reads:—“4. Chief Male Nurse For salary purposes Chief Male Nurses in psychiatric hospitals which are approved as training schools for mental nursing or nursing of the mentally subnormal (in Scotland, mentally deficient) by the General Nursing Council are divided into three categories, as under:—

(a) Chief Male Nurses whose duties and responsibilities are equal in all respects to those of the Matron;

(b) Chief Male Nurses who do not qualify for inclusion in category (a) above, but who have substantial training responsibilities and satisfy the following conditions:

(i) are responsible for the recruitment and interviewing of candidates as male Student Nurses and are finally responsible for accepting them for training;

(ii) where there is a preliminary training school at the hospital, are wholly or jointly responsible for the arrangements at the school; and

(iii) are responsible for the training of male Student Nurses, making the requisite arrangements for lectures, etc., with the tutors and Charge Nurses.

(c) Chief Male Nurses who do not qualify for inclusion in either category (a) or (b) above.

The intention of the Council is that category (a) should be reserved for cases where there is absolute equality of duties and responsibilities as between the Chief Male Nurse and the Matron. In order that the greatest possible measure of uniformity may be achieved in the grading of individual officers, the Council have agreed that the responsibility for determining whether a Chief Male Nurse qualifies for inclusion in category (a) shall lie with the appropriate Regional Hospital Board . . . . ".
In the new structure each side could constitute an area under a Senior Nursing Officer (Grade 8), or a division if large enough. However, if there is a single nursing service, controlled by one nursing head, it will be much simpler than at present to adjust the organisation of the hospital to accord with medical plans as these develop.

(ii) Middle Management

7.24 In Chapter 5 we have discussed more fully the functions of the Senior Nursing Officer (Grade 8) and the Nursing Officer (Grade 7). The application of our proposals to psychiatric hospitals should not be difficult. A Senior Nursing Officer (Grade 8) will control an area which might be a male or female side in a medium-sized hospital or a "mixed" area with its clinical team. Below will be Nursing Officers (Grade 7) controlling units such as groups of wards, a day hospital or a department for industrial or social therapy. At night will be a Night Superintendent (Nursing Officer, Grade 7) in charge of each area. Two or more Night Superintendents in a Nursing Division will be co-ordinated by a Senior Night Superintendent (Grade 8).

(iii) First-line Management

7.25 We found the following variations in the system of control of a ward by day.

(a) One Charge Nurse or Ward Sister in control working a "long day" and relieved by a Deputy Charge Nurse/Deputy Ward Sister on days off.

(b) One Charge Nurse or Ward Sister in control working a "middle shift", with a Deputy Charge Nurse/Deputy Ward Sister on each day shift.

(c) Two Charge Nurses/Ward Sisters each regarded as in control of their own shift, supported by Staff Nurses and with no designated Deputy Charge Nurse/Deputy Ward Sister.

We have already explained our view that the best arrangement is for a single person to be regarded as in control throughout the day.* If under a shift system there are to be two Charge Nurses (Grade 6) to a ward the junior should report to the senior, both being responsible to the Nursing Officer (Grade 7). We have regarded the Whitley grades of Deputy Ward Sister and Deputy Charge Nurse as included in Grade 5 (Staff Nurse). These grades are outside our terms of reference however and we only assert the principle that in the staffing structure there should be no more grades than are actually required for the jobs. We realise that heavy responsibility may be carried by nurses who take charge in the absence of the Charge Nurse (Grade 6) and we feel this could be recognised by distinguishing categories within Grade 5.†

(iv) Co-ordination of nursing in mixed hospital groups

7.26 In groups consisting entirely of hospitals either for the mentally ill or for the mentally subnormal, there will be no difficulty in applying the recommendation that there should be a single group nursing head, with control in all hospitals, in the grade of Principal Nursing Officer (Grade 9) or Chief Nursing Officer (Grade 10) according to the size of the group. Similarly in

*See Chapter 4, paragraph 4.31.
†See Chapter 3, paragraph 3.42.
groups consisting of hospitals of both types, a single group nursing head, with control, can readily be appointed. It was suggested to us in evidence that it would be advisable for a holder of such a post to be qualified both on the mental and the mental subnormality (or mental deficiency) parts of the Register. Our own view is that qualification in a single branch of psychiatric nursing is all that should be required.

7.27 We found less unanimity as regards the institution of posts of a group nursing head in the "mixed" groups containing both psychiatric and general hospitals. Some of those who gave evidence saw no difficulty in this; others thought that a person without psychiatric training would be unable to understand and represent the needs of psychiatric nursing.

7.28 In the future it seems likely that psychiatric and general hospitals will be more closely associated. Some new district general hospitals are to be built in the grounds of existing psychiatric hospitals, and their governing bodies are likely to be amalgamated. There are also other circumstances in which amalgamation of psychiatric and non-psychiatric hospital groups is taking place. Such association, together with the inclusion of psychiatric units in district general hospitals, is likely to strengthen the professional bonds between psychiatric and general nurses. These bonds will be further strengthened by the institution of combined schools of nursing providing training for all parts of the Register as well as by joint participation in training courses for management.

7.29 We have concluded that co-ordinated presentation of the views of the nursing service to the governing body is as necessary in "mixed" groups of psychiatric and non-psychiatric hospitals as in homogeneous groups. We see no inherent obstacle to the function being discharged by a Chief Nursing Officer (Grade 10). Having in mind views strongly presented to us in evidence we suggest that, when such a post is first introduced, it may be advisable for the holder, particularly if without experience of psychiatric nursing, to exercise a coordinating function, rather than one of control in relation to the psychiatric hospital of the group, and likewise for a psychiatric trained holder without experience of general nursing in relation to non-psychiatric hospitals. What is essential is that the holder should have undergone appropriate training in management.

(v) Psychiatric nursing staff in district general hospitals

7.30 In the guidance issued on hospital buildings for psychiatric patients, it is proposed that "each therapeutic team should be responsible for the treatment of a complete cross-section of patients, in whatever accommodation they may be. This means that medical teams should be responsible for both short-stay and long-stay beds, and the nursing staff should do periods of service in each section. Such a scheme is necessary for training purposes: and it would ensure that proper attention is paid to the longer-stay patients."*

7.31 This requirement will be easier to fulfil in groups where a mental illness hospital and the psychiatric unit of a district general hospital are organised to provide a comprehensive psychiatric service. The psychiatric department of the district general hospital could belong to the Nursing Division of the mental

illness hospital. In this way regular interchange of nursing staff, both for basic training and for post-certificate experience, could readily take place.

7.32 Where the district general hospital is in a different management group from that of the psychiatric hospital the system of transfer could be used for the interchange of staff between the mental illness hospital and the psychiatric unit. The necessary administrative arrangements would have to be worked out between the group nursing heads of the management groups concerned and approved by the governing bodies. Thereafter detailed arrangements could be made at the level of middle management. Present systems, under which student nurses are “seconded” for training in hospitals of other hospital management groups, provide a precedent for the kind of arrangement suggested.

(vi) Teaching departments in psychiatric hospital groups

7.33 In Chapter 6 we have suggested, as one of the criteria for constituting a teaching department as a separate Teaching Division, under a Principal Tutor (Principal Nursing Officer, Grade 9), that there should be a total of at least 250 student and pupil nurses in training, that is, not less than six posts for Registered Tutors (units). Only exceptionally will a management group consisting entirely of psychiatric hospitals have as many as 250 student and pupil nurses in training; and this total is unlikely to be reached, even with the expansion of training schools which will follow upon the introduction of the grade of enrolled nurse to psychiatric hospitals. It would follow that nearly all the teaching departments would be controlled by a Senior Tutor (Senior Nursing Officer, Grade 8); so that, unless a group were exceptionally large and organised in two separate Nursing Divisions, a post of Chief Nursing Officer (Grade 10) would not be instituted. In consequence career prospects in psychiatric hospital groups would be adversely affected for all senior nurse administrators, and especially for tutorial staff.

7.34 We therefore recommend that, in groups consisting exclusively of psychiatric hospitals, a Teaching Division under a Principal Tutor (Principal Nursing Officer, Grade 9) should be instituted, if there are four units or more in the teaching department, that is, as many as 160 student and pupil nurses.*

(vii) Job Descriptions

7.35 In Appendix 6 Chart A shows the organisation of a large psychiatric hospital in a group in which there is also a district general hospital and Chart C shows that of a large mental illness hospital which forms a group on its own. Job descriptions related to the former are given in Appendix 7 for posts in each grade down to Charge Nurse (Grade 6).

Nurse Education

7.36 Some statistics relating to tutorial staff are given in Table VII:

*It has been advocated that the ratio of student nurses should be much lower in psychiatric nurse training than in general nurse training “because of the emphasis on discussion methods”. (Royal College of Nursing. 1961. The nurse tutor: a new assessment. P.14). If the ratio is revised, the criterion proposed in this paragraph for posts of Principal Tutor (Principal Nursing Officer, Grade 9) should be reconsidered. It should also be reconsidered if there is substantial improvement in recruitment for psychiatric nurse training.
### Table VII
**Tutorial staff**

<table>
<thead>
<tr>
<th>Type of hospital</th>
<th>Number of tutorial staff</th>
<th>% of tutorial staff who are unqualified</th>
<th>% of senior nurses who are in tutorial posts</th>
<th>% of senior nurses with higher educational qualifications who are in tutorial posts</th>
<th>% of senior nurses with the S.T.D. who are in tutorial posts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. ENGLAND AND WALES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric</td>
<td>205</td>
<td>30</td>
<td>2</td>
<td>6</td>
<td>84</td>
</tr>
<tr>
<td>Other</td>
<td>1,229</td>
<td>32</td>
<td>5</td>
<td>7</td>
<td>90</td>
</tr>
<tr>
<td>Total</td>
<td>1,434</td>
<td>32</td>
<td>4</td>
<td>7</td>
<td>89</td>
</tr>
<tr>
<td><strong>B. SCOTLAND</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric</td>
<td>39</td>
<td>54</td>
<td>3</td>
<td>6</td>
<td>88</td>
</tr>
<tr>
<td>Other</td>
<td>142</td>
<td>40</td>
<td>5</td>
<td>7</td>
<td>81</td>
</tr>
<tr>
<td>Total</td>
<td>181</td>
<td>43</td>
<td>4</td>
<td>6</td>
<td>82</td>
</tr>
</tbody>
</table>

**Source:** Statistical enquiry.

**Notes:**
1. Staff in posts of Principal Tutor, Nurse Tutor in sole charge, Registered or Qualified Nurse Tutor and Unqualified Nurse Tutor.
2. Those who replied to the questionnaire: the numbers for England and Wales may be compared with the following Ministry of Health statistics for all tutorial staff at 30.9.1964:

<table>
<thead>
<tr>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric hospitals</td>
<td>266</td>
<td>215</td>
</tr>
<tr>
<td>Other hospitals</td>
<td>1,558</td>
<td>305</td>
</tr>
<tr>
<td>Total ...</td>
<td>1,824</td>
<td>520</td>
</tr>
</tbody>
</table>

3. "Senior nurses" in this context means all staff included in the statistical enquiry except midwifery staff and staff in maternity hospitals in the grades of Assistant Matron and above.
4. University degree, or higher school certificate or its equivalent.
5. Sister Tutor's Diploma.

7.37 It is clear that there are not nearly enough Registered Nurse Tutors to fill all tutorial posts: nor at the present rate of qualification are there likely to be enough to fill them in the future.* It has also been made clear to us in evidence

*The following figures for Great Britain relate to nurses studying for the Sister Tutor's Diploma:

<table>
<thead>
<tr>
<th>Year</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>21</td>
<td>43</td>
<td>64</td>
</tr>
<tr>
<td>1961</td>
<td>25</td>
<td>42</td>
<td>67</td>
</tr>
<tr>
<td>1962</td>
<td>29</td>
<td>44</td>
<td>73</td>
</tr>
<tr>
<td>1963</td>
<td>35</td>
<td>50</td>
<td>85</td>
</tr>
<tr>
<td>1964</td>
<td>30</td>
<td>45</td>
<td>75</td>
</tr>
</tbody>
</table>

The average number qualifying annually (73) is less than 4% of all nurses in tutorial posts.
that many tutors find their position unsatisfying. We have particularly considered means of making a career in teaching more attractive. This is not however the only line of solution in bringing supply and demand into balance for properly qualified nurse tutors. Their use could and is being economised in a number of ways: these are the concern primarily of the General Nursing Councils and they include making it easier for nurses to obtain teaching qualifications and the amalgamation of schools of nursing.

(i) The present role of tutorial staff

7.38 Among reasons given by tutors for dissatisfaction are:

(1) subordination of tutors to nurse administrators whose formal post-registration qualifications may be inferior;

(2) non-acceptance of the tutor as the person responsible for the education of the student nurse;

(3) incomplete control of their own departments.

There is also sometimes resentment with the way in which Matrons carry out their function of reconciling conflicting demands of nursing service and nurse training.

7.39 In regard to the first point, so far as it is a valid criticism, the position will be improved by our proposals, set out in Chapter 9, for formal training courses for all nurse administrators. In regard to the second and the third of these points, the facts are that nurse training comprises two main elements—theoretical instruction, which is given by Nurse Tutors and Teachers of Pupil Nurses, and practical instruction which in the past has been mainly undertaken by Ward Sisters and Staff Nurses, now supplemented by Clinical Instructors. It is the Matron (and, where applicable, the Chief Male Nurse) who, as head of the training school, is responsible to the governing body for training as a whole, as well as for reconciling it with nursing service. The part which nurse tutors play in managing the whole training function, or even the theoretical part of it, varies from one hospital to another according to the extent of delegation by the Matron to the Principal Tutor. Even if friction is avoided by goodwill and tact on all sides, the uncertainty as to the tutors' proper role makes for insecurity. The job has many of the disadvantages of that of some Assistant Matrons.*

7.40 Useful work is done by some Nurse Education Committees in smoothing over the difficulties which arise in reconciling the needs of training and nursing service as well as in providing guidance on training policy. The part which the Principal Tutor plays in these committees varies—in some cases as member, or even as chairman, in others as secretary or simply in attendance. This variety in practice also illustrates the uncertainty over the role of the Principal Tutor. But however effective a committee may be in mitigating the ill-effects of conflict between functions, the better way is to prevent it by a more suitable allocation of functions. The role of the Nurse Education Committees is considered in Chapter 8.

7.41 Dissatisfaction with the job is believed to cause an undue proportion of nurse tutors to give up nurse teaching. Statistics of nurse tutors who abandon

*See Chapter 5, paragraph 5.12.
nursing prematurely are lacking.* Our statistical enquiry revealed however about 12% of nurses with tutorial qualifications in non-tutorial posts over Great Britain as a whole. About a half of this 12% were found to be Matrons or Chief Male Nurses in training schools: in England and Wales these constituted 6% of Matrons (and 8% of Chief Male Nurses) with charge of training schools, and in Scotland 10% of the Matrons (there appeared to be no Chief Male Nurses with a tutorial qualification). The proportion of heads of training schools who themselves had attained the grade of Principal Tutor is probably much lower. It must be frustrating for Principal Tutors, having attained that grade at a comparatively early age, to find their experience and capacities unrecognised in terms of status.†

(ii) The role of tutorial staff in the new structure

7.42 We have been greatly interested in the proposals of the Platt Report for the reform of nursing education. A central recommendation is that each School of Nursing should function as an educational institution with “an identity separate from that of the hospitals which provide practical experience indispensable to nursing education”.‡ Having regard to our terms of reference we have formulated our recommendations in the context of the existing system in which nursing service and nurse training are administered together under one authority. We believe however that if Teaching Divisions were to be established, as we recommend, for functionally integrated hospital management groups, two important recommendations made in the Platt Report would be substantially realized—recognition of the needs, as students, of nurses in training, and appointment of registered nurse tutors to be Principals of Schools of Nursing with a proper sphere of authority. The implications of our proposals, so far as concerns tutorial staff, are explained in the following paragraphs.

7.43 The role of the tutorial staff, in all grades, should be made more satisfying by the following means:

1. improved career prospects through the institution of larger schools of nursing to form Teaching Divisions under Principal Tutors (Principal Nursing Officer, Grade 9);
2. devolving on the tutorial staff the control both of student and pupil nurses and of Clinical Instructors;
3. delegation by the Principal Tutor (Principal Nursing Officer, Grade 9) to other tutorial staff of some administrative functions.

7.44 The first proposal has already been outlined in Chapter 6.** If adopted, it will result in more posts in top management (Principal Nursing Officer, Grade 9) than at present, becoming available to tutorial staff; and Principal Tutors (Principal Nursing Officer, Grade 9) will be eligible for further promotion to

*The deficiency may be filled by a study being undertaken by the King Edward’s Fund (Reference B/23/2 in the “List of Hospital Studies”, compiled by the Ministry of Health).
†The most usual age for first appointment as Principal Tutor is between 35 and 39 years. This compares with 40–44 for Matrons and Chief Male Nurses. 40–49 for Deputy Matrons (40–44 in psychiatric hospitals in England and Wales), and 40–44 for Deputy Chief Male Nurses (45–49 in Scotland).
**See Chapter 6, paragraph 6.18. For Teaching Divisions in groups consisting exclusively of psychiatric hospitals see also paragraph 7.34 above.
Grade 10 (Chief Nursing Officer). Forming large schools will also facilitate a degree of specialisation in the subjects taught by each tutor.

7.45 The second proposal is derived from the recognition that tutorial staff have a primary interest in the whole nurse training function, whereas for other nurses it is subsidiary to the function of caring for the patient. Where a Teaching Division is constituted, the function of selecting student and pupil nurses should belong to the Principal Tutor (Principal Nursing Officer, Grade 9) and be exercised in consultation with the Nursing Division. Where a teaching department forms part of the Nursing Division, tutorial staff should advise on their selection. In all cases the tutorial staff should allocate student and pupil nurses for practical training to *units* (in accordance with a plan of training agreed in advance in the Nursing Division), assignment within the *unit* of individual student and pupil nurses being left to the *unit* Matron (Nursing Officer, Grade 7). The function of nurse tutors should not be confined to the class-room. They should follow the progress of student and pupil nurses in the wards and departments of the hospitals. Clinical Instructors should be part of the teaching department.

7.46 The third proposal aims at increasing the job-satisfaction of teaching posts below the level of Principal Tutor (Principal Nursing Officer, Grade 9). We recognise that the grading of tutorial staff is primarily related to the value of the *professional* element of their work rather than the managerial.* It may also be expected that most tutorial staff will find that the part of their work which gives the greatest satisfaction is actual teaching, but many people, after experience in exercising a technical function are attracted to management, feeling that they have a contribution to make. Accordingly each Tutor (Nursing Officer, Grade 7) should have a distinct *sphere of authority*. This could well consist of an in-take of nurses in training with whose progress the Tutor will be concerned throughout their period of training. The same applies to the jobs of Unqualified Tutors. They however will be in Grade 6 (Charge Nurse), though on becoming qualified and assuming the full duties of Tutor they will automatically be promoted to Grade 7 (Nursing Officer). Other teaching posts in Grade 6 (Charge Nurse), those of Teacher of Pupil Nurses and Clinical Instructor, are best regarded as posts in which nurses test their aptitude for teaching before going on to become Registered Tutors. These posts entail co-operation with Ward Sisters, but prior experience as Ward Sister, as distinct from formal preparation for the job, does not seem to be necessary.†

*In all teaching posts, except perhaps that of head of a very large Teaching Division, the job is predominantly actual teaching. For this reason all posts intended to be filled by Registered Tutors (or Midwife Teachers) should be counted as *units* for the purpose of grading the post of the head of the department in which they work. This is in contrast to nursing service posts.
†There is no Whitley grade of Clinical Instructor or Teacher of Pupil Nurses. The General Nursing Council for Scotland maintain a Register of Clinical Instructors in accordance with Rules made in 1962. The requirements for registration may be summarised as:—(1) registered general nurse; (2) two years' post-registration experience as a Sister or male Charge Nurse in charge of a ward in an approved training school (or three years' acceptable equivalent experience); (3) holding a Clinical Instructor Certificate awarded on completion of an approved six-months' course. In England and Wales a register is not kept by the General Nursing Council; but the Royal College of Nursing have comparable requirements for admission to courses in preparation for their Clinical Instructor Certificate and their Teacher of Pupil Nurses Certificate.

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7.47 The sphere of authority of the Senior Tutor (Senior Nursing Officer, Grade 8) will consist in organising the teaching of a group of subjects and controlling the Tutors (Grade 7) and Clinical Instructors and Teachers of Pupil Nurses (Grade 6) who teach them. Personnel functions in relation to pupil nurses will suitably be delegated to Teachers of Pupil Nurses. In a hospital group consisting of a number of hospitals, in which training is conducted for different parts of the register, it may be expected that some Senior Tutors (Senior Nursing Officer, Grade 8), and in some cases Tutors (Nursing Officer, Grade 7) will work at a distance from the headquarters from which nurse training is administered by the Principal Tutor (Principal Nursing Officer, Grade 9). In other cases a Teaching Division may not be constituted, either because training is conducted on too small a scale or on account of other difficulties (see Chapter 6, paragraph 6.18). Then the Senior Tutor (Senior Nursing Officer, Grade 8) or exceptionally a Tutor (Nursing Officer, Grade 7) in full charge, will be responsible to a nurse in Grade 9 (Principal Nursing Officer) or Grade 10 (Chief Nursing Officer), who may not be a qualified tutor. Nurses in Grades 9 and 10 however will have undergone a course in top management and will have an insight into training needs: there will be no interference with the professional work of the nurse tutor in middle management.

(iii) Job descriptions

7.48 In Appendix 6 there are charts showing the organisation of the Teaching Division in different kinds of hospital groups. Job descriptions for the tutorial staff of the Teaching Division in a group consisting of a large district general hospital and a large psychiatric hospital are given in Appendix 7.
CHAPTER 8

Committees and Conferences

8.1 In taking evidence we enquired what committees and other facilities for consultation, etc., were thought to be helpful to nursing heads in carrying out their administrative functions. We also looked into present practice.

PRESENT PRACTICE AND VIEWS EXPRESSED IN EVIDENCE

8.2 Evidence received for the most part centred on the question of what committees nursing heads should attend.

(i) Committees relating particularly to nursing

8.3 The following were named as committees on nursing and nurse training in which nursing heads should take part:

- Group Matrons' (or Matrons' Advisory) Committee
- Nurse Education (or Nurse Training) Committee
- Nursing (or Nursing Advisory or Nursing Services) Committee
- Nursing Staff (or Nursing Staff Consultative) Committee
- Procedures (or Nursing Procedures) Committee (or Sub-Committee).

8.4 Advice on some of these has been given in hospital memoranda in England and Wales, though not in Scotland.

8.5 H.M.(54)4 recommended the use of a Matrons' Advisory Committee "comprising all the matrons of hospitals in the group", whereby they nominated their own representative to attend meetings of the Board of Governors or Hospital Management Committee to "put forward their problems (as distinct from any matters on which the Board or Committee may desire the advice of a particular Matron)."* The same memorandum recommended that, together with the other Matrons and Chief Male Nurses, Matrons of separate maternity hospitals and Superintendent Midwives "should be members of the Group Nursing and Midwifery Advisory Committee".

8.6 H.M.(61)38 drew attention to the General Nursing Council's recommendation that for each training school there should be a Nurse Education Committee "whose membership, in addition to representatives of the Board of Governors or Hospital Management Committee, should include the Matron, representatives of the tutorial staff, of the ward and departmental sisters and of the medical staff participating in nurse training, together with representatives from the public health field and the field of general education." The memorandum suggested that "nurse education committees can give much assistance and advice on nurse training problems to Boards and Committees" and asks that those responsible for nurse training schools that have not already "appointed such a committee... should do so as soon as possible." H.M.(54)4 had already said that "in a group nurse training school" (where several hospitals, each under its own Matron are grouped to form one training school) "it is desirable

*Paragraph 7 of the H.M. states that this will also apply "in mental hospitals to the chief male nurse".
that there should be a nursing education sub-committee consisting of the 'Matron and Superintendent of the Nurse Training School' and the matrons of the other hospitals concerned, together with nurse tutors and selected ward sisters": there was also a footnote—"It would, of course, be open to the Hospital Management Committee to include in such a Sub-Committee other members, medical or lay ".

8.7 The setting up of a Nursing Staff Committee, with other staff committees, was recommended to Hospital Management Committees in memorandum H.M.C.(48)1, paragraph 13. These committees were to be "representative of the different groups of staff concerned (e.g., medical, nursing), which should act as advisers of the Management Committees on their sphere of the hospitals' work as well as raising questions affecting the welfare of their constituents... It will, of course, be for the staff themselves to constitute these committees, and not for the Management Committees to appoint them...

(ii) Other committees affecting nursing

8.8 The following were named by those giving evidence as important committees, concerned indirectly with nursing or with day-to-day management of hospitals, which nurses should attend:—

- Catering Committee
- Control of Infection Committee
- Finance (or Finance and General Purposes) Committee
- House Committee
- Laundry Committee
- Maternity Liaison Committee
- Medical and Nursing Liaison Committee
- Medical Staff Committee (to be attended occasionally)
- Planning Committee
- Supplies Committee.

8.9 Some of these clearly are standing committees, or sub-committees, which may exercise powers delegated by the governing body—the Finance Committee, for example, which must consist wholly of members of the appointing body. In regard to the membership of such committees the Ministry of Health offered the following guidance in memorandum R.H.B.(49)143; "Officers including doctors and matrons should of course be invited freely to attend meetings of Management Committees and their sub-committees, and it is by attendance as advisers in this way rather than as members that they can make the fullest contribution to the work of the Committees". Advice regarding attendance at them by Matrons and Chief Male Nurses has already been reviewed in Chapter 2.

8.10 On the other hand, the membership of certain others of the committees named is likely to consist almost entirely of officers, for instance, the Medical and Nursing Liaison Committee. In between the two extremes, there are committees variously constituted, both of members and of officers.

(iii) Our comments

8.11 It is clear that there are great differences among hospital management groups in the numbers and kinds of committees set up and in the membership
and functions even of committees which bear the same title. There are also variations in procedure. For example, in some groups the governing body at its meetings largely confirms the decisions of its standing committees. Evidence was given to us that in such groups, no advantage was seen in either all the Matrons or a representative of them standing the meetings of the governing body. Again, in some groups Matrons and other officers participate as members of standing committees, while in others the convention is that officers are in attendance.

8.12 In the face of such variety we find it difficult to pronounce on the helpfulness of particular committees to nursing heads in carrying out their functions. Two observations made to us in evidence seem much to the point: first, that every effort should be made to reduce the number of "nursing committees" by combining functions and, second, that, where there is a failure of communication between the principal administrative officer and the nursing heads, formal meetings may well be necessary to ensure that consultation can take place. Our impression, from our study of committees in relation to nursing, is that there are too many; their procedures are sometimes unnecessarily cumbersome; and in some respects the work they do could better be done by means of informal consultation between nurses and other officers. We look forward to the outcome of enquiries into this aspect of hospital management.* The recommendations we make in regard to nursing are unlikely to be fully effective unless there is reappraisal of the entire role of committees in hospital management.

8.13 In the remainder of this chapter we describe the kinds of meetings (committees and conferences) which we think are necessary for the fulfilment of the nursing function in hospitals under the proposed new nursing staff structure.

**General Considerations**

8.14 Confusion can be caused by indiscriminately using the term "committee" for meetings which are different in kind and proceeding to apply practice and procedures appropriate in one situation to others for which they are unsuited. In modern practice committees often combine policy-making and executive capacities, the right to act being inherent in the committee itself, not in other people charged with carrying out the committee's decisions. This is the position of the Hospital Management Committee or Board of Management itself. There are other committees, however, which do not make decisions or give orders, but merely act as bodies for the exchange of information and advice, for example, the Nursing Staff Committee. In between there is a composite type of committee, in which it is not always clear whether the right to take decisions and the right to act are inherent in the committee itself or in officers who are members of it or in the governing body (the Hospital Management Committee) which has constituted it: some Nurse Education Committees are examples of this kind.

8.15 For the purposes of making recommendations, we have thought it advisable to define our terms and to use them in accordance with the definitions. We accordingly distinguish between committees and conferences:

1. A **committee** is a meeting at which **decisions** are taken. There are two kinds:

*See Chapter 3, footnote to paragraph 3.16.*
(a) A *directive committee*, at which a decision is made on a form of policy, that is, on the right thing to do, though not necessarily on the right way of doing it (which is left to officers or other executive agency).

(b) An *executive committee*, at which a decision is made on the right way of carrying out a decision. If agreement cannot be reached the responsible officer makes the decision.

(2) A *conference* is a meeting at which conclusions may be reached, but decisions on action are not made. There are two kinds:

(a) An *informative conference*, at which views are exchanged or information is passed on but conclusions are not reached.

(b) A *conclusive conference*, in which members, in addition to exchanging information, analyse, judge and assess possibilities, aiming to reach conclusions on what ought to be done.

A *committee* will always confer, for decisions must be made in the light of the best information and advice available, but a *conference* cannot make decisions.

8.16 We think that the administration of nursing would be greatly simplified if before a "committee" is set up, consideration is given to the category into which it is intended to take its place so that its terms of reference and powers, if any, are drawn up accordingly.

8.17 In applying these ideas to the nursing function in hospitals we have had three objectives particularly in view:

1. to provide channels of communication through which the governing body and its standing (usually *directive*) committees can draw on the collective advice of nurses, as well as that of other officers, in making decisions, largely on policy;

2. to provide channels of communication through which nurses exercising delegated powers to make executive decisions are able to consult with other officers, including other nurses, in making them;

3. to provide channels of communication through which nurses are able to contribute information and advice in the light of which executive decisions can be made by non-nursing administrators exercising delegated powers.

8.18 A particular meeting will often serve more than one object. For instance, a ward meeting may serve as a *conclusive conference*, enabling the Charge Nurse (Grade 6) to make decisions on organisation as well as giving an opportunity for the ward staff to be informed of decisions made by higher authority or for their opinions to be sought on changes proposed (*informative conference*) before decisions are made.

**Directives Committees for Nursing**

8.19 Many governing bodies have established "Nursing Committees". Their composition varies, but generally they consist mainly of members of the governing body and some of the medical staff, with nurses (Matrons) co-opted and in a minority. In this respect they differ from Medical Committees which
consist almost entirely of medical staff. The main uses made of Nursing Committees seem to be:—

(1) as a channel of advice to the governing body on matters affecting nursing;

(2) to co-ordinate implementation of nursing policy among the hospitals of a group;

(3) to exercise delegated powers, for instance, in respect of appointments of senior nurses.

8.20 Under the proposed new staffing structure these functions are such that they can be discharged by officers—that is the senior nurse administrator (Chief Nursing Officer, Grade 10, or Principal Nursing Officer, Grade 9) and other senior nurses acting in consultation with administrative officers and the medical staff. There are at present many management groups in which nursing is administered in the same way as other major activities in the hospital, under the direction of standing committees which deal with particular aspects of the work of the hospital rather than with particular kinds of staff, for example, the Finance Committee. We think this to be the more suitable arrangement. It is already often difficult to find enough business for the Nursing Committee, particularly when there are also House Committees.

8.21 Under the new arrangement the senior nurse administrator in control of nursing in a group will attend meetings of the relevant directive committees of the governing body and meetings of the governing body itself, in order to report on nursing in the group, to represent the needs of nurses and to assist in the formulation of nursing policy. For these purposes she will contribute to the papers presented to the committee and setting out matters for decision. In preparing her contributions she will draw on the collective advice of her senior nursing colleagues by means of a conference (compare the present Matrons’ Advisory Committees); and they in turn through conferences will consult their own subordinates, their colleagues in other departments and the medical staff.

8.22 Where a Principal Nursing Officer (Grade 9) or a Chief Nursing Officer (Grade 10) co-ordinates the nursing in a group, without control in all hospitals, the arrangements will be the same, but the nursing heads whom she co-ordinates should also have the right of access to meetings of the governing body and its directive committees.

8.23 We recognise that, unless and until the committee structure of Hospital Management Committees and Boards of Management is overhauled (see paragraph 8.12 above), it may be found difficult in some groups to dispense entirely with the Nursing Committee as a directive committee. In these circumstances we recommend that, as a temporary measure, the position of nurses on them be strengthened. We suggest the following constitution for a directive Nursing Committee, exercising powers delegated by the governing body:—

Terms of reference:

To receive reports from officers and House Committees on all matters affecting nursing and to make decisions on nursing policy subject to confirmation by the governing body.
Composition:

Voting members

Three members of the governing body (including a member of the Finance Committee and a member of the Establishment Committee) of whom one should be chairman, together with the Chairman and Vice-Chairman of the governing body as ex-officio members.

Two medical members.

Co-opted members

The group nursing head (Chief Nursing Officer, Grade 10, or Principal Nursing Officer, Grade 9).

All nurses immediately subordinate to the group nursing head in Grade 9 or Grade 8 (Senior Nursing Officer).

Any nurses in other grades directly co-ordinated (though not controlled) by the group nursing head.

The Group Secretary.

If the convention in the group is that officers, being employees, are not appointed, to be members of standing committees, this need not be disturbed, provided it is accepted that the nursing officers attend by right to contribute to the discussion and to the conclusions reached.

8.24 In relation to nursing two kinds of executive committee can be distinguished, first, those whose decisions affect nursing incidentally, and, second, those dealing specifically with nursing. In either kind they can be at two levels:

1. executive committees which include members of the governing body;
2. executive committees of officers.

Executive Committees

(i) Executive committees of members

8.25 On occasion the standing committees of the governing body—the Finance Committee, Establishments Committee, etc.—take executive decisions as well as decisions on policy. Some of these relate to nursing, and the senior nurse administrator of the group should attend as an officer (or be represented by another nurse) to give information, in addition to contributing to the papers setting out the matters for decision. A form of participation by nurses, where there is a separate Nursing Committee, has already been described. The governing principle is that whenever decisions are taken affecting nursing there should be a nurse present who is competent to contribute to the discussion preceding the decision.

8.26 From time to time ad hoc executive committees, or sub-committees, are set up to select nurses for the more senior nursing posts. Suggestions for their composition are made in Chapter 9.

8.27 Local National Hospital Service Reserve Committees also fall in this category of executive committee: here members of the Hospital Management

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Committee are joined with representatives of voluntary nursing organisations and other people co-opted for the personal contribution they are able to make.*

8.28 House Committees are best considered under the head of conferences, since hospital authorities in England and Wales have been advised that they should not have executive functions conferred upon them.†

(ii) Executive committees of officers

8.29 The greater the extent to which executive powers are delegated by the governing body to officers, the more important it is that for purposes of co-ordination they should consult with their colleagues, both within their own departments and in others, in making decisions. At the present time this function of co-ordination is fulfilled largely by standing committees of the governing body. However this is not invariably so now and we envisage that in the future a greater part of the work of co-ordination will be undertaken at officer level. To a large extent it can be undertaken through informal meetings, but—to avoid overlooking the need—it will probably be desirable for some meetings for the purpose to be formal and regular and constituted with the governing body’s approval. Accordingly some executive committees of officers should be established for certain activities, in addition to any directive committees which may deal with their policy aspects.

8.30 Executive committees of officers should be established and should include nurses, to facilitate the making of decisions on matters affecting nursing, such as catering, control of infection, co-operation with medical staff and liaison between hospital and other maternity services.‡ These are all matters on which the views of nurses must be heard before decisions are taken by those to whom they fall to be made under arrangements approved by the governing body. We attach particular importance to the institution and effective functioning of a Medical and Nursing Liaison Committee to take account of the continual developments in medicine and surgery. The committees to be set up in any particular hospital group or hospital and the level of nursing representation at them, as that of other hospital interests, will be determined by the nature of the case. The principles of decentralisation and delegation should be observed, so that decisions are made as close as possible to the scene of activity and at a management level no higher than is strictly necessary.

8.31 There should also be executive committees of nurses, relating strictly to nursing, but with officers of other departments attending where necessary. Few will need to be formally constituted for they will take place in the regular course of nursing duty. A Senior Nursing Officer (Grade 8) will normally have short meetings at the beginning of each day with unit Matrons (Nursing Officer, Grade 7) to make decisions about day-to-day management, and likewise unit Matrons

† R.H.B.(49)107/B.G.(49)92.
‡ Chairmen of Hospital Management Committees in England and Wales were asked in H.M.(59)69 to take the initiative in convening maternity liaison committees as recommended in paragraphs 310 and 311 of the Report of the Maternity Services Committee (Cranbrook Report). In paragraph 311 the Committee says: "We consider, however, that in all areas these Committees should consist not of lay members but of persons working in the maternity services in the area, such as consultant obstetricians, domiciliary and hospital midwives, medical staff of the local health authority and general practitioner obstetricians". We endorse this.

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with their Charge Nurses (Grade 6). In most training schools it will generally be advisable for a Nursing Procedures Committee to be regularly constituted to standardise nursing procedures with particular reference to the practical training of student and pupil nurses.

CONFERENCES

8.32 Conferences are held to exchange information (informative conference) or both to exchange information and to reach conclusions (conclusive conference) in the light of which decisions can be made on action. A distinction can again be made between, first, those affecting nursing incidentally, and, second, those dealing with nursing specifically.

8.33 The House Committee, which is composed of members of the governing body and co-opted lay members and medical staff, is in the nature of a conclusive conference. Decisions are taken by officers in accordance with the conclusions reached if they are within their delegated powers; otherwise the recommendations are passed to the governing body or its standing committees who proceed to make the necessary decisions. Nurse administrators usually seem to find that the House Committees are helpful to them in their work. A House Committee established for a single hospital should be attended by the nursing head in that hospital, whatever her grade. One which is established for several hospitals should similarly be attended by the nursing heads. In a large management group, where there is a Chief Nursing Officer (Grade 10), she would not normally find it necessary to attend, though it will be desirable for her to do so occasionally, in addition to the other nursing representatives.

8.34 The Nurse Education Committee for a training school is also in the nature of a conclusive conference. It can make recommendations to the governing body or its standing committees or, where matters lie within their delegated powers, officers are able to make decisions in accordance with the conclusions reached. Under the new staffing structure the committee will no longer need to perform a co-ordinating function since this will be carried out by the senior nurse administrator of the group. A useful advisory function will remain. The membership should be revised and the numbers of hospital nurses who are members (as described in paragraph 8.6 above) could probably be reduced. In a group where a Teaching Division is constituted we would expect the nursing representatives to be the Principal Tutor (Grade 9) and the Senior Tutors (Grade 8), together with the Chief Nursing Officer (Grade 10), who would decide whether it was desirable to be accompanied by one or more senior nurses from a Nursing Division.

8.35 From time to time it will be useful to institute informal meetings of officers, including nurses working in a hospital or in a particular part of a hospital for the purpose of consultation. Their nature and the extent to which such conferences, at whatever level, need to be formalised is a matter for decision by the governing body and its chief officers.

8.36 Informal discussions in hospitals in which all can participate as equals, from whatever department and of whatever grade, can be particularly useful in improving understanding of the hospital's problems. They are often productive of ideas which can then be taken to a conference in which conclusions can be reached. The discussions should be directed to the consideration of
specific problems. A useful by-product can be the kind of increased self-knowledge on the part of individual participants which is the prime object of "sensitivity training". * 

8.37 Conclusive conferences dealing with nursing specifically will naturally take place during the course of the routine meetings of nurses (executive committees, referred to in paragraph 8.31 above). From time to time it will be desirable to hold rather larger meetings of nurses, much as "Ward Sisters' meetings" are held with Matrons at the present time. Occasional meetings of all the senior nurses (Grade 6 and above) in a Nursing Division may be useful, as also meetings between nurses in different divisions (midwifery, teaching and nursing). For a regular two-way flow of information, to enable the chief nurse administrator to draw on the collective opinion of nurses as well as to inform them of nursing policy, it will usually be best to rely on the regular meetings of senior nurses within their units and areas.

8.38 To complete the chain of communication there should be informal ward meetings of the kind described in paragraph 8.18 above, for it is on the ward (section) team under the Charge Nurse (Grade 6) that the patient immediately relies for nursing care. Since the patient and his care is the first and last object of all hospital administration he, too, should be included in the chain of communication. In many psychiatric hospitals community ward meetings including patients and staff are now recognised as an essential part of hospital communications and we recommend the adoption of this practice in any situation to which it is applicable.

8.39 In hospitals and groups where a chain of communications is established in this way, there will be ample opportunity for the views of the nursing staff and the management to be made known to one another, so that there will be less scope for a Nursing Staff Committee of the kind described in paragraph 8.7. It will however probably be found useful if, in each of the larger hospitals of a group, meetings take place at which each grade of nursing staff is represented. A suitable title for such a meeting would be "Nursing Staff Representative Council" and its purpose would be to discuss matters affecting staff welfare so that needs can be brought to the notice of the management.

*See Chapter 4, paragraph 4.27.
CHAPTER 9

Preparation and Selection for Nursing Administration

9.1 For full benefit to be derived from the new staffing structure nurses must be systematically prepared and selected for senior posts. Hitherto it has been difficult to do this since, above the level of Ward Sister, not only are the grades exceedingly numerous but the functions of posts in the same grade are not uniform and sometimes they are inappropriate. With the new structure these difficulties will be removed. In this chapter, after reviewing briefly the present arrangements for selection and preparation, we set out our proposals.

THE PRESENT POSITION

(i) Preparation

9.2 For appointment as Staff Nurse, registration on the appropriate part of the Register is necessary and, for appointment as Staff Midwife, enrolment on the Roll of Midwives. To obtain further promotion completion of an additional course of formal instruction is not obligatory, except for teaching posts: to become a Registered, or Qualified, Nurse Tutor it has been necessary to obtain the Sister Tutor’s Diploma and, to become a Qualified Midwife Teacher, the Midwife Teachers’ Diploma. These qualifications relate to the professional aspects of nursing, rather than to the administrative (managerial). To enhance their eligibility for senior administrative posts, nurses commonly obtain more than one basic statutory qualification. This is indicated in Table VIII.

TABLE VIII
Senior staff holding only one basic statutory qualification (1)

<table>
<thead>
<tr>
<th>Grade</th>
<th>ENGLAND AND WALES</th>
<th>SCOTLAND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matron/Chief Male Nurse</td>
<td>33</td>
<td>26</td>
</tr>
<tr>
<td>Deputy Matron/Deputy Chief Male Nurse, Senior Assistant Matron/Senior Assistant Chief Male Nurse, Assistant Matron/Assistant Chief Male Nurse</td>
<td>50</td>
<td>36</td>
</tr>
<tr>
<td>Departmental Sister/Departmental Charge Nurse</td>
<td>56</td>
<td>29</td>
</tr>
<tr>
<td>Ward Sister/Charge Nurse</td>
<td>68</td>
<td>56</td>
</tr>
<tr>
<td>Other senior nursing staff</td>
<td>55</td>
<td>37</td>
</tr>
</tbody>
</table>

Source: Statistical enquiry.
Notes: (1) The table excludes midwifery staff below the level of Assistant Matron and all tutorial staff.
(2) The following are the principal qualifications counted:—
S.R.N. (or R.G.N.), S.C.M., R.M.N., R.N.M.S., R.S.C.N., R.F.N., R.N.M.D., S.E.N.
R.M.P.A. held in combination with a registrable psychiatric qualification has been counted as one statutory qualification.

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9.3 There has been no recognition, as a condition for appointment to senior administrative nursing posts, of courses of study comparable to that for the Sister Tutors' Diploma and the Midwife Teachers' Diploma. Our statistical enquiry has shown that comparatively few nurses have undergone a formal course of instruction in nursing administration (see Table 8 in Appendix 5).

9.4 Nevertheless, realisation of the need for formal preparation for nursing administration has been growing. Since 1950, hospital authorities have been authorised to grant study leave, with or without pay, and expenses to nurses and midwives undertaking courses of post-certificate study provided by recognised professional organisations and educational institutions. Latterly they have also been authorised to pay the fees for certain courses. Valuable work is being done by the Royal College of Nursing and the King Edward's Hospital Fund in organising courses in nursing administration. Increasing numbers of nurses attend their courses for Ward Sisters and Charge Nurses, and for Matrons and Chief Male Nurses, and there is unsatisfied demand for places on them. Hospital authorities and educational institutions have also begun to provide courses of instruction. Table IX shows that the number of administrative courses undertaken in proportion to the number of staff is greatest for nurses appointed to their present grade since 1960.

**Table IX**

<table>
<thead>
<tr>
<th>Period during which appointed to present grade</th>
<th>Ratio of courses to staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to 1945</td>
<td>1 : 140</td>
</tr>
<tr>
<td>1945 to 1954</td>
<td>1 : 66</td>
</tr>
<tr>
<td>1955 to 1959</td>
<td>1 : 47</td>
</tr>
<tr>
<td>1960 to 1964</td>
<td>1 : 21</td>
</tr>
</tbody>
</table>

*Source: Statistical enquiry*

9.5 The difficulty remains that relatively few nurses have an opportunity of undergoing such instruction. Moreover the courses offered may not be entirely satisfactory. The present staffing structure makes it difficult to devise courses for nurses who have already attained the grade of Ward Sister. Further promotion may not be sought and, if it is sought, the functions of the post in the next grade cannot be clearly foreseen. A course may therefore contain irrelevant material and be unnecessarily long, so that hospital authorities are reluctant to release nurses to attend. On the other hand, a shorter course may not cover the necessary ground. This inherent difficulty of devising preparatory courses for nurses entering the middle grades is removed when—as in our proposed staffing structure—the distinctive functions of nurses in middle management are recognised. A further difficulty is that the present distribution of courses is uneven, a disproportionate number being held in London; many nurses may therefore be deterred from attending.

(ii) Selection

9.6 Proper selection of nurses for senior posts has been hampered by defects in the staffing structure. There are so many senior nursing grades and such dis-
parity in the functions of posts in the same grade that it has not been possible to apply uniform criteria in making appointments. Possible consequences are, on the one hand, inefficiency, and, on the other, frustration which may cause some able people to leave nursing.

9.7 The important part that efficient selection procedures could play in the recruitment and training of nurses was recognised by the Working Party which reported in 1947*:

"There can be little doubt that the introduction of suitable selection methods for filling senior posts would make a substantial contribution to the overall problem" (viz. wastage and staffing difficulties).

9.8 In recent years it has become increasingly the practice for hospital authorities to use experienced nurses and midwives as external assessors on selection committees for the most senior nursing posts. Guidance was issued in 1963 by the Scottish Home and Health Department making this practice obligatory in appointing Matrons and Chief Male Nurses and in filling certain other senior posts. Similar guidance is being issued by the Ministry of Health. This, with the practice of advertising vacancies in the press, goes some way towards preventing bias and widening the field of selection in making appointments; it needs to be supplemented.

**A New Scheme for Preparation and Selection: General Considerations**

9.9 The starting point for the scheme which we outline is the job descriptions in Appendix 7: these set out the functions of the jobs for which senior nurses must be prepared and selected. An underlying assumption is that nurses will not be required to manage "housekeeping",† this being a function of the hospital administration. If in smaller hospitals "housekeeping" is managed by nurses (but with more assistance than at present from administrative and specialist officers), the content of the training, as well as the job description, should be adjusted.

9.10 The scheme proceeds from the basis that management, that is, the work of ordering and co-ordinating jobs and the people who do them, is an integral part of the work of all senior nurses. It will be less prominent at the executive level (Staff Nurse, Grade 5, and Charge Nurse, Grade 6) than at the programming level (Nursing Officer, Grade 7, and Senior Nursing Officer, Grade 8) and the policy-forming level (Principal Nursing Officer Grade 9, and Chief Nursing Officer, Grade 10). In the top posts of a group, there is a distinctive element—critical appraisal of the whole nursing function. So, while in general three stages of preparation will suffice, the need to prepare potential group nursing heads for the special aspects of their work must also be recognised.

9.11 For successful performance of a job, vocational training is necessary; this can be practical—given "on the job" (by precept), or theoretical—through formal instruction (by concept). Both forms should be used in preparing

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†By "housekeeping" is meant services which can be organised centrally for a hospital or a hospital group, such as catering, cleaning, linen, laundry and staff residences (paragraph 3.28 above).
nurses for the administrative and personnel as well as for the professional functions of senior posts. The formal instruction should be related to the training “on the job” and, so far as possible, be given locally and in immediate preparation for roles about to be undertaken, so as to be economical in time and effort. The aim in formal instruction should be to build progressively on preparation given at earlier stages. Practical instruction should also be progressive, nurses being posted to jobs of increasing difficulty within the grade. This will enable them to show merit and earn promotion. The length and content of courses of theoretical instruction should be determined by the requirements of the job. The cost, being in the interests of effective management, should be met by the hospital service, not by the nurse. Some at least of the courses should be so arranged that they can be attended by married women who work part time.

9.12 We believe that in the present intake of nurses there is no shortage of people who, if developed systematically by training, will fit to hold senior posts. The task is to recognise, train and retain sufficient nurses to fill them. Men in general nursing should have equal opportunity with women to be trained and appointed to senior posts. To prepare nurses for posts in Grade 10 (Chief Nursing Officer) particularly, it may be necessary to select some of exceptional administrative ability to undertake further general studies and perhaps to supplement these by entrants from the universities.

9.13 It is an important function of managers to develop managerial talent in their subordinates. Many nurse administrators do their utmost to discharge it, in the interests of the whole hospital service and not only of their own hospitals. It is hampered however by difficulties already described, including inadequacies in training courses for administration and in the methods of making appointments to senior posts.

9.14 The system of job specification and the new staffing structure which we have proposed will simplify the provision of formal training; it will also make it easier than at present to arrange progressive training “on the job”. By this we mean assigning nurses tasks of progressive difficulty within a sphere of authority, with occasional transfer from one sphere of authority to another in order to broaden experience. We regard “planned movement” in this sense as applicable to all nurses, not only to a selected few. For this reason and because of the large numbers involved we do not therefore recommend its organisation from a distance by regional committees as proposed by the Lycett Green Committee for administrative and clerical staff.*

9.15 In the larger hospital management groups based on the concept of the district general hospital there should be ample scope for the practice of “planned movement” for nurses up to Grade 7 (Nursing Officer) inclusive. In smaller or dispersed groups opportunities will be fewer, but it should be possible to arrange transfers for the purpose between hospitals and, with the assistance if necessary of Nursing Officers of Regional Hospital Boards, between groups.

9.16 For filling posts in Grade 8 (Senior Nursing Officer) and above the primary requirement is proved administrative ability. At this stage of a career a nurse’s aptitude in this respect should have become apparent and have been recorded

*Ministry of Health, 1963, Report of the committee of enquiry into the recruitment, training and promotion of administrative and clerical staff in the hospital service. London, H.M.S.O., paragraphs 144 to 152.
in annual reports. The need therefore is to ensure that in making appointments proper consideration is given to the merits of all qualified applicants, not only local candidates. We think this object can be achieved by the use of outside nurse assessors with access to past annual reports of all candidates. These should be kept at the headquarters of the hospital group in which nursing officers work and be made available to the nominated assessor. For nurses in grades up to Charge Nurse (Grade 6) we envisage the records being kept by the head of the division.

9.17 For the operation of this system of assessors and for regulating the formal courses of preparation for each of the three levels of management, co-ordination is necessary over an area wider than that of the individual management group. We therefore recommend the establishment of national and regional committees comprising representatives of the Royal College of Nursing, the Royal College of Midwives and other professional nursing organisations and of the nursing staffs of Hospital Management Committees and Boards of Governors (in Scotland, Boards of Management) and of Regional Hospital Boards. Their objects would be:—

(1) to direct and co-ordinate arrangements for the preparation of nurses for senior posts;
(2) to assist hospital authorities in making appointments to posts in Grade 8 (Senior Nursing Officer) and above by providing assessors.

We consider that the Royal College of Nursing and the Royal College of Midwives should play a prominent part in effecting such co-ordination and we suggest that, with other professional organisations, they might consider instituting advanced professional qualifications, including a fellowship in nursing administration.

(f) Regional nursing staff committees

9.18 A nursing staff committee should be constituted in each region (as a conclusive conference)* by the Regional Hospital Board, in consultation with the national nursing staff committee, Boards of Governors and Hospital Management Committees (or Boards of Management), and the two Royal Colleges. The committee could normally consist of not more than 12 members who would be nurses, but in the London Metropolitan regions which include a large number of teaching hospitals the number might need to be increased. Not less than half, including ex officio, the Nursing Officer of the Regional Hospital Board, should be nurses employed in the hospital service within the region, representative of the different branches of nursing. Members would be appointed on the nomination of the interests represented.

9.19 Appointment could be for three years, with one third of the members retiring annually, but remaining eligible for re-appointment for one further term of three years. Each committee would determine its own procedure; and it would have the power to co-opt additional members, who need not be nurses, for particular purposes, from within or outside the hospital service. Committees should be responsible to the national nursing staff committee but periodically they should report on their activities to the hospital authorities within their region.

*See Chapter 8, paragraph 8.15.
9.20 In each region where the amount of training to be given justifies it we recommend that the Regional Hospital Board should establish a training centre to function, so far as the content and duration of administrative training courses for nurses are concerned, under the direction of the regional nursing staff committee. In some regions centres have already been established, with Training Officers, for administrative and clerical and other staff. We recommend that these be adapted for use—with other centres—for the post-registration training of nurses, as is already done in some regions, and that there should be nurses on the staff of these training centres.

9.21 We envisage that the regional nursing staff committees will undertake the functions of the "regional steering committees" proposed by the Minister of Health's Standing Nursing Advisory Committee to supervise the post-certificate clinical training of nurses.* So far as matters within our own terms of reference are concerned, their main functions would be:

(1) Maintaining a regional panel of nurse assessors for appointments to posts in Grades 8, 9 and 10.

(2) Advising on means of providing sufficient preparatory courses for first-line and middle management in the region and also arranging them, when this seems desirable.

(ii) National nursing staff committee

9.22 There should be two national nursing staff committees, responsible to the Health Ministers, one for England and Wales, the other for Scotland. The former at least will have to be rather larger than a regional committee if it is to be fully representative of hospital service and nursing interests. The membership should consist of nurses in the same way as the regional committees, but there should also be educationists with knowledge of nursing and management, and the Chief Nursing Officers of the Health Department should be members ex-officio. We recommend that the members be appointed by the Health Ministers after consultation with the appropriate authorities and organisations. Appointments might similarly be for three years, with one third of the members retiring annually, but remaining eligible for re-appointment. The committee should determine its own procedure: in view of the wide scope of its functions it would probably have to work through sub-committees, to which it should be empowered to co-opt additional members, including persons who are not nurses.

9.23 The main functions of the national committees should be:—

(1) Co-ordinating the work of regional nursing staff committees; prescribing standards for centres providing training in management; and controlling the syllabuses for courses in management.

(2) Advising on means of providing preparatory courses for top management.

*Post-certificate education has been the subject of study by a sub-committee of the Minister of Health's Standing Nursing Advisory Committee: their first report is to deal in particular with registered nurses in general hospitals up to and including the grade of Ward Sister (Central Health Services Council, Report for the year ended 31st December, 1964. H.M.S.O. London, paragraph 89).
(3) Maintaining a national panel of assessors for appointments to posts in Grade 10 (Chief Nursing Officer), including that of Regional Hospital Board Nursing Officer.

(4) Advising nurses in Grades 9 and 10 on opportunities for leave for study and research.

(5) Promoting the interchange of senior nurses between regions, and between hospital authorities and the Health Departments.

(iii) Selection procedures

9.24 A distinction is to be made between the power of appointment and the function of selecting the person to be appointed. The power of appointment of nurses (and with it the power of dismissal) rests with the governing body of the hospital. It is exercised on the governing body's behalf by the principal administrative officer, who is authorised to issue formal letters of appointment. We need make no further reference to it here except to emphasise that, together with all the paper work in determining entitlement to salary, leave, etc., it should remain with the hospital administrators. What we are concerned with is the function of selection, including the steps to be taken in reaching decisions.

9.25 If hospital authorities are to derive full benefit from our proposals there must be a degree of uniformity in selection procedures for all senior nursing posts, in Grade 6 (Charge Nurse) and above. There are five stages:—

1. staff reporting;
2. advertisement of vacancy;
3. short-listing;
4. institution of selection panel;
5. interview.

9.26 The effectiveness of the whole system will depend greatly on the quality of reporting on their staff by senior nurses. Instruction on staff reporting is accordingly to be included in the preparatory courses for Charge Nurses (Grade 6) as well as in those for middle management. Consideration might well be given also to the introduction of standard forms for annual reports on nurses.

9.27 Vacancies in posts of Charge Nurse (Grade 6) should usually be made known at least within the region. Posts in Grade 7 (Nursing Officer) and above should invariably be advertised in the press.

9.28 The material derived from staff reports will facilitate the compiling of short lists. For posts in Grade 6 (Charge Nurse) and Grade 7 (Nursing Officer) this can be done by the Principal Nursing Officer (Grade 9) or a nurse in Grade 8 deputed for the purpose.

9.29 For appointments to posts in Grade 8 and above we envisage that the nurse assessors, as well as being members of the selection committees, would co-operate in drawing up short lists with members deputed from the selection committees, usually the senior nurse administrators of the groups to which the appointments were being made except in the case of top posts of management groups. For the purpose of drawing up a short list it will be desirable for the assessor to obtain from each candidate's employing authority their personal
files containing annual confidential reports. Information from these reports but not the reports themselves would be made available to the selection committees.

9.30 The techniques of personnel selection and interviewing are important. Instruction on them is to be included in the course of preparation for nurses in middle management. It is equally important that members of governing bodies of hospitals and others on selection panels should have some knowledge of them.

9.31 We now set out our proposals for preparation and selection for each level of management. An outline syllabus for a preparatory course of instruction at each level is given in Appendix 9.

First-line Management: Staff Nurse (Grade 5) and Charge Nurse (Grade 6)

(i) Preparation

9.32 Preparation begins at the level of the Student Nurse. The three-year basic training course prepares for the professional aspects of the job of Staff Nurse; and there will also be learnt, "on the job", some of the managerial elements. Since, however, a Staff Nurse, and perhaps even a third-year student, may have to deputise for the Charge Nurse (Grade 6) in managing the work of the ward some formal preparation for this should be included in the basic training.*

Much depends on the first approach to a nurse's work. From the beginning there should be emphasis on the purpose of a hospital's activities and on the role of the patient. If our view of nursing administration is accepted, we hope that it will take its place in all lectures and textbooks used for instructing student and pupil nurses. A definitive textbook on nursing administration is required.

9.33 During the third year in particular the Student Nurse should receive some formal instruction in management. This, supplemented by practical experience in different units and by in-service study days after qualification, should be sufficient preparation for the managerial work of the Staff Nurse. Training in management will be only a part of the post-certificate training of Staff Nurses for they will also undertake further clinical training, to qualify as midwives or in specialised nursing.

9.34 On selection for promotion to Charge Nurse (Grade 6) and before taking charge of a ward or other section in a unit, the Staff Nurse should attend a preparatory course covering management and professional subjects. In preparing for first-line management the emphasis should be on teaching the operational principles of management, rather than the theoretical basis for them. We have sought to bring this out in Part A of the first syllabus in Appendix 9, which is suited to being taught in an educational institution (e.g., a technical college) or the Regional Hospital Board's training centre. Part B of the syllabus needs to be further elaborated to take into account professional aspects of particular

*Some useful instruction is already included, e.g. "Outlines of the history and background of nursing. Outlines of the Health Service. The Hospital, the various departments and functions, including its relationship with the Local Health Services . . . . Relationship between the nurse, the patient and the relatives. The place of the nurse in the hospital team, relationship with medical staff and other hospital workers". (The General Nursing Council for England and Wales, 1962. Syllabus of subjects for examination for the certificate of general nursing, p.4.)
branches of nursing. It would be taught by senior nurses and other officers of
the hospital service and it would best be undertaken at general and psychiatric
hospitals designated within each region as training centres with the approval of
the regional nursing staff committee. The two parts of the course would together
last about four weeks. A longer course, even if desirable, will be impracticable
if, as we recommend, the preparation is to be given to all who enter the grade of
Charge Nurse, and not, as at present to a selected few.

9.35 After promotion the Charge Nurse (Grade 6) should from time to time
take part in study days and undergo short refresher courses. Those with a
particular aptitude should be encouraged to specialise, for example, as Theatre
Sisters or, if interested in teaching, as Clinical Instructors or Teachers of Pupil
Nurses.

(ii) Selection and posting

9.36 Unlike student and pupil nurses who accept the liability to be transferred,
within the training school, from one hospital or part of it to another, the
qualified nurse usually does not. In particular the nurse who is a married woman
will seek a post convenient to her home. This may be in part of a hospital the
remainder of which is at a distance or spread over a fairly wide area. In such a
case and in separate small hospitals the decision to accept the services of a
Staff Nurse, and of enrolled nurses and nursing auxiliaries, within authorised
limits should usually be taken locally by the senior nurse, that is the unit Matron
(Nursing Officer, Grade 7) or occasionally a Charge Nurse (Grade 6).

9.37 In large hospitals, accommodated on a single site, more flexibility in the
posting of nurses will be possible. It will therefore be more convenient for such
decisions to be made by the Senior Matron (Senior Nursing Officer, Grade 8)
who co-ordinates a number of units included in an area, but in consultation
with the unit Matron concerned (Nursing Officer, Grade 7). Transfers of Staff
Nurses from one area to another can be arranged, through consultation among
Senior Nursing Officers (Grade 8), in accordance with the policy laid down by
the Principal Nursing Officer (Grade 9) of the division.

9.38 In the case of Charge Nurses (Grade 6) also, the size and circumstances of
the hospital will to some extent determine the grade of senior nurse to take the
decision on engagement or promotion. In a large hospital, on a single site, we
would expect it to be taken by the Principal Nursing Officer (Grade 9) in charge
of the division, in consultation with the Senior Nursing Officer (Grade 8), if
any, and the Nursing Officer (Grade 7) of the unit concerned and its consultant
medical staff.

MIDDLE MANAGEMENT: NURSING OFFICER (GRADE 7) AND SENIOR NURSING
OFFICER (GRADE 8)

9.39 A characteristic feature of middle management is concentration within a
limited field. The expertise may be of a kind applicable in more than one sort of
unit—for example, equally as Nursing Officer of a general medical unit in a
district general hospital as of a small general or geriatric hospital; or it may
be specialised—as Nursing Officer in charge of operating theatres or in a mid-
wifery unit or in teaching nursing or midwifery.
(i) Preparation

9.40 For the most part nurses can prepare themselves for the professional elements of their jobs while working in relevant hospital departments, with the help of in-service training and special clinical training courses. For teaching posts however they have been required to obtain formal qualifications—the Sister Tutor's Diploma and the Midwife Teachers' Diploma. We consider that in all cases preparation for the professional functions of nursing posts should be complemented by courses of instruction designed to prepare nurses for the administrative and personnel functions. This preparation would usually be undertaken after the Charge Nurse (Grade 6) had qualified professionally for further promotion and immediately prior to taking up a post.

9.41 We recommend that the preparatory course for middle management should be in two parts:

(1) instruction in the general theory of management (lasting about four weeks);
(2) instruction relating management theory to the functions of particular posts (lasting about eight weeks).

The two parts must be properly co-ordinated.

9.42 An outline syllabus for the first part (Part A) of the proposed course is given in Appendix 9. Part A could be taught in colleges of technology and extramural departments of universities. Some part of the course could be common to nurses, administrators and doctors.

9.43 We have in mind that Part B would be given in centres such as those of the Royal College of Nursing and the King Edward's Hospital Fund and we very much hope that they will be able to undertake Part A as well. These are unlikely however to be able to deal with the numbers of nurses requiring instruction and new centres will need to be established in regions which are not conveniently served at present. For Part B of the course the field work and demonstrations will need to be varied according to the kind of job to be taken up—whether in teaching or nursing service; in psychiatric nursing or midwifery; in a general nursing unit; or in a specialised unit, such as operating theatres, to which the specimen syllabus for Part B of the course in Appendix 9 relates. For midwives and nurse tutors the instruction will need to be co-ordinated, as indicated below, with preparation for the Midwife Teachers' Diploma or for recognition as Registered Nurse Tutor.

9.44 For teaching posts, as for nursing service posts, formal training needs to be complemented by practical training, "on the job". In the formal instruction needed for the job of the Registered Nurse Tutor there are three elements:

(1) the theoretical basis of nursing practice;
(2) teaching methods;
(3) management in teaching posts.

9.45 The third element is recognized in the syllabus for the two-year course of preparation for the Sister Tutor's Diploma of London University: this includes a separate section, "Development and Organisation of the School of Nursing" (25 hours lectures, together with visits) covering the following subjects:—
"Principles of Administration. The place of the School of Nursing in the Hospital. Relationship with the lay and nursing administration departments and with the management authorities. Organisation within the teaching department. Relationship with other members of the teaching staff. Personal problems. Use of authority and discipline. Communications. Planning the curriculum, correlation of theory and practice in the education and training of student nurses. The preliminary course, "block" terms and study days. Experimental and comprehensive schemes of training. Independent and University schools of nursing. Nursing Education Committees, preparation of agenda, minutes and reports. Finance and budgeting, Area Nurse Training Committees. Education Acts and their application to nursing education". *

It seems to us that such instruction in the managerial element of the job could better be given separately. A nurse having qualified as Registered Nurse Tutor (through a course in nursing theory and teaching methods of less than the present two years' duration) would join with nursing service colleagues in Part A of the preparatory course for middle management. This would then be complemented by Part B of the course devised to teach the application of management theory to teaching posts in middle management.

9.46 In midwifery, teaching is less clearly distinguished from practice than in general nursing. Many midwives are encouraged to prepare for the Midwives' Diploma, in which the emphasis is on deepening clinical knowledge, whether or not they propose to specialise in teaching. There seems to us a case for separating that part of the syllabus which deals with clinical subjects to form Part I of the preparation for the Diploma. It would then be complemented, for midwives who wished to take up teaching, by Part II, devoted to instruction in teaching methods. On selection for promotion to Nursing Officer (Grade 7), whether in a teaching post or as Matron in charge of a unit, Midwifery Sisters would take the course of preparation for middle management already described (see paragraphs 9.42 to 9.44). A midwife who wished to change direction later and take up teaching could do so by taking Part II of the Midwife Teachers' Diploma.

9.47 In this way, all midwives would continue to be encouraged to increase their efficiency by studying for the Diploma; those without aptitude for teaching would not, as at present, be penalised by failure; and those fitted for promotion into middle management would be better prepared for the administrative and personnel functions of their posts.

(ii) Selection and posting

9.48 We consider that normally the decision to appoint a Nursing Officer (Grade 7) should be made by a selection panel consisting of the Principal Nursing Officer (Grade 9), as chairman; a Senior Nursing Officer (Grade 8) and a representative of the consultant medical staff. Promotion to Senior Nursing Officer (Grade 8) would be decided by a selection panel with a regional nurse assessor. We suggest that the panel should consist of a member of the employing authority, as chairman, a member of the medical staff, the Chief Nursing Officer (Grade 10) of the group, (if any, otherwise the Principal Nursing Officer (Grade 9)) and a regional assessor, with the Group Secretary in attendance. In very small hospital groups these arrangements would need to be modified.

9.49 It is desirable that all Senior Nursing Officers (Grade 8) should be appointed to serve within the hospital group rather than in a single hospital. This is as much in the interests of the nurse, in order to gain experience, as in that of the employing authority, for flexibility in staffing. Some posts of Nursing Officer (Grade 7) would also suitably be group appointments. Posting should always be arranged to take into account the convenience and experience of the nurse as well as the exigencies of the service. Occasionally posts on the staff of Nursing Officers of Regional Hospital Boards could be filled, by arrangement with Regional Hospital Board Nursing Officers, through secondment of Nursing Officers (Grade 7) instead of being filled by nurses who have been promoted Senior Nursing Officer (Grade 8).

**Top Management: Principal Nursing Officer (Grade 9) and Chief Nursing Officer (Grade 10)**

9.50 It should be possible for some able nurses to look for promotion to Principal Nursing Officer (Grade 9) between the ages of 35 and 39, after about 15 years' experience of nursing since registration, divided between first-line and middle management. Our statistical survey showed, in England and Wales, less than 2 per cent of Matrons of hospitals with 300 beds or more as under 40 years of age: in Scotland there appeared to be none.

(i) Preparation

9.51 On selection for promotion the Principal Nursing Officer (Grade 9) should undertake a further formal course of instruction. It will be the same for all, irrespective of the kind of division to be controlled, whether nursing or teaching or midwifery. A syllabus is given in Appendix 9. The full period proposed for such a course is 12 weeks. It should be recognised, however, that top management cannot be taught, it can only be learnt by reflection on experience. The purpose of the top management course is to help the potential top manager to do this by exposition of theory and case studies.

9.52 These courses should be held in educational institutions concerned with nursing studies. They may be institutes of higher education, such as the extramural departments of universities taking particular interest in the study of hospital administration and nursing, or centres established on the initiative of the nursing profession, for example, those of the Royal College of Nursing and the colleges of the King Edward’s Hospital Fund. Preferably the courses should be residential and be attended by hospital administrators and doctors as well as nurses.

9.53 Some Principal Nursing Officers could be seconded for experience to the Health Departments; this would be useful for potential Chief Nursing Officers (Grade 10).

9.54 For the Chief Nursing Officer a preparatory course will not be needed. The primary requirements are a mature personality, a developed critical sense and good judgement. Critical ability is not a quality which a purely vocational training is likely to develop. It will be useful if some nurses have taken their basic nursing qualification by means of a university course, such as is provided by the University of Manchester over four years, and by the University of Edinburgh over five years; or alternatively have undertaken after registration,
a course for a certificate or diploma in social sciences (preferably of one year's duration) for a diploma in nursing administration as proposed by the University of London. Such post-registration university courses should be undertaken by nurses (usually in Grade 7) of exceptional administrative promise: and the value could be judged by the proportion of nurses attending them who eventually perform successfully in posts of Chief Nursing Officer (Grade 10).

9.55 The following diagram shows the three ways of reaching the top posts.

![Diagram showing the three ways of reaching the top posts.](image)

9.56 We envisage that some Chief Nursing Officers (Figure 2) will attain the grade before the age of 40 and of these some could be selected to attend a course at the Administrative Staff College, together with civil servants and industrialists of comparable standing. Otherwise Chief Nursing Officers are more likely to be giving instructions to others than receiving it, and it will be advantageous if, with the encouragement of the national nursing staff committee, some are given "sabbatical" leave for study and research with carefully prepared terms of reference. Such occasional leave is likely to be most beneficial to the hospital service.

(iii) Selection

9.57 The selection of Senior Nursing Officers for promotion to Principal Nursing Officer (Grade 9) should be made by selection panels with regional
nurse assessors. The selection panel should consist of three members of the employing authority, including a medical member (one to act as chairman), the Chief Nursing Officer (Grade 10), if any, and a regional assessor, with the Group Secretary in attendance.

9.58 For promotion to Chief Nursing Officer (Grade 10), including posts of Regional Hospital Board Nursing Officer, a short list of the most suitable applicants should be compiled with the help of the regional and national nurse assessors. Selection should be made by a panel consisting of up to five members of the employing authority including a medical member (one to act as chairman), a national assessor and a regional assessor, with the principal administrative officer of the authority in attendance.

Numbers of Places Required on Training Courses

9.59 An indication of the total numbers of posts under the new staffing structure, at the different levels of management, for which nurses will need to be prepared in the long term, can be obtained by using the criteria for instituting posts in middle and top management set out in Chapters 5 and 6. If the ratios implied in these criteria are applied to the present number of posts (whole-time equivalent) which fall within the grade of Charge Nurse (Grade 6)—that is, Ward Sister, Charge Nurse, etc.—the following approximations result:

Table X

<table>
<thead>
<tr>
<th>Grade</th>
<th>ENGLAND AND WALES</th>
<th>SCOTLAND</th>
<th>GREAT BRITAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge Nurse (Grade 6)</td>
<td>32,000</td>
<td>3,500</td>
<td>35,500</td>
</tr>
<tr>
<td>Nursing Officer (Grade 7)</td>
<td>7,600</td>
<td>850</td>
<td>8,450</td>
</tr>
<tr>
<td>Senior Nursing Officer (Grade 8)</td>
<td>2,200</td>
<td>200</td>
<td>2,400</td>
</tr>
<tr>
<td>Principal Nursing Officer (Grade 9)</td>
<td>850</td>
<td>90</td>
<td>940</td>
</tr>
<tr>
<td>Totals</td>
<td>42,650</td>
<td>4,640</td>
<td>47,290</td>
</tr>
</tbody>
</table>

Notes: (1) Numbers in Table III rounded.
(2) Including teaching staff based on the present number of student nurses and pupil midwives.

9.60 An indication of the annual numbers of nurses who will need to attend training courses for first-line management is given by the present rate of turnover in posts which would fall within Grade 6 (Charge Nurse): at present 12% of the nurses in them have under one year’s service. Comparable estimates of annual numbers of nurses needing to attend training courses in middle and top management cannot be made, for at the present time frequency of turnover in posts which fall within the middle and top management grades is exaggerated by transition between posts now differently graded but which under the proposed staffing structure would fall within the same grade. In the following table, therefore, in relation to training for middle and top management, numbers are based on our expectation of the average length of tenure of posts in Grade 7 (Nursing Officer) and Grade 9 (Principal Nursing Officer); for it is on entering these grades that nurses will receive their management training.

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9.61 These are large numbers and it is one of the factors that we have taken into account in the duration of the courses which we have recommended—for first-line management, four weeks (in two parts); for middle management, 12 weeks (in two parts, of four weeks and eight weeks); and for top management, twelve weeks (in the early years to be reduced to six weeks). The figures in these two tables are no more than approximations, since much depends on changes in the rate of turnover of senior nurses through promotion and retirement.

**Table XI**

<table>
<thead>
<tr>
<th>Training Requirements in the First Five Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated annual numbers of places required on training courses for management</td>
</tr>
<tr>
<td>GREAT BRITAIN</td>
</tr>
<tr>
<td>First-line management (Grade 6) ... ... 4,300</td>
</tr>
<tr>
<td>Middle management (Grade 7) ... ... 750</td>
</tr>
<tr>
<td>Top management (Grade 9) ... ... 100</td>
</tr>
</tbody>
</table>

9.62 The estimates made in the foregoing paragraphs relate to the position when the new staffing structure has been introduced in all hospital groups. In the immediate future the position will be rather different, because:

(i) demand for places on training courses for middle and top management will depend on the progress made in introducing the new staffing structure (see Chapter 10);

(ii) training in first-line management will need to be provided not only for nurses entering Grade 6 (Charge Nurse), but also to some of the Ward Sisters, etc., whose present posts will fall within the grade.

9.63 For many Ward Sisters, etc., who have already been in first-line management for a long time, formal preparation for their present work will be inappropriate. For some, short refresher courses of the kind already extensively provided will be all that is necessary; others will be selected for promotion to Grade 7 (Nursing Officer) and should be prepared for middle management. We suggest that the aim should be for all Ward Sisters and Charge Nurses, with under five years' service in the grade and for whom there is no immediate prospect of further promotion, to attend training courses covering Part A (theory) of the course in first-line management outlined in Appendix 9. Our statistical enquiry showed that half the Ward Sisters and Charge Nurses had under five years' service: this being so, the short-term programme over a period of five years would need to provide each year two weeks' formal training for up to 2,500 nurses already in first-line management as well as four-week courses for about 4,300 nurses on promotion to Grade 6 (Charge Nurse).

9.64 During the period of introduction of the new staffing structure it will be necessary to take account of the training needs of nurses appointed to Grade 8 (Senior Nursing Officer) and Grade 10 (Chief Nursing Officer) as well as those in Grade 7 (Nursing Officer) and Grade 9 (Principal Nursing Officer). On the assumption that the rate at which groups change over to the new structure is
evenly phased over five years, it will be necessary to provide middle management courses annually for about 1,700 nurses to be appointed to posts in Grade 7 and for about 450—500 nurses likely to be appointed to posts in Grade 8 (Senior Nursing Officer). Similarly the programme will need to provide top management courses for about 250 nurses a year, about three-quarters of whom are likely to be filling posts in Grade 9 (Principal Nursing Officer). The magnitude of these numbers suggests that the middle management training course also will need to be compressed during this period into a shorter duration than 12 weeks; and that, for some nurses who have already attended certain administrative courses (see Table IX), preparation for middle management should be limited to short induction courses conducted within their hospital groups. Similarly the duration of the preparatory course for top management should be reduced from 12 to six weeks until the initial demand for places has been met.
CHAPTER 10

Application of Proposals and Programme for Implementation

10.1 Our proposals call for radical changes of attitude towards nursing administration, on the part of the nursing profession and of hospital management; and also for corresponding changes in the institutional forms in which past attitudes have been expressed—the grading structure, the organisation of the nursing services and the means of preparing nurses for their administrative functions. We believe that attitudes are already changing. Carefully considered and concerted action however will be necessary if they are to find scope for expression, and this action will have to be preceded by a wide range of consultation by the Health Departments. In this chapter we set out the main heads under which action needs to be taken and we suggest a programme for carrying it out.

MAIN HEADS OF ACTION

10.2 Once the proposals have been accepted, action falls to be taken at three different levels:

(1) locally, within hospital management groups;

(2) regionally, on the initiative of Regional Hospital Boards and Boards of Governors; and

(3) nationally, on the initiative of the Health Departments.

(i) Action within hospital management groups

10.3 In each hospital management group it will be necessary to review the organisation of the nursing services of the group. In comparatively few groups are they at present organised on a group basis, or in the process of being so organised. Of the remainder, some groups are so constituted that the new staffing structure could be introduced with little reorganisation, but in most fairly extensive reorganisation will be needed. Exceptionally, as in the sparsely populated regions of northern Scotland, where the hospital groups are very small, it will be difficult to alter the present arrangements and further action will be impracticable except, in due course, to apply the new Whitley grades.

10.4 In most groups the main outline of the reorganisation (into divisions) which should take into account developments under the Hospital Plans, will readily suggest itself. The next step will be to constitute jobs on the lines of the job descriptions we have drawn up, starting with the Ward Sister (Charge Nurse, Grade 6). There will be some work now done which should not enter into the jobs of qualified nurses and alternative means of doing it, often as a service provided by the administration, will have to be planned. Then, on the basis of the section (the sphere of authority of the Charge Nurse), the structure can be built up in units, areas and divisions. During this process the first outline of the organisation may need to be modified. Job descriptions can then be made out for the posts needed in the various grades.

10.5 The work to be done in jobs in middle management (Grades 7 and 8) and top management (Grades 9 and 10) will be markedly different from what is ordinarily done by nurses in the middle and top Whitley grades at the present time. It is essential that the nurses to hold top-management posts (Grades 9 and
10) should have undergone the preparatory courses for top management before the new structure is introduced in any management group.

(ii) Action within hospital regions

10.6 The Regional Hospital Boards, in concert with Boards of Governors, will have a number of tasks to perform:

1) A regional nursing staff committee in each region must come into operation. This will play an important part from the outset in the arrangement of training courses and in assisting with the selection of nurses for posts in Grade 8 and above.

2) Arrangements must be made for courses of preparation for first-line management to be instituted within each region, and for holding preparatory courses for nurses in middle management.

3) The authorisation of the Regional Hospital Board, and for teaching hospitals in England and Wales, that of the Ministry of Health, will be required for posts to be established in Grade 8 (Senior Nursing Officer) and Grade 9 (Principal Nursing Officer).

(iii) Action to be undertaken nationally

10.7 To begin with, there will have to be extensive consultation by the Health Departments with the hospital authorities, the professional organisations, the trades unions, the General Nursing Councils and the Central Midwives Boards. On their completion action under the following heads will need to be set in train.

1) The proposed grading structure must be translated into new Whitley grades.

2) The national committee for nursing staff will have to begin on their work of controlling the syllabuses of courses in management and co-ordinating the work of regional committees.

3) Training courses in middle management and top management will have to be established, some by bodies already concerned in hospital and nursing studies, others by institutions new to this field.

4) The Health Departments' approval will be needed to the establishment in hospital management groups of posts in Grade 10 (Chief Nursing Officer).

Considerations Affecting Implementation of the Proposals

10.8 Acceptance of our proposals necessitates intensive re-appraisal of the nursing function in all hospitals and, to some extent, reorganisation of the nursing services in each group. Reorganisation will be greater or less according to the extent to which nursing administration is already organised on a group basis and the degree of integration which it is decided to achieve, for instance, whether the nursing head of the group is to control all the nursing, or to control part only and to co-ordinate the rest. A variety of solutions will be possible as is exemplified in the organisation charts in Appendix 6.
10.9 Careful consideration will be needed in each group before conclusions are reached on the way in which the nursing services should be organised. Equal care must be given to means of relieving nurses of work which can better be carried out by the administration and in the drawing up of job descriptions for the various posts. In carrying out their tasks governing bodies will often need to seek outside advice from the Regional Hospital Board or from the Health Department to supplement the guidance given in hospital memoranda.

10.10 A limiting factor in implementing the proposals will be lack of facilities for holding preparatory courses at the various levels of management. Much will depend on the speed with which the present facilities can be adapted and supplemented.

10.11 Having regard to these considerations and, since the success of the reforms we propose would be prejudiced by ill-conceived or hasty action to apply them, we recommend that in the first instance the new staffing structure be applied in one or two groups in each region, together with a few selected teaching hospital groups in England and Wales. These would act as pilot schemes to test the means of applying the principles we have advocated. In each case, after introduction of the new structure, practice could be checked against the job descriptions by means of work study. This would offer an opportunity of revising the model job descriptions, if necessary. Thereafter, as facilities for management training are developed and as the Nursing Officers of Regional Hospital Boards are able successively to give their attention to the situation in individual hospital groups, application of the new staffing structure can be extended throughout the country.

10.12 If the new staffing structure is applied gradually and not simultaneously in all hospital groups, it follows that two Whitley grading structures—the present one and the new one—will co-exist for some time (not more than five years, we hope), the new structure being applicable in groups where the necessary re-organisation has taken place.

**Programme for Implementation**

10.13 In the past, development in the senior nursing staff structure in hospitals has been by way of elaboration of the Nightingale pattern in response to needs as these have made themselves felt. A complete re-appraisal of the system has not hitherto been undertaken. We realise that, for those who have worked with a system which has for so long been the accepted pattern, it will not be easy to comprehend immediately or assess a novel and somewhat complicated set of proposals.

10.14 Although strictly outside our terms of reference, it may be helpful to those who have to consider the practicability of our proposals, if we outline the kind of programme for their implementation which we ourselves have had in mind. What follows is by way of suggestion only and we would not wish it to be regarded as an integral part of our proposals.

(i) Presentation of the principles

10.15 The wide range of consultations that Health Departments will necessarily undertake with interested bodies (see paragraph 10.7 above) will serve to introduce the principles underlying our proposals to many who may later participate
in their application. If it is decided to adopt them, in whole or in part, it seems to us unlikely that hospital memoranda together with our own report will in themselves be an entirely effective means of communication. It will be helpful if the concepts are presented, through a series of conferences, national and regional, with the aid of diagrams, elaborated into sets of visual aids, which could be used by those who will have the task of implementing the new staffing structure in the hospital services. The meaning of some of the terms we have used, such as section, unit, area and division, would be more readily understood by means of diagrams than by the written or spoken word alone, and so also their application to the nursing services of individual groups.

(ii) Programme for implementation

10.16 The programme for carrying out our proposals, as we envisage it, is in five stages. In each stage action will take place more or less simultaneously under more than one head. Whitley negotiations are omitted from the programme, questions of pay being outside our terms of reference; but we regard it as essential that negotiation of salaries for the grades should proceed urgently, as soon as the staffing structure is accepted in principle.

Stage 1

A. Presentation of the concept of the new senior nurse staffing structure by means of conferences attended by representatives of nursing, medical and administrative organisations and of associations of hospital authorities.

B. Presentation of the concept of the new structure within regions by Regional Hospital Boards in concert with Boards of Governors.

Stage 2

A. Selection by Regional Hospital Boards and Health Departments of groups for pilot schemes.

B. Appointment of regional and national committees for nursing staff.

C. Arrangement, by the Health Departments in consultation with the national committees, of pilot preparatory courses for top and middle management, through the medium of one or two suitable educational institutions, and for first-line management, by means of a selected Regional Hospital Board training centre.

Stage 3

A. Appointment of Chief and Principal Nursing Officers designate to groups selected for the pilot schemes, to coincide with

B. holding of first top-management courses to be attended by them and the Regional Hospital Board Nursing Officers.

Stage 4

A. Institution of the new structure in the selected hospital groups.

B. Selection and preparation of nurses in middle management in the selected groups.
Stage 5

A. Institution, as opportunity permits, throughout the country of courses in first-line management for nurses newly appointed to Grade 6 (Charge Nurse) and of a short-term programme for a proportion of nurses already holding posts in Grade 6.

B. Extension of courses of preparation for middle management and top management, as the new staffing structure is introduced throughout the hospital services.

BRIAN SALMON (Chairman)
JOHN GREENE
JANET T. LOCKE
T. T. PATERSON
MURIEL B. POWELL
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STEPHEN WHITTAKER

F. D. K. WILLIAMS (Secretary)
17th December, 1965.
The following main recommendations should be read in the context of the paragraphs cited.

Future pattern of nursing administration

(1) The job of the senior nurse administrator should be made less burdensome by relieving her of control of services for the management of which nursing expertness is not necessary, and by delegation to nurses in middle management (paragraphs 3.26 to 3.33).

(2) The jobs of senior nursing staff should be graded according to the quality of the decisions to be taken: that is, whether such decisions are appropriate to top management, middle management or first-line management (paragraph 3.35).

(3) Nursing posts down to and including Staff Nurse should be placed in one of six grades, two to each level of management (paragraph 3.36).

(4) Local titles of posts in these grades should not have prefixes such as "assistant" or "deputy" which imply that a post has no proper function of its own (paragraphs 1.9 and 3.37).

(5) Job descriptions should be prepared in order to grade posts according to uniform national standards. Where these reveal the functions of a job to be ill-matched, job analysis and job specification should be used to reconstitute the job (paragraph 3.40).

First-line management (Grades 5 and 6)

(6) The grade of Charge Nurse (Grade 6) should include posts now in the Whitley grades of Ward Sister/Charge Nurse, Midwifery Sister, Night Sister/Night Charge Nurse and Departmental Sister/Departmental Charge Nurse in category (c) (paragraph 4.3).

(7) Defects in the job of the Ward Sister (Charge Nurse, Grade 6) should be remedied by relieving her of some tasks, by clarifying lines of control and communication, and by providing the support of effective middle management (paragraphs 4.20 to 4.29).

(8) There should be one Charge Nurse (Grade 6) in control of each ward (paragraph 4.31).

(9) All posts in Grade 6 (Charge Nurse) should have a definite sphere of authority (paragraphs 4.19 and 4.34).

Middle management (Grades 7 and 8)

(10) The jobs of nurses in middle management should be changed from "staff" to "line", so as to give each a definite sphere of authority (paragraphs 5.20 to 5.21).

(11) Nurses in middle management should be relieved of non-nursing work by the provision of services under the control of hospital administrators; by
the appointment of staff other than nurses under the control of nurse administrators; and by the provision of adequate clerical assistance (paragraphs 5.22 to 5.32).

(12) The sphere of authority of a Nursing Officer (Grade 7) in a non-teaching post should consist of a number of sections each under a Charge Nurse (Grade 6) (paragraphs 5.33 to 5.34).

(13) Posts of Nursing Officer (Grade 7) should be either specialized, with control of specialist units such as midwifery, or non-specialized, with control for instance in a small general hospital (paragraphs 5.40 to 5.43).

(14) The posts of Nurse Tutor and Night Superintendent are among those which can be graded Nursing Officer (Grade 7) (paragraphs 5.35 and 5.43).

(15) Except in a teaching department and a small hospital, a Nursing Officer’s units should carry with it control of at least three but no more than six sections under Charge Nurses (Grade 6) (paragraphs 5.46 to 5.49).

(16) Where co-ordination of units under Nursing Officers (Grade 7) is necessary below the level of top management they should form an area under the control of a Senior Nursing Officer (Grade 8) (paragraphs 5.50 to 5.52).

(17) The number of units co-ordinated by a Senior Nursing Officer (Grade 8) should usually be from three to six (paragraph 5.58).

(18) Regional Hospital Board posts now graded as “Assistant Nursing Officer” should be graded Senior Nursing Officer (Grade 8) or Nursing Officer (Grade 7) (paragraph 5.56).

Top management (Grades 9 and 10)

(19) Areas and units controlled by nurses in middle management can be brought together to form a division under the control of a Principal Nursing Officer (Grade 9) (paragraphs 6.16 to 6.17).

(20) The aim should be to form a single school of nursing for the hospitals of a management group to constitute a teaching division (paragraph 6.18).

(21) In hospital groups with more than one division under Principal Nursing Officers (Grade 9) a Chief Nursing Officer (Grade 10) should be appointed to co-ordinate their work and that of nurses in charge of units and areas outside the divisions (paragraph 6.19).

(22) The Chief Nursing Officer (Grade 10) may either have control in all hospitals in the group, or alternatively control in some hospitals and a coordinating function only in others. These alternative forms of structure also apply in smaller groups where the post of group nursing head is held in Grade 9 (Principal Nursing Officer) (paragraphs 6.19 to 6.20 and 6.42 to 6.46).

(23) Nurses in top management should have managerial experience and training and should not be required to have a basic qualification in each kind of nursing represented within their spheres of authority (paragraph 6.23).

(24) Midwifery training should be excluded from the function of the Teaching Division (paragraph 6.27).
(25) A division under a Principal Nursing Officer (Grade 9) should have not less than six and not more than about 12 units, under Nursing Officers (Grade 7) (paragraphs 6.32 to 6.35).

(26) A group nursing head should represent the nursing services at meetings of the governing body and its committees and be responsible directly to the governing body although she is accountable (that is, reports to) the principal administrative officer (paragraphs 6.37 to 6.38).

(27) Posts of Regional Hospital Board Nursing Officer should be in Grade 10 (Chief Nursing Officer), except in the smaller Scottish regions where Grade 9 may be appropriate (paragraph 6.55).

Midwifery, psychiatric nursing and nurse education

(28) In a hospital group, midwifery, psychiatric nursing and teaching should be administered with the rest of nursing but their control should be decentralised and delegated (paragraph 7.1).

(29) The special characteristics of midwifery must be recognised in the organisation of maternity departments included in general hospitals (paragraph 7.9).

(30) There should be one nursing head in each psychiatric hospital with control of all the nursing staff (paragraphs 7.19 to 7.23).

(31) In hospital groups consisting exclusively of psychiatric hospitals a Teaching Division should be instituted if there are four units or more in the teaching department (paragraphs 7.33 to 7.34).

(32) The role of tutorial staff should be made more satisfying through the institution of larger schools of nursing to form Teaching Divisions under Principal Tutors (Principal Nursing Officers, Grade 9). Control both of student and pupil nurses and of Clinical Instructors should be devolved on tutorial staff; and some administrative functions should be delegated by the Principal Tutor (Grade 9) to other tutorial staff, particularly Senior Tutors (Grade 8) (paragraphs 7.42 to 7.46).

Committees and conferences

(33) Before a "committee" is set up, its category (e.g., whether a directive or executive committee or a conference) should be determined and the terms of reference drawn up accordingly (paragraphs 8.14 to 8.16).

(34) The committee system should provide channels through which the governing body and its standing committees can draw on the collective advice of nurses before making decisions on policy. Through committees nurses should be able to contribute to the executive decisions to be made by other officers (paragraphs 8.17 to 8.18).

(35) Much of the work now undertaken by Nursing Committees should be undertaken by senior nurses in consultation with other officers. Where Nursing Committees are to be continued the nursing representation on them should be strengthened (paragraphs 8.19 to 8.23).

(36) Where decisions affecting nursing are taken by standing committees of the governing body a nurse should be present to contribute to the discussion (paragraph 8.25).
(37) The roles of House Committees in relation to nursing and of Nurse Education Committees in relation to nurse training should be that of conclusive conferences (paragraphs 8.32 to 8.34).

Preparation and selection for nursing administration

(38) Nurses should be systematically prepared for senior posts in the three levels of management, by practical training "on the job" and by courses of instruction (paragraphs 9.9 to 9.15).

(39) National and regional nursing staff committees should be established to direct and co-ordinate arrangements for preparing nurses for senior posts and to assist hospital authorities in making appointments to posts in Grades 8, 9 and 10 by providing assessors (paragraphs 9.16 to 9.23).

(40) There should be uniform procedures for selecting nurses for senior posts (paragraphs 9.24 to 9.30).

(41) On selection for promotion to Charge Nurse (Grade 6), Staff Nurses (Grade 5) should attend a preparatory course lasting four weeks (paragraph 9.34).

(42) The selection of nursing staff for posts of Staff Nurse (Grade 5) and below should normally be made by the Nursing Officer (Grade 7) controlling the unit or the Senior Nursing Officer (Grade 8) controlling the area; and for posts of Charge Nurse (Grade 6) by the Principal Nursing Officer (Grade 9) controlling the division (paragraphs 9.36 to 9.38).

(43) On selection for promotion to Nursing Officer (Grade 7), Charge Nurses (Grade 6) should attend a preparatory course for middle management, lasting 12 weeks (paragraphs 9.40 to 9.47).

(44) The selection of nurses for posts of Nursing Officer (Grade 7) and Senior Nursing Officer (Grade 8) should be made by panels (paragraph 9.48).

(45) All Senior Nursing Officers (Grade 8) and some Nursing Officers (Grade 7) should be appointed to serve within a hospital group rather than a single hospital (paragraph 9.49).

(46) Nurses selected for promotion to Principal Nursing Officer (Grade 9) should undertake a top-management course lasting 12 weeks (six weeks initially) (paragraphs 9.51 to 9.52).

(47) Selection of senior nurses for posts in the grades of Principal Nursing Officer (Grade 9) and Chief Nursing Officer (Grade 10) should be made by selection panels consisting of members of the employing authority and nurse assessors (paragraphs 9.57 to 9.58).

Application of the proposals

(48) Before the new staffing structure is introduced in a hospital management group the nursing organisation should be reviewed and jobs constituted in accordance with the job descriptions (paragraphs 10.3 to 10.5).

(49) The new staffing structure should be applied gradually, beginning with one or two groups in each region and with selected teaching hospitals (paragraphs 10.8 to 10.11).

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APPENDIX 1

Glossary

This glossary explains the sense in which certain terms are used in the Report and Appendices. The definitions apply strictly where terms are italicised in the text.

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DEFINITIONS

1. A function is a contribution towards the achievement of the purpose of an enterprise. A major function, such as the nursing function, may be sub-divided into minor functions, such as psychiatric, general or midwifery, and these further subdivided. Groupings of tasks (which, in themselves, are aggregations of finer subdivisions) constitute jobs. The word function may also be used as synonymous with job, being the contribution a person makes towards the achievement of the common purpose.

2. A role is the part a person plays in relation to other members of the enterprise in the fulfilling of his function.

3. Managing is the function of ordering and co-ordinating other functions and the persons fulfilling them. Management is the process involved in the function managing.

(a) In top-management jobs nurses have policy-forming tasks of proposing the objectives and limitations of nursing in achieving the purpose of the hospital.

(b) In middle-management jobs nurses have programming tasks of setting the limits within which those who execute the policy may act, by determining nursing procedures and jobs.

(c) In first-line management nurses have executive tasks in applying the nursing programme to individual patients.
4. **Structural authority** is the right, vested in the position and so the role of manager, to command and to expect and enforce obedience of others in order that the function of managing (advising and co-ordinating) may be fulfilled. The right stems from the necessity for management. (It is sometimes called line authority).

5. The **sphere of authority** of a manager are the functions, and the persons fulfilling the functions, which the manager has the right to manage; and he or she is said to control them. The sphere of authority of the Chief Nursing Officer of a hospital are the nursing services and the nursing staff which he or she controls.

6. A person controlled is said to be responsible to the person in control, that is, to the one who exercises structural authority (full control—see 12(a) below).

7. When the sphere of authority is large the manager may delegate some of the rights and duties to another. **Delegation** then consists of:—

   (a) assigning functions,

   (b) specifying the kind of decision appropriate to them, and

   (c) vesting with structural authority and so handing over the control necessary for the implementation of these functions and decisions.

8. **Decentralisation** is delegation of such a nature that the optimum number of functions and highest appropriate kinds of decision are fulfilled as near as possible to the scene of activity.

9. **Sapiential authority** is the right, vested in a person, to be heard by reason of expertness or knowledge—just as one person, relative to another, may be an "authority" on a particular subject. (It is sometimes referred to as staff authority and does not involve structural authority, the right to command). Structural authority which stems from the position a manager assumes, is enhanced by his personal, sapiential authority, recognised in promotion by merit.

10. A person who exercises sapiential authority advises, instructs (meaning teaches) and informs, and is said to direct others (as distinct from control, implying command). A person directed is not obliged to act upon the advice, instruction or information of the one who directs, as distinct from being obliged to obey the rightful order of one who controls.

11. Those directed constitute the **field of influence** of the person who directs. Thus the Chief Nursing Officer has sapiential authority on the subject of nursing in the hospital group and has the right to be heard when any matter is discussed, at governing authority or other level, which involves the nursing services in that hospital group. This right stems from the need to have the best advice or information upon which a decision can be based. The Chief Nursing Officer's field of influence extends from the governing body downwards, the sapiential authority being limited to the subject of nursing services and staff.

12. **Co-ordination** of functions can be carried out by the exercise of either structural or sapiential authority, that is by control or direction:

   (a) Co-ordination by **full control**, when those co-ordinated are responsible to and receive their orders or functions and their co-ordination from the
same person—as nurses on the ward are controlled and are responsible to the ward sister.

(b) Co-ordination by actual control, when those co-ordinated and the co-ordinator are responsible to a third person, and the control consists only of ordering what is necessary for co-ordination of functions—for example, the Group Secretary, as “executive authority” of the governing body has the right (delegated to him by the governing body) to co-ordinate medical, nursing and other services, but medical and nursing officers themselves decide on the fulfilling of their functions, and are responsible for them, as is the Group Secretary for his, only to the governing body. These officers “report to” the Group Secretary. They render an account to him and so are accountable, but they are not responsible to him. These reports are necessary for co-ordination, and for the scrutiny of the governing body which must know whether its orders are being carried out.

(c) Co-ordination by direction—by the exercise of sapiential authority—when the co-ordinator, by reason of knowledge or expertness, is entitled to advise or inform another (pointing out or directing) on what he/she must or ought to do in order to fulfil his/her functions for which he/she is responsible to a third person. That is to say the person co-ordinated is not obliged (required) to act on the advice but must pay particular heed to it and act in its light because of the knowledge of the co-ordinator.

In this Report co-ordination, when italicised, refers to this third form of co-ordination, and is symbolised in structural diagrams by an interrupted line. For example, a Chief Nursing Officer may have control of a large hospital where the Principal Nursing Officers are responsible to him/her, being co-ordinated by full control. He/she may also have directive co-ordination of the duties of the nursing heads of other hospitals, but they are responsible to the governing body not to the C.N.O. and are not absolutely obliged to act upon his/her advice; although, if it is based upon knowledge of the need for co-ordination, they would be unwise not to act upon it. The Group Secretary in such a case can have no right to interfere in the co-ordination of the nursing services of these hospitals, he can only co-ordinate these services with the medical and other services, using actual control.

13. A person is said to be transferred to another sphere of authority when his/her tasks are co-ordinated with the tasks of others in that sphere of authority by one who exercises structural authority therein.

14. A person is said to be seconded to another sphere of authority when his/her tasks are co-ordinated with the tasks of those in that sphere of authority by the use of sapiential authority.

15. A section is the sphere of authority of a Charge Nurse (Grade 6), e.g. a ward.

16. A unit consists of a group of sections and is the sphere of authority of a Nursing Officer (Grade 7).

17. An area consists of a group of units and is the sphere of authority of a Senior Nursing Officer (Grade 8).
18. A division consists of a group of units (which may or may not be grouped in areas) and is the sphere of authority of a Principal Nursing Officer (Grade 9).

19. Job analysis is the study of a job by breaking it down into its tasks, processes and operations.

20. Job description is the description of a job as the result of job analysis.

21. Job grading is the ranking of jobs according to the kind of decisions involved.

22. Job specification is a compound of job description and job grading.

23. Professional functions are those requiring nursing qualifications and are not necessarily managerial.

24. Administrative (or managerial) functions relate to co-ordinating jobs and the people who do them (and may not always require nursing qualifications.)

25. Personnel functions relate to the welfare of subordinates.
APPENDIX 2

Questionnaire accompanying invitation to submit written evidence

The following questionnaire was circulated to a number of organizations and hospital authorities, who were invited to submit written evidence on the basis of the questions asked. Comment on any appropriate subject not dealt with in the questionnaire was also invited.

The questions were:

1. Content of nursing administration
   (a) What are the principal administrative nursing functions to be discharged in hospitals? It would be helpful to have included:—
      (i) those relating essentially to nursing and nursing education,
      (ii) those relating to other matters in which nursing administration has an interest.
   (b) Is the function of administering the nursing service compatible with that of responsibility for training students and pupils?
   (c) Should midwifery be administered separately from other nursing?

2. The head of the nursing and education services ("Top management")
   (a) Where there is more than one hospital administered by a Board of Governors or Hospital Management Committee (or Board) should the "top-level" decisions in the exercising of these functions be made independently by a nursing head in each hospital within the group? Or should some or all of them be made in respect of all the hospitals in the group by one or more group heads?
   (b) Would a group head also have nursing control in a hospital or be divorced from direct control of a hospital?
   (c) What should be the channels of responsibility between the nursing heads (including group heads) and the governing bodies of hospitals, and what committees and other facilities for consultation etc. are necessary or helpful to nursing heads in carrying out their functions?

3. Senior supporting staff ("Middle management")
   (a) How should administrative functions be distributed to senior supporting staff (including hospitals where group heads are appointed, but excluding departmental and ward sisters):—
      (i) where there is a school of nursing administered by the governing body of the hospital,
      (ii) in psychiatric hospitals,
      (iii) in district general hospitals including psychiatric and obstetric units,
(iv) in other hospitals:—
   a) with an obstetric unit, 
   b) without an obstetric unit?

(b) Is there a place among such supporting staff for non-nurses to participate?

4. Other senior nursing staff. ("First-line management").
   (a) What are the principal administrative functions of ward and departmental 
       sisters?
   (b) Could any of these be carried out by non-nurses?

5. Preparation of nursing staff for administrative posts
   (a) What qualifications are to be required in candidates for the various 
       posts? What further training is necessary?
   (b) By what procedures are they to be selected?
   (c) What career structure is necessary to attract suitable candidates?
List of those who gave evidence

The following gave written and oral evidence:

Association of Hospital Management Committees
Association of Hospital Matrons
Association of Mental Hospital Matrons
Association of Scottish Hospital Boards of Management
Association of Scottish Hospital Matrons
Miss A. I. C. Bone
British Medical Association
Central Midwives Board
Central Midwives Board for Scotland
Professor T. E. Chester
General Nursing Council for England and Wales
General Nursing Council for Scotland
Institute of Hospital Administrators
King Edward’s Hospital Fund
Dr. T. F. Main
National Association of Chief Male Nurses
National Association of Hospital Management Committee Group Secretaries
Regional Hospital Board Nursing Officers (England and Wales)
Regional Hospital Board Nursing Officers (Scotland)
Royal College of Midwives (and its Scottish Council)
Royal College of Nursing (and its Scottish Board)
Royal College of Physicians and Surgeons of Glasgow
Royal Medico—Psychological Association
Miss E. Stephenson
Sub-Committee of the Advisory Committee on Nursing and Sister Tutor’s Diplomas (Department of Extra-Mural Studies, University of London)
Teaching Hospitals Association
Trades Union Congress Nursing Advisory Committee.

The following gave written evidence only:

Association of British Paediatric Nurses
Association of Dental Hospitals of Great Britain and Northern Ireland
K. Barnard, Esq.
G. C. Bateson, Esq.
Miss E. Bennett
Bethlem and Maudsley Hospitals
Birmingham Regional Hospital Board
British Medical Association (Scottish Office)
Central Consultants’ Committee (England and Wales)
Central Consultants’ Committee (Scotland)
Charing Cross Hospital
S. C. A. Clifford, Esq.
T. Coady, Esq.
East Anglian Regional Hospital Board
Eastern Regional Hospital Board
Dr. L. Findlay
Miss Gibbon
Guy's Hospital
C. W. Halling, Esq.
Hammersmith and St. Mark's Hospitals
Hospital for Sick Children
King's College Hospital
Dr. D. Lawson
Leeds Regional Hospital Board
Liverpool Regional Hospital Board
London Hospital
Dr. D. Macmillan
Manchester Regional Hospital Board
Mental Health Tutors' Association
Middlesex Hospital
Moorfields Eye Hospital
National Hospital for Nervous Diseases
Newcastle Regional Hospital Board
North-Eastern Regional Hospital Board
North-East Metropolitan Regional Hospital Board
Northern Regional Hospital Board
North-West Metropolitan Regional Hospital Board
Oxford Regional Hospital Board
Miss E. Patmore
Queen Charlotte's and Chelsea Hospitals
J. R. Robinson, Esq.
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Royal Free Hospital
Royal Marsden Hospital
Royal National Orthopaedic Hospital
St. John's Hospital for Diseases of the Skin
St. Thomas' Hospital
Scottish Association of Medical Administrators
Sheffield Regional Hospital Board
D. Sheldon, Esq.
Society of Mental Nurses
Society of Registered Male Nurses
South-Eastern Regional Hospital Board
South-East Metropolitan Regional Hospital Board
South-Western Regional Hospital Board
South-West Metropolitan Regional Hospital Board
Tavistock Institute of Human Relations
United Birmingham Hospitals
United Bristol Hospitals
United Cardiff Hospitals
United Leeds Hospitals
United Liverpool Hospitals
United Manchester Hospitals
United Newcastle Hospitals
United Oxford Hospitals
United Sheffield Hospitals
University College Hospital
Westminster Hospital

The following gave oral evidence only:

National Staff Committee
Professor R. W. Revans.
APPENDIX 4

List of hospitals visited

Bangour Village Hospital, Broxburn, West Lothian
Barnsley Hall Hospital, Bromsgrove
Bellshill Maternity Hospital, Glasgow
Broadgreen Hospital, Liverpool
Cardiff Royal Infirmary
East Glamorgan Hospital, Pontypridd
Ellen Badger Hospital, Shipston-on-Stour
Kent and Canterbury Hospital, Canterbury
Lambeth Hospital, London
Lea Hospital, Bromsgrove
The Middlesex Hospital, London (including St. Luke's—Woodside Hospital)
Monroe Devis Maternity Home, Stratford-upon-Avon
Moorhaven Hospital, Ivybridge
New Cross Hospital, Wolverhampton
Northampton General Hospital
Nunnery Fields Hospital, Canterbury
Queen Mother's Hospital, Glasgow
The Royal Hospital, Wolverhampton
Royal Infirmary of Edinburgh
St. Audry's Hospital, Woodbridge
Simpson Memorial Maternity Pavilion, Edinburgh
Southmead Hospital, Bristol
South Warwickshire Children's Recovery Hospital, Stratford-upon-Avon
Queen Elizabeth Hospital, Birmingham
Victoria Infirmary, Glasgow
APPENDIX 5

The Statistical Enquiry

1. Method

The enquiry was addressed to all staff in post in National Health Service hospitals in Great Britain in the grades above midwifery sister, ward sister and charge nurse; to all midwifery sisters, ward sisters and charge nurses in one-third of non-teaching hospitals in England and Wales and of teaching and non-teaching hospitals in Scotland and in all teaching hospitals in England and Wales.

In the tables giving the findings from the enquiry the figures for midwifery sisters, ward sisters and charge nurses in non-teaching hospitals in England and Wales have been multiplied by 3 to give overall figures. For Scotland all figures for those grades have been scaled-up by multiplying by 3.

The questionnaires were sent in July 1964 to group secretaries and house governors who were asked to enter the names and the Whitley grades of those staff to be included in the enquiry. The questionnaires were then given to the nursing heads for distribution to the staff concerned. Each of these was given a letter explaining the purpose of the enquiry and an envelope marked 'confidential' for the return of the questionnaire. The overall response rate to the enquiry was 85%. The findings given in the tables relate to those who returned questionnaires, no adjustment being made for those who did not respond.

The data collected in the enquiry have been analysed separately for England and Wales and for Scotland, for women and for men, and for different kinds of hospitals grouped as follows:

Groups used in the enquiry Kinds of hospitals included*

A. England and Wales

General acute (01); mainly acute (02); partly acute (03); orthopaedic (14); children's (acute) (17).

Maternity maternity (11).

Long stay mainly long-stay (04); long-stay (05); chronic (06).

Psychiatric mental illness (12); mental subnormality (13).

Other preconvalescent (07); convalescent (08); rehabilitation (09); isolation (10); tuberculosis and chest (15); tuberculosis, chest and isolation (16); eye (18); other (19).

B. Scotland

General general (1a); mainly general (1b); general (sick children) (1e).

Maternity maternity (6).

Long-stay general (mainly chronic sick) (1e); general (chronic sick) (1d).

Psychiatric mental illness (7); mental deficiency (8).

Other convalescent (2); isolation (3); tuberculosis (4); isolation and tuberculosis (I) (5a); isolation and tuberculosis (T) (5b); miscellaneous (9).

*The numbers in brackets are those given in the classification scheme of hospitals as defined in Notes on Form SH3 for 1964 for England and Wales and in Scottish Health Statistics, 1963, for Scotland.
The data collected have been analysed for each grade of staff but for this appendix the grades have been grouped into the broader bands shown in the tables. Group described in the tables as “Deputy, etc., matron” and “Deputy, etc., matrons/chief male nurse” include the deputy, senior assistant and assistant grades.

2. The number of staff, their country of birth, whether whole-time or part-time, and whether married (Table 1)

The numbers of staff included in the enquiry were 37,393 in England and Wales and 4,802 in Scotland. In England and Wales 80%, and in Scotland 85% of the staff were women. Of the staff in England and Wales 84% and in Scotland 95% were born in Great Britain. Northern Ireland and the Republic of Eire between them contributed 11% of the staff in England and Wales and 1 to 2% of that in Scotland. The remainder, 5% in England and Wales and 3% in Scotland, were born elsewhere.

Of the staff in England and Wales 8%, and in Scotland 4% worked part-time. Practically no men worked part-time. Of midwifery sisters and ward sisters 12% in England and Wales and 5% in Scotland worked part-time.

Of the women who were working whole time, 33% in England and Wales and 21% in Scotland were or had been married. Practically all the men working whole time were married as were most of the women working part time. Of the women working whole time in the grades of assistant matron and above, 19% in England and Wales and 12% in Scotland were or had been married. The corresponding figures for midwifery sisters and ward sisters in England and Wales were 22% and 41% respectively and in Scotland 13% and 26% respectively.

3. The age of the staff (Table 2)

Of the staff in England and Wales, 36% were aged under 40 and 17% were aged 55 or over. For women the proportions were 39% and 16% and for men 25% and 20%. Of women who were matrons about 2% were aged under 40 and 41% were aged 55 or more. The matrons in smaller hospitals tended to be older than those in larger hospitals. Of the women in the grades of deputy, senior assistant and assistant matron, 11% were aged under 40 and 26% aged 55 or more. Of the men who were matrons/chief male nurses, 6% were aged under 40 and 33% were aged 55 or more; in the deputy, senior assistant and assistant grades the proportions were 17% and 28%.

Of the midwifery tutorial staff, women nursing tutorial staff, midwifery sisters and ward sisters, 33%, 22%, 56% and 48% were aged under 40; the proportions aged 50 or more were 24%, 43%, 19% and 25%. In these grades there were proportionately more older persons among the nursing staff than among the midwifery staff. Of charge nurses 26% were aged under 40 and 42% were aged 50 or more; there was a higher proportion of older staff among charge nurses than among midwifery sisters or ward sisters.
The age distribution of the various grades of staff varied in the different kinds of hospital. Thus the proportion of matrons aged 55 or over was 40% in general and maternity hospitals, 46—47% in long-stay and other hospitals and 32% of matrons (women) in psychiatric hospitals. The pattern for deputy, senior assistant and assistant matrons was much the same. In general hospitals 58% of ward sisters were aged under 40 and 17% aged 50 or over; in long-stay hospitals 35% and 33%; in psychiatric hospitals 14% and 59%; and in other hospitals 45% and 22%.

In Scotland 39% of the total staff were aged under 40 and 17% were aged 55 or more. The corresponding figures for the women were 42% and 16% and for the men, 20% and 19%. Of the women who were matrons 2% were aged under 40 and 45% were aged 55 or more. Of the women in the deputy, senior assistant and assistant grades the corresponding proportions were 12% and 26% and of the men 14% and 24%.

Of midwifery sisters, ward sisters and charge nurses the proportions aged under 40 were 63%, 51% and 21% and the proportions aged 50 or more 12%, 26% and 44%.

4. The number of staff who will reach retiring age within 10 years (Table 3)

Within five years from the time of this enquiry 41% of the women who were matrons and 33% of the men who were matrons/chief male nurses in England and Wales will reach the age of 60; the corresponding figures for women and men in the deputy, senior assistant and assistant grades are 26% and 28%. The proportions reaching the age of 60 within 10 years are much higher—72%, 65%, 53% and 52% respectively. In Scotland the proportions reaching the age of 60 within 10 years are 73% of matrons, 52% of the women in the deputy, senior assistant and assistant grades and 42% of the men in the deputy, senior assistant and assistant grades.

5. Length of time spent in the current grade (Table 4)

Of the matrons and chief male nurses in England and Wales about 40% of each had been 10 or more years in their current grade. Of women in the deputy, senior assistant and assistant grades, 24% had been in their grade for 10 years or more as compared with 15% of the men in these grades.

The proportions of women nursing tutorial staff, departmental sisters and ward sisters who had been in their grade for 10 years or more were greater than for the corresponding midwifery grades—33%, 32% and 31% respectively for the nursing grades and 16%, 23% and 25% respectively for the midwifery grades. Proportionately fewer men had been 10 years or more in such grades.

In the various kinds of hospitals, just over 40% of matrons of general-maternity and other hospitals had been 10 or more years in their current grade; for matrons of long-stay hospitals the proportion was 37% and for women matrons of psychiatric hospitals 33%. For staff in the grades of deputy, senior
assistant or assistant matron the proportions were—general hospitals 24%, maternity hospitals 30%, long-stay hospitals 21%, psychiatric hospitals 19% and other hospitals 29%; and for ward sisters in general hospitals 29%, long-stay hospitals 33%, psychiatric hospitals 36% and other hospitals 30%.

In Scotland, 46% of matrons had spent 10 or more years in their current grade; and 21% of women and 10% of men in the deputy, senior assistant and assistant grades. As in England and Wales a higher proportion of the nursing staff than of the corresponding midwifery staff had spent fairly long periods in their current grade, as had a higher proportion of the women than of the men.

6. Age at appointment to current grade (Table 5)

Women appointed matron in the period 1960 to 1964 in hospitals in England and Wales with 500 or more beds were mainly aged 40 to 54; the most usual age of those appointed in hospitals with 100 to 499 beds was 45 to 49; those in hospitals with fewer beds tended to be older. Of the men matrons and chief male nurses appointed in England and Wales 20% were aged under 40 and 24% aged 50 or more; the corresponding proportions for the women were 10% and 37%.

Of the women appointed to general hospitals in England and Wales as matrons 32% were aged 50 or more. For other kinds of hospitals the corresponding proportions were—maternity hospitals 28%, long-stay hospitals 46%, psychiatric hospitals 35% and other hospitals 45%. 22% of the deputy, senior assistant and assistant matrons appointed to general hospitals were aged 50 or more, and 34% of those appointed to long-stay hospitals.

Of the 85 women appointed as matrons in Scotland 8 were aged under 40, 44 aged 40 to 49, 25 aged 50 to 54 and 8 aged 55 or more.

In England and Wales 57% of midwifery sisters, 61% of ward sisters and 17% of charge nurses were appointed under the age of 30 and 16%, 17% and 44% at the age of 40 or above. The corresponding figures for Scotland were—under the age of 30, 60%, 61%, 18% and at the age of 40 or above 11%, 16%, 46%.

7. Years of service between appointment as ward sister/charge nurse and as matron/chief male nurse (Table 6)

For all hospitals taken as one group and indeed broadly for each kind of hospital the most common period of service in England and Wales between appointment as ward sister and as matron was 10 to 14 years, but the range was considerable. For men who were matrons/chief male nurses the most common period of service since appointment as charge nurse was 5 to 9 years, but again there was considerable variation.

Of the 85 women appointed as matrons in Scotland 5 had served up to 5 years since appointment as ward sister, 18 had served 5 to 9 years, 23 had served 10 to 14 years, 23 had served 15 to 19 years and 16 had served 20 years or more.
8. Statutory nursing qualifications (Table 7)

In England and Wales the statutory qualification most frequently held was S.R.N. or R.G.N.—by 80% of the staff. 32% of the staff were S.C.M. and 19% were R.M.N. Of the staff in the grades of assistant matron/assistant chief male nurse and above in psychiatric hospitals, 68% were R.M.N.

For 64% of the staff the qualification taken first was S.R.N. or R.G.N. A qualification in psychiatric nursing was taken first by 26% of the staff. Of the staff in psychiatric hospitals 6% first became S.R.N. or R.G.N.; practically all the rest first took a qualification in psychiatric nursing.

Table 7 shows the proportions of staff who were doubly qualified in general nursing (S.R.N. or R.G.N.) and midwifery (S.C.M.) or in general nursing (S.R.N. or R.G.N.) and in psychiatric nursing (R.M.N., R.N.M.S., R.M.N.D., or R.M.P.A.). In England and Wales of women who were matrons 73% were doubly qualified, mostly in general nursing and midwifery and of men who were matrons/chief male nurses 73%, all in general nursing and psychiatric nursing. Of the matrons and chief male nurses in psychiatric hospitals, 75% were doubly qualified in general and psychiatric nursing; and this was so for 53% of the staff in the deputy, senior assistant and assistant grades.

Of the staff in Scotland 82% were S.R.N. or R.G.N., 47% were S.C.M. and 17% were R.M.N. The proportions of women who were doubly qualified in general nursing and midwifery or psychiatric nursing were 85% of those in the grade of matron, 81% of those in the grades of deputy, senior assistant and assistant matron, 61% of nursing tutorial staff and 45% of ward sisters. Of the charge nurses 17% were doubly qualified in general and psychiatric nursing.

9. Age of qualifying S.R.N. and whether trained in teaching or non-teaching hospitals

Of the staff in England and Wales who became S.R.N. in the period 1960 to 1964, 59% did so at the age of 21 or 22, 10—11% at the age of 23, 25% at the age of 24 to 29 and 5% at the age of 30 or more. These figures do not necessarily show the age distribution of all nurses who qualified S.R.N. in the period 1960 to 1964. Some who did so will have been staff nurses at the time of the enquiry and some could have left the hospital service.

Of the matrons appointed in the years 1955 to 1964 to general hospitals of 500 or more beds, 200 to 499 beds, 100 to 199 beds and less than 100 beds, 53%, 35%, 29% and 17% respectively qualified as S.R.N. at teaching hospitals. For the other types of hospitals, the proportion of matrons trained at teaching hospitals was less than for general hospitals, except for hospitals with fewer than 100 beds. For hospitals of that size the proportions were much the same for general, maternity and other hospitals.

Of all the deputy, senior assistant and assistant matrons 20% were trained in teaching hospitals; the corresponding proportion in general hospitals was 25%. The proportion of midwifery tutorial staff trained in teaching hospitals was 30%, of nursing tutorial staff 23%, of midwifery sisters 20% and of ward sisters 19%.
10. Educational qualifications

We enquired into educational qualifications of higher school certificate or equivalent or above. Of the 37,393 staff in the enquiry in England and Wales 88 had a university degree and 3,254 a certificate of higher education. Thus some 9% of the staff had such an educational qualification; of women who were matrons 15%; of women in the grades of deputy, senior assistant and assistant matron 10%; of women nursing tutorial staff 14%; of midwifery tutorial staff 17%; of midwifery sisters 9%; and of ward sisters 9%. Of the men 5% had such an educational qualification.

In general, long-stay and other hospitals, 10% of the staff had such an educational qualification; in psychiatric hospitals 5%.

In Scotland 27% of the staff had a university degree or certificate of higher education—29% of the women and 15% of the men. Of the women matrons 34% were so qualified, of women in the grades of deputy, senior assistant and assistant matron 20%; of the women nursing tutorial staff 40%; of midwifery tutorial staff 67%; of midwifery sisters 30%; and of ward sisters 27%.

11. Administrative courses (Table 8)

The staff in the enquiry were asked to state whether they had undertaken administrative training of the kinds listed in Table 8 or any courses of equivalent standing. In both England and Wales and Scotland, of the courses listed, more nurses had attended the Ward Sisters' Course of the King Edward's Fund Staff College than any other; next came the course leading to the Administrative Certificate of the Royal College of Nursing.

In England and Wales one administrative course had been attended per 33 staff and in Scotland per 24 staff. Among women who were matrons the ratio was one per 9 staff in England and Wales and one per 14 staff in Scotland; among women in the grades of deputy, senior assistant and assistant matron one per 12 staff and per 9 staff; among women tutorial nursing staff, one per 8 staff and per 11 staff; and among ward sisters one per 45 staff and per 24 staff. Few midwifery sisters had undertaken such courses. 100—150 staff had undertaken some other administrative course.

Among the men one administrative course had been attended per 88 staff in England and Wales and per 37 staff in Scotland. For charge nurses the ratios were one per 228 staff and one per 57 staff.

Very few of the staff in maternity, long-stay or psychiatric hospitals had undertaken such administrative courses.

12. Matrons who were heads of training schools; and deputy matrons answerable to matrons elsewhere (Table 9)

Overall 7% of women who were matrons in England and Wales were responsible for a maternity department (but not a midwifery training school), 28% for a nurse training school and 5% for a midwifery training school. Another 6% were responsible for both a nurse training school and a midwifery training school;
most of these were in hospitals with 300 or more beds. Of men who were matrons/chief male nurses 62% were heads of nurse training schools.

In general hospitals 32% of matrons were heads of nurse training schools and 14% had both nurse and midwifery training schools. In psychiatric hospitals 55% of the matrons and chief male nurses were heads of nurse training schools.

In Scotland of women who were matrons 11% were responsible for a maternity department (but not a midwifery training school), 21% for a nurse training school and 5% for a midwifery training school. A further 4% had both a midwifery training school and a nurse training school. Most of the men who were matrons/chief male nurses were heads of a nurse training school.

Some deputy, senior assistant and assistant matrons were answerable to matrons centred at another hospital. Of the men and women in England and Wales in the grades of deputy, senior assistant and assistant matron/chief male nurse 20% were answerable to matrons centred elsewhere. In Scotland the proportion was 19%.

13. Tutorial and midwifery qualifications held by matrons

In England and Wales 6% of the women who were matrons and heads of nurse training schools held the Sister Tutor’s Diploma. If the beds were 500 or more, 12% held the diploma; in smaller hospitals, about 4%. Of the men who were heads of nurse training schools 8% held the diploma.

Of the matrons responsible for midwifery training school, 10% were not S.C.M.; of those in charge of a maternity department but not a midwifery training school, 9% were not S.C.M.

Of the women who were matrons in Scotland who were heads of a nurse training school, 10% held the Sister Tutor’s Diploma; none of the men who were heads of a nurse training school had the diploma. Of the 26 matrons responsible for a midwifery training school all were S.C.M.; of the 46 matrons in charge of a maternity department but not a midwifery training school 3 were not S.C.M.

14. Breaks in nursing service in hospital (Table 10)

Of the staff in the enquiry in England and Wales 24% had had a break in their hospital service. For women the proportion was 28% and for men 6%. The range among the women was from 56% of nursing tutorial staff to 21% of ward sisters; and among the men from 29% of nursing tutorial staff to 4% of charge nurses. Overall the most common occasion of a break in service was other nursing service, but there were variations between the different grades of staff. Thus among nursing tutorial staff the most frequent reason was for further study while among ward sisters marriage and family commitments were prominent.

Of the staff in Scotland 21% had had a break in service—24% of the women staff and 4% of the men. The range among the women was from 57% of nursing tutorial staff to 17% of ward sisters.
Of the staff who had had a break in service, 28% in *England and Wales* and 21% in *Scotland* returned to hospital service in a lower grade.

15. Matrons who moved from one hospital to another

The matrons in the enquiry were asked to state whether or not they had moved as matrons from one hospital to another, the sizes of the hospitals from and to which they moved and the ages at which the moves were made.

Of all matrons in *Great Britain*, 23% moved from a first to a second hospital, 6% from a second to a third hospital and 1 to 2% from a third to a fourth hospital. A large proportion of the moves were made from larger to smaller hospitals or to hospitals of much the same size. Thus of the first and second moves somewhat less than one half were made to larger hospitals; of the third moves only about 9 out of 35 were to larger hospitals.

The first move was most frequently made at the age of 40 to 49—in about 60% of cases, and about equal numbers were made earlier and later. The second and third moves were made predominantly at the age of 40 to 54.
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### Grade

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<tr>
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</tbody>
</table>

**Notes:**

1. Includes 15 male matrons.

2. Includes 21 male deputy matrons, 11 male senior assistant matrons and 98 male assistant matrons.

3. Includes 4 male deputy matrons and 4 male assistant matrons.
### Table 2

#### Age of the staff

**A. ENGLAND AND WALES**

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<th>Grade</th>
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<th>40-44</th>
<th>45-49</th>
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<th>60 or over</th>
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</tr>
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<td>Women</td>
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<td></td>
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<td></td>
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<td>22</td>
<td>32</td>
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<td>21</td>
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<td>21</td>
<td>5</td>
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<tr>
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<td>17</td>
<td>12</td>
<td>19</td>
<td>24</td>
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<td>Women</td>
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<td>15</td>
<td>17</td>
<td>26</td>
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<td>17</td>
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Printed image digitised by the University of Southampton Library Digitisation Unit
## B. SCOTLAND

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<th>Age (years)</th>
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<th></th>
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<th></th>
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<td>40-44</td>
<td>45-49</td>
<td>50-54</td>
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<td>60 or over</td>
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<td>623</td>
<td>527</td>
<td>641</td>
<td>708</td>
<td>786</td>
<td>620</td>
<td>166</td>
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<td>100</td>
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<td>23</td>
<td>20</td>
<td>5</td>
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<td>14</td>
<td>12</td>
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<td>31</td>
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<td>—</td>
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<td>1</td>
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<td>—</td>
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<td>60</td>
<td>66</td>
<td>39</td>
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<td>6</td>
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<td>306</td>
<td>249</td>
<td>57</td>
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<td>45</td>
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<td>114</td>
<td>129</td>
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<td>2</td>
<td>5</td>
<td>4</td>
<td>—</td>
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<td>27</td>
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<td>38</td>
<td>49</td>
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<td>14</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>24</td>
<td>—</td>
<td>—</td>
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<td>3</td>
<td>8</td>
<td>3</td>
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<td></td>
</tr>
</tbody>
</table>

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Table 3
The number (per cent) of certain grades of staff who will reach the ages of 55 years and 60 years in 5 and 10 years from the time of the enquiry

### A. ENGLAND AND WALES

<table>
<thead>
<tr>
<th>Grade</th>
<th>Had already reached the age of 55 or will reach it in</th>
<th>Had already reached the age of 60 or will reach it in</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 years</td>
<td>10 years</td>
</tr>
<tr>
<td></td>
<td>Per cent of staff in grade</td>
<td></td>
</tr>
<tr>
<td>Matron</td>
<td>Women</td>
<td>72</td>
</tr>
<tr>
<td>Matron/chief male nurse</td>
<td>Men</td>
<td>65</td>
</tr>
<tr>
<td>Deputy, etc., matron</td>
<td>Women</td>
<td>53</td>
</tr>
<tr>
<td>Deputy, etc., matron/chief male nurse</td>
<td>Men</td>
<td>52</td>
</tr>
<tr>
<td>Midwifery tutorial staff</td>
<td>Men</td>
<td>24</td>
</tr>
<tr>
<td>Nursing tutorial staff</td>
<td>Women</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Men</td>
<td>23</td>
</tr>
</tbody>
</table>

### B. SCOTLAND

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number of staff</th>
<th>Had already reached the age of 55 or will reach it in</th>
<th>Had already reached the age of 60 or will reach it in</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 years</td>
<td>10 years</td>
<td>5 years</td>
</tr>
<tr>
<td>Matron</td>
<td>Women</td>
<td>284</td>
<td>208</td>
</tr>
<tr>
<td>Matron/chief male nurse</td>
<td>Men</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Deputy, etc., matron</td>
<td>Women</td>
<td>290</td>
<td>151</td>
</tr>
<tr>
<td>Deputy, etc., matron/chief male nurse</td>
<td>Men</td>
<td>90</td>
<td>38</td>
</tr>
<tr>
<td>Midwifery tutorial staff</td>
<td>Men</td>
<td>36</td>
<td>9</td>
</tr>
<tr>
<td>Nursing tutorial staff</td>
<td>Women</td>
<td>131</td>
<td>48</td>
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<tr>
<td></td>
<td>Men</td>
<td>50</td>
<td>10</td>
</tr>
</tbody>
</table>

138
### Table 4
The length of time spent in the current grade

#### A. ENGLAND AND WALES

<table>
<thead>
<tr>
<th>Grade</th>
<th>Years spent in current grade</th>
<th>Per cent of staff in grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 1</td>
<td>1</td>
</tr>
<tr>
<td>Matron</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Matron/chief male nurse</td>
<td>4</td>
<td>9</td>
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<tr>
<td>Deputy, etc., matron</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Deputy, etc., matron/chief male nurse</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Midwifery tutorial staff</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Nursing tutorial staff</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Departmental midwifery sister</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Departmental sister</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Departmental charge nurse</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>Midwifery sister</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Ward sister</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Charge nurse</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Other senior midwifery staff</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Other senior nursing staff</td>
<td>16</td>
<td>13</td>
</tr>
</tbody>
</table>

| Matron/chief male nurse  | 284 | 16 | 14 | 14 | 22 | 23 | 65 | 130 |
| Deputy, etc., matron  | 14 | 1 | 2 | — | — | 2 | 7 | 2 |
| Deputy, etc., matron/chief male nurse  | 290 | 35 | 28 | 32 | 32 | 28 | 74 | 61 |
| Midwifery tutorial staff  | 36 | 5 | 6 | 5 | 2 | 4 | 8 | 6 |
| Nursing tutorial staff  | 131 | 16 | 13 | 13 | 7 | 10 | 36 | 36 |
| Departmental midwifery sister  | 36 | 8 | 3 | 5 | 3 | 3 | 10 | 4 |
| Departmental sister  | 201 | 19 | 38 | 28 | 18 | 15 | 53 | 30 |
| Departmental charge nurse  | 6 | — | 1 | 1 | 2 | 2 | — | — |
| Midwifery sister  | 501 | 108 | 57 | 69 | 36 | 42 | 90 | 99 |
| Ward sister  | 2,331 | 255 | 207 | 198 | 222 | 156 | 495 | 798 |
| Charge nurse  | 516 | 63 | 51 | 45 | 30 | 27 | 153 | 147 |
| Other senior midwifery staff  | 18 | — | 1 | 2 | 1 | 2 | 7 | 5 |
| Other senior nursing staff  | 274 | 35 | 49 | 33 | 23 | 19 | 64 | 51 |

#### B. SCOTLAND

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number of staff</th>
<th>Years spent in current grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 1</td>
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<tr>
<td>Matron</td>
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<td>16</td>
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<tr>
<td>Matron/chief male nurse</td>
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<td>1</td>
</tr>
<tr>
<td>Deputy, etc., matron</td>
<td>290</td>
<td>35</td>
</tr>
<tr>
<td>Deputy, etc., matron/chief male nurse</td>
<td>90</td>
<td>6</td>
</tr>
<tr>
<td>Midwifery tutorial staff</td>
<td>36</td>
<td>5</td>
</tr>
<tr>
<td>Nursing tutorial staff</td>
<td>131</td>
<td>16</td>
</tr>
<tr>
<td>Departmental midwifery sister</td>
<td>36</td>
<td>8</td>
</tr>
<tr>
<td>Departmental sister</td>
<td>201</td>
<td>19</td>
</tr>
<tr>
<td>Departmental charge nurse</td>
<td>6</td>
<td>—</td>
</tr>
<tr>
<td>Midwifery sister</td>
<td>501</td>
<td>108</td>
</tr>
<tr>
<td>Ward sister</td>
<td>2,331</td>
<td>255</td>
</tr>
<tr>
<td>Charge nurse</td>
<td>516</td>
<td>63</td>
</tr>
<tr>
<td>Other senior midwifery staff</td>
<td>18</td>
<td>—</td>
</tr>
<tr>
<td>Other senior nursing staff</td>
<td>274</td>
<td>35</td>
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### TABLE 5

**Age on appointment to current grade of staff appointed in the period 1960 to 1964**

**A. ENGLAND AND WALES**

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<th>Age (years) on appointment to current grade</th>
<th>Per cent of staff in grade</th>
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<td>Matron</td>
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</tr>
<tr>
<td>Matrons/chief male nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals with 500 or more beds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>200—499</td>
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<td>3</td>
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<td>100—199</td>
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<tr>
<td>under 50</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Matrons/chief male nurse</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Deputy, etc., matron</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Deputy, etc., matron/chief male nurse</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Midwifery tutorial staff</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Nursing tutorial staff</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Departmental midwifery sister</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Departmental sister</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Departmental charge nurse</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Midwifery sister</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Ward sister</td>
<td></td>
<td>57</td>
</tr>
<tr>
<td>Charge nurse</td>
<td></td>
<td>61</td>
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<td>17</td>
</tr>
<tr>
<td>Other senior nursing staff</td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

**For Other senior nursing staff:**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Age (years) on appointment to current grade</th>
<th>Per cent of staff in grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 30</td>
<td>30—34</td>
</tr>
<tr>
<td>Matrons/chief male nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matrons/chief male nurse</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>Deputy, etc., matron</td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>

140

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### TABLE 6

**Years of paid service between first appointment as ward sister/charge nurse and current appointment as matron/chief male nurse**

**Persons appointed to their current grade in the period 1960 to 1964**

#### A. ENGLAND AND WALES

<table>
<thead>
<tr>
<th>Grade</th>
<th>Years between appointment as ward sister/charge nurse and as matron/chief male nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 5</td>
</tr>
<tr>
<td>Matron</td>
<td>Number</td>
</tr>
<tr>
<td>Hospitals with 500 or more beds</td>
<td>...</td>
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<td>200—499</td>
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<tr>
<td>100—199</td>
<td>11</td>
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<tr>
<td>50—99</td>
<td>4</td>
</tr>
<tr>
<td>under 50</td>
<td>11</td>
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<tr>
<td>Matron/chief male nurse</td>
<td>Men</td>
</tr>
<tr>
<td>9</td>
<td>26</td>
</tr>
</tbody>
</table>

#### B. SCOTLAND

<table>
<thead>
<tr>
<th>Grade</th>
<th>Years between appointment as ward sister/charge nurse and as matron/chief male nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 5</td>
</tr>
<tr>
<td>Matron</td>
<td>Number</td>
</tr>
<tr>
<td>Matron/chief male nurse</td>
<td>Men</td>
</tr>
<tr>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
# Table 7

## Statutory qualifications held

### A. ENGLAND AND WALES

<table>
<thead>
<tr>
<th>Grade</th>
<th>SRN or RGN</th>
<th>SCM</th>
<th>RMN (2)</th>
<th>RMNS (1)</th>
<th>RSCN</th>
<th>RTN</th>
<th>RNMD (1)</th>
<th>SEN</th>
<th>RMPA (2)</th>
<th>Qualifications held in combination (3)</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Per cent of staff with qualification</td>
</tr>
<tr>
<td>All staff</td>
<td>80</td>
<td>32</td>
<td>19</td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Matron</td>
<td>97</td>
<td>64</td>
<td>9</td>
<td>1</td>
<td>5</td>
<td>15</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Matron/Chief male nurse</td>
<td>77</td>
<td>—</td>
<td>66</td>
<td>10</td>
<td>—</td>
<td>—</td>
<td>17</td>
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<td>3</td>
<td>—</td>
</tr>
<tr>
<td>Deputy, etc., matron</td>
<td>87</td>
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<td>1</td>
<td>5</td>
<td>43</td>
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<td>62</td>
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<td>—</td>
<td>15</td>
<td>1</td>
<td>15</td>
<td>—</td>
</tr>
<tr>
<td>Midwifery tutorial staff</td>
<td>99</td>
<td>98</td>
<td>—</td>
<td>—</td>
<td>4</td>
<td>4</td>
<td>—</td>
<td>1</td>
<td>—</td>
<td>97</td>
</tr>
<tr>
<td>Nursing tutorial staff</td>
<td>100</td>
<td>52</td>
<td>4</td>
<td>—</td>
<td>8</td>
<td>12</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>52</td>
</tr>
<tr>
<td>Departmental midwifery sister</td>
<td>96</td>
<td>98</td>
<td>—</td>
<td>—</td>
<td>4</td>
<td>7</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>94</td>
</tr>
<tr>
<td>Departmental sister</td>
<td>98</td>
<td>36</td>
<td>2</td>
<td>—</td>
<td>5</td>
<td>10</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>36</td>
</tr>
<tr>
<td>Departmental charge nurse</td>
<td>96</td>
<td>—</td>
<td>24</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>7</td>
<td>—</td>
<td>20</td>
</tr>
<tr>
<td>Midwifery sister</td>
<td>92</td>
<td>99</td>
<td>1</td>
<td>—</td>
<td>3</td>
<td>4</td>
<td>—</td>
<td>3</td>
<td>—</td>
<td>89</td>
</tr>
<tr>
<td>Ward sister</td>
<td>80</td>
<td>23</td>
<td>16</td>
<td>—</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td>Charge nurse</td>
<td>45</td>
<td>—</td>
<td>52</td>
<td>3</td>
<td>—</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>17</td>
<td>—</td>
</tr>
<tr>
<td>Other senior midwifery staff</td>
<td>99</td>
<td>98</td>
<td>2</td>
<td>—</td>
<td>2</td>
<td>8</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>97</td>
</tr>
<tr>
<td>Other senior nursing staff</td>
<td>92</td>
<td>36</td>
<td>6</td>
<td>—</td>
<td>4</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>35</td>
</tr>
<tr>
<td>Women</td>
<td>Men</td>
<td>59</td>
<td>42</td>
<td>3</td>
<td>—</td>
<td>2</td>
<td>12</td>
<td>3</td>
<td>14</td>
<td>—</td>
</tr>
</tbody>
</table>
### B. SCOTLAND

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number of staff</th>
<th>SRN or RGN</th>
<th>SCM</th>
<th>RMN(1)</th>
<th>RNMS(1)</th>
<th>RSCN</th>
<th>RFN</th>
<th>RNMD(1)</th>
<th>SEN</th>
<th>RMFA(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All staff</td>
<td>4,802</td>
<td>3,052</td>
<td>2,265</td>
<td>806</td>
<td>27</td>
<td>177</td>
<td>709</td>
<td>138</td>
<td>31</td>
<td>210</td>
</tr>
<tr>
<td>Per cent</td>
<td></td>
<td>82</td>
<td>47</td>
<td>17</td>
<td>1</td>
<td>4</td>
<td>15</td>
<td>4</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

| Matron ... Women            | 284             | 281        | 203  | 31     | 13      | 79   | 2   | 3       | 203 | 38      |
| Matron/chief male nurse ... Men | 14             | 11         | 11   | 1      | 2       | 2    | 2   |         | 11  |         |
| Deputy, etc., matron Women  | 290             | 273        | 154  | 82     | 1       | 7    | 78  | 6       | 154 | 81      |
| Deputy, etc., matron/ chief male nurse Men | 90         | 60         | 72   | 3      |         | 6    | 8   |         | 59  |         |
| Midwifery tutorial staff ... | 36              | 36         | 36   | 4      | 6       | 4    | 6   |         | 36  |         |
| Nursing tutorial staff Women| 131             | 131        | 73   | 6      | 11      | 40   | 1   | 1       | 73  | 7       |
| Men                         | 50              | 50         | 37   | 2      | 1       | 1    |     |         |     |         |
| Departmental midwifery sister ... Women | 36          | 36         | 36   | 2      | 6       | 2    | 6   |         | 36  |         |
| Departmental sister ...      | 201             | 199        | 114  | 15     | 45      | 1    | 1   | 113     | 3   |         |
| Departmental charge nurse    | 6               | 6          | 4    | 3      | 1       | 1    | 3   | 5       |     |         |
| Midwifery sister ...         | 501             | 483        | 498  | 30     | 51      | 9    | 1   | 480     | 3   |         |
| Ward sister ...              | 2,331           | 1,950      | 993  | 327    | 61      | 60   | 18  | 117     | 990 | 57      |
| Charge nurse ...             | 516             | 159        | 3    | 273    | 9       | 3    | 105 | 66      | 90  |         |
| Other senior midwifery staff | 18              | 18         | 18   | 1      | 2       | 1    | 2   | 18      |     |         |
| Other senior nursing staff ... Women | 274        | 247        | 137  | 34     | 13      | 76   | 3   | 4       | 135 | 19      |
| Men                         | 24              | 12         | 14   |        |         | 1    | 4   |         |     |         |

**Notes:**

1. The RMFA may also be held.
2. If the RMPA is held together with RMN or RNMS or RMND it is not included in this column.
3. Key: A = general nursing (SRN or RGN) and midwifery (SCM),
   B = general nursing (SRN or RGN) and psychiatric nursing (RMN, RNMS, RNMD, RMPA).
### Table 8

Number of staff who have undertaken certain administrative courses

#### A. ENGLAND AND WALES

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number of staff</th>
<th>Administrative qualifications (1)</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>All staff...</td>
<td>37,393</td>
<td>12</td>
<td>277</td>
</tr>
<tr>
<td>Matron...</td>
<td>1,835</td>
<td>1</td>
<td>109</td>
</tr>
<tr>
<td>Matron/Chief male nurse</td>
<td>210</td>
<td>—</td>
<td>1</td>
</tr>
<tr>
<td>Deputy, etc., matron...</td>
<td>2,469</td>
<td>4</td>
<td>106</td>
</tr>
<tr>
<td>Deputy, etc., matron/Chief male nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwifery tutorial staff</td>
<td>236</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nursing tutorial staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matron/chief male nurse</td>
<td>904</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Deputy, etc., matron/Chief male nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental midwifery sister</td>
<td>281</td>
<td>—</td>
<td>1</td>
</tr>
<tr>
<td>Departmental sister</td>
<td>2,191</td>
<td>—</td>
<td>25</td>
</tr>
<tr>
<td>Departmental charge nurse</td>
<td>153</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Midwifery sister</td>
<td>3,247</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Ward sister</td>
<td>15,766</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Charge nurse</td>
<td>5,251</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Other senior midwifery staff</td>
<td>203</td>
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<td>2</td>
</tr>
<tr>
<td>Other senior nursing staff</td>
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<td></td>
</tr>
<tr>
<td>Matron/chief male nurse</td>
<td>2,851</td>
<td>—</td>
<td>3</td>
</tr>
<tr>
<td>Deputy, etc., matron/Chief male nurse</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Departmental midwifery sister</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental sister</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Departmental charge nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwifery sister</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward sister</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charge nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other senior midwifery staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other senior nursing staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matron/chief male nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deputy, etc., matron/Chief male nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental midwifery sister</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental sister</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Departmental charge nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwifery sister</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward sister</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charge nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other senior midwifery staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other senior nursing staff</td>
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</tr>
</tbody>
</table>

(1) Includes all who have completed at least one course.
### B. SCOTLAND

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number of Staff</th>
<th>Administrative qualifications (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>B</td>
</tr>
<tr>
<td>All staff...</td>
<td>4,802</td>
<td>2</td>
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<tr>
<td>Matron</td>
<td>Women</td>
<td>284</td>
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<td>Matron/chief male nurse</td>
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<td>Deputy, etc., matron</td>
<td>Women</td>
<td>290</td>
</tr>
<tr>
<td>Deputy, etc., matron/chief male nurse</td>
<td>Men</td>
<td>90</td>
</tr>
<tr>
<td>Midwifery tutorial staff</td>
<td>Women</td>
<td>131</td>
</tr>
<tr>
<td>Nursing tutorial staff</td>
<td>Women</td>
<td>36</td>
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<tr>
<td>Departmental midwifery sister</td>
<td>-</td>
<td>36</td>
</tr>
<tr>
<td>Departmental sister</td>
<td>-</td>
<td>201</td>
</tr>
<tr>
<td>Departmental charge nurse</td>
<td>-</td>
<td>6</td>
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<tr>
<td>Midwifery sister</td>
<td>-</td>
<td>501</td>
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<tr>
<td>Ward sister</td>
<td>Women</td>
<td>2,331</td>
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<tr>
<td>Charge nurse</td>
<td>Men</td>
<td>516</td>
</tr>
<tr>
<td>Other senior midwifery staff</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>Other senior nursing staff</td>
<td>Women</td>
<td>274</td>
</tr>
<tr>
<td></td>
<td>Men</td>
<td>24</td>
</tr>
</tbody>
</table>

**Note:**

(1) **Key:**

- **A** = Diploma in Nursing Administration (University of Edinburgh).
- **B** = Administrative Certificate of R.C.N.
- **C** = One-year Administrative Course at King Edward’s Fund Staff College.
- **D** = Ward Sister’s Certificate of R.C.N.
- **E** = Three-months Ward Sister’s Course at King Edward’s Fund Staff College.
- **F** = Diploma in Nursing.

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# Table 9
Matrons and chief male nurses responsible for maternity departments and training schools

## A. England and Wales

<table>
<thead>
<tr>
<th>Grade</th>
<th>Responsibilities(1)</th>
<th>Per cent of staff in grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Matron, Hospitals with 1,000 or more beds</td>
<td>Women</td>
<td></td>
</tr>
<tr>
<td>&quot; &quot; 700-999 beds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; &quot; 500-699 &quot;</td>
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<td></td>
</tr>
<tr>
<td>&quot; &quot; 300-499 &quot;</td>
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<td></td>
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<td>&quot; &quot; 200-299 &quot;</td>
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<td>&quot; &quot; 100-199 &quot;</td>
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<td></td>
</tr>
<tr>
<td>&quot; &quot; 59-99 &quot;</td>
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<td></td>
</tr>
<tr>
<td>&quot; &quot; 20-49 &quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; &quot; 10-19 &quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matron/chief male nurse</td>
<td>Men</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## B. Scotland

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number of staff</th>
<th>Responsibilities(1)</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Matron, Hospital with 1000 or more beds</td>
<td>Women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; &quot; 700-999 beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot; &quot; 500-699 &quot;</td>
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</tr>
<tr>
<td>&quot; &quot; 300-499 &quot;</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>&quot; &quot; 200-299 &quot;</td>
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<td></td>
</tr>
<tr>
<td>&quot; &quot; 100-199 &quot;</td>
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<tr>
<td>&quot; &quot; 50-99 &quot;</td>
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<td></td>
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<tr>
<td>&quot; &quot; 20-49 &quot;</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>&quot; &quot; 10-19 &quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matron/chief male nurse</td>
<td>Men</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:**
(1) Key: A = maternity department (without a midwifery training school).
B = nurse training school.
C = midwifery training school (including a maternity department).
**Table 10**

Staff who had breaks in their hospital service

**A. ENGLAND AND WALES**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Per cent of staff having breaks in service</th>
<th>Reasons for breaks in service</th>
<th>Per cent of number of breaks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Other nursing service</td>
<td>Non-nursing service</td>
</tr>
<tr>
<td>All staff</td>
<td>24</td>
<td>35</td>
<td>3</td>
</tr>
<tr>
<td>Women:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matron</td>
<td>46</td>
<td>46</td>
<td>2</td>
</tr>
<tr>
<td>Deputy, etc., matron</td>
<td>41</td>
<td>46</td>
<td>2</td>
</tr>
<tr>
<td>Midwifery tutorial staff</td>
<td>23</td>
<td>47</td>
<td>1</td>
</tr>
<tr>
<td>Nursing tutorial staff</td>
<td>56</td>
<td>26</td>
<td>2</td>
</tr>
<tr>
<td>Departmental midwifery sister</td>
<td>23</td>
<td>47</td>
<td>1</td>
</tr>
<tr>
<td>Departmental sister</td>
<td>32</td>
<td>40</td>
<td>3</td>
</tr>
<tr>
<td>Midwifery sister</td>
<td>23</td>
<td>34</td>
<td>2</td>
</tr>
<tr>
<td>Ward sister</td>
<td>21</td>
<td>29</td>
<td>3</td>
</tr>
<tr>
<td>Other senior midwifery staff</td>
<td>23</td>
<td>47</td>
<td>2</td>
</tr>
<tr>
<td>Other senior nursing staff</td>
<td>40</td>
<td>31</td>
<td>3</td>
</tr>
<tr>
<td>Men:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing tutorial staff</td>
<td>29</td>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td>Other staff</td>
<td>5</td>
<td>47</td>
<td>16</td>
</tr>
</tbody>
</table>

**B. SCOTLAND**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number</th>
<th>Reasons for breaks in service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All staff Having breaks in service Other nursing service Non-nursing employment Marriage Family commitments Further study Other reasons</td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>4,802</td>
<td>1,010</td>
</tr>
<tr>
<td>Women:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matron</td>
<td>284</td>
<td>115</td>
</tr>
<tr>
<td>Deputy, etc., matron</td>
<td>290</td>
<td>117</td>
</tr>
<tr>
<td>Midwifery tutorial staff</td>
<td>36</td>
<td>6</td>
</tr>
<tr>
<td>Nursing tutorial staff</td>
<td>131</td>
<td>75</td>
</tr>
<tr>
<td>Departmental midwifery sister</td>
<td>36</td>
<td>6</td>
</tr>
<tr>
<td>Departmental sister</td>
<td>201</td>
<td>58</td>
</tr>
<tr>
<td>Midwifery sister</td>
<td>501</td>
<td>87</td>
</tr>
<tr>
<td>Ward sister</td>
<td>2,351</td>
<td>408</td>
</tr>
<tr>
<td>Other senior midwifery staff</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>Other senior nursing staff</td>
<td>274</td>
<td>108</td>
</tr>
<tr>
<td>Men:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing tutorial staff</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Other staff</td>
<td>650</td>
<td>18</td>
</tr>
</tbody>
</table>

Printed image digitised by the University of Southampton Library Digitisation Unit
These organisation charts illustrate how the proposed staffing structure could be applied in hospital groups of different kinds.

Chart A is no more than a model: notes on it explain the assumptions on which posts have been provided in each grade.

In Charts B to H, the hospital groups, though imaginary are similar to existing groups. A short note on each describes the present arrangements of the hospitals, geographical and administrative. Numbers shown against each grade of staff are of posts, not total complement. Some outlying cottage hospitals are shown with a Nursing Officer (Grade 7) in control, on the assumption that staff engaged in services, such as catering and cleaning are transferred to her sphere of authority. Exercise of a co-ordinating function only by a group nursing head is indicated by a broken line on the chart; exercise of control by a continuous line.

**Chart** | **Type of group** | **Name**
---|---|---
A | Group consisting of a large district general hospital and a large mental illness hospital, with a Chief Nursing Officer (Grade 10) in control. | “St. Dominic’s Board of Governors”
B | Group consisting of a large general teaching hospital, with a Chief Nursing Officer (Grade 10) in control. | “Western Hospital Management Committee”
C | Group consisting of a single large mental illness hospital, with a Chief Nursing Officer (Grade 10) in control. | “North Manford Hospital Management Committee”
D | Group with a Chief Nursing Officer (Grade 10), with control in a large general hospital and co-ordinating a large maternity hospital and a mental illness hospital. | “Barchester and District Hospital Management Committee”
E | Group including three large general hospitals, one controlled and the others co-ordinated by a Chief Nursing Officer (Grade 10). | “Greshambury and Ullathorne Hospital Management Committee”
F | Group consisting of a large mental subnormality hospital and two mental illness hospitals, all controlled by a Chief Nursing Officer (Grade 10) | “Ambridge and District Hospital Management Committee”
G | Smaller group consisting of a medium-sized general hospital and several small hospitals, controlled by a Principal Nursing Officer (Grade 9) | “Kilwhillie and Skerrymore Board of Management”
H | Group consisting of a number of smaller hospitals, with a Principal Nursing Officer (Grade 9) with control in some and a co-ordinating function in others. | ---
St. Dominic's is a teaching hospital on a single site

Chart B: St. Dominic's Hospital Board of Governors

Teaching Division

Chief Nursing Officer

Nursing Division

Midwifery Division

Senior Night Superintendent

Clinical Instructors and Teachers of Pupil Nurses

School of Nursing with training for the Register and Roll and a Centre for Post-Certificate Training: Student Nurses and Pupil Nurses 150 Post-Certificate Students

Specialties

Number of Beds

Psychiatric, Neurological, Neurosurgical, Geriatric 330

Medical 350

Surgical 330

Obstetrics 120

Pediactrics and Gynaecology 170

Operating Theatres and Recovery Wards

Post - L.D.N.O. 3 P.M.O. 13 S.N.O. 42 N.G. 150 C.M.
The group consists of a single mental illness hospital with 1500 beds. The nursing service is controlled by a Chief Male Nurse (category (a)) and a Matron, on the male and female sides respectively. The hospital has a Medical Superintendent.
The group has seven hospitals, with a total of 2,295 beds. Nearly half the beds are in the two branches of North Manford Hospital and nearly a third in Whitestone Hospital. The hospitals are in five different places, which is reflected in the present nursing administration. The mental illness hospital is at one centre (13 miles from North Manford Hospital) and has a Matron and a Chief Male Nurse. The other six hospitals are in four centres with a Matron at each centre: North Manford; Greenacroft, Thornywood and Mapleton Hospitals (close to each other and about 10 miles from North Manford); Westwood Maternity Hospital (6 miles from North Manford); and Northern Hospital (13 miles from North Manford). There are five hospital secretaries in the group—one to each centre. All the hospitals, except Northern and Westwood Maternity Hospitals, have Medical Superintendents and North Manford has one at each branch.
The group has 1,700 beds in fourteen hospitals—Seven General, three small Maternity, two Chronic Sick, one Chest Hospital and a Convalescent Home. Eight of the hospitals (with seven independent nursing heads) are in three main population centres, within 10 miles of each other and each with a large General Hospital. The other six hospitals (each with independent nursing heads) are dispersed up to 15 miles away. There are nine Hospital Secretaries and the administrative headquarters are at the Crosse Street branch of the Barchester Royal Infirmary.
The group consists of two mental illness hospitals and a mental subnormality hospital, each with its own Matron and Chief Male Nurse. Greshambury House (mental subnormality, 1500 beds) is adjacent to Manor House (mental illness, 200 beds). Ullathorne Park (mental illness, 600 beds) is three miles away. Greshambury House and Manor House each have their own Physician Superintendent. Each hospital has its own hospital secretary, who in the case of Ullathorne Park is also the Group Secretary.

---

**CHART F: GRESHAMBURY & ULLATHORNE HOSPITAL MANAGEMENT COMMITTEE**

Teaching Division

- **Area** (Senior Tutor)
  - **Unit** (tutor)
  - **Unit** (tutor)
  - **Unit** (tutor)

Chief Nursing Officer

Nursing Division A

- **Area**
  - **Unit**
  - **Unit**
  - **Unit**
  - **Unit**
  - **Unit**
  - **Unit**
  - **Unit**
  - **Unit**
  - **Section** (nursing and administration)
  - **Night Charge Nurses**
  - **Night Superintendent**

Nursing Division B

- **Area**
  - **Unit**
  - **Unit**
  - **Unit**
  - **Unit**
  - **Unit**
  - **Unit**
  - **Unit**
  - **Unit**
  - **Section**
  - **Section**

---

**PARTICULARS OF HOSPITALS**

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of Beds</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Subnormality</td>
<td>1500</td>
<td>Greshambury House Hospital</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>600</td>
<td>Ullathorne Park Hospital</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>200</td>
<td>Manor House Hospital</td>
</tr>
</tbody>
</table>

**POSTING**

- **ICNS**
- **SNR.**
- **2 SNR.**
- **21 NO.**
- **M. C. L.**
- **2300 BEDS**

155
The group has eight hospitals, with a total of 530 beds. Five of these hospitals, with 460 beds, are in Ambridge. Of the remainder, two (Arkwright Hall and Borchester Cottage) are 7 miles away at Blakey Hill, and the other is at Blakey Hill, 6 miles away. All have independent nursing heads except Blakey Hill Hospital, in which the Matron of Ambridge General has control. There are four hospital secretaries, among them the Group Secretary (of Ambridge General) who also acts as hospital secretary for Ambridge Children's and Blakey Hill Hospitals.

**CHART G: AMBRIDGE AND DISTRICT HOSPITAL MANAGEMENT COMMITTEE**

The group has eight hospitals, with a total of 530 beds. Five of these hospitals, with 460 beds, are in Ambridge. Of the remainder, two (Arkwright Hall and Borchester Cottage) are 7 miles away at Blakey Hill, and the other is at Blakey Hill, 6 miles away. All have independent nursing heads except Blakey Hill Hospital, in which the Matron of Ambridge General has control. There are four hospital secretaries, among them the Group Secretary (of Ambridge General) who also acts as hospital secretary for Ambridge Children's and Blakey Hill Hospitals.
CHART H: KILWHILLIE AND SKERRYMORE BOARD OF MANAGEMENT

The 670 beds in the group are in seven hospitals, each with independent nursing heads. The hospitals are in or around three main centres of population, Kilwhillie, Locheven (3 miles N.E. of Kilwhillie) and Skerrymore (7 miles S.W. of Kilwhillie). The group has three hospital secretaries. The administrative headquarters are at Kilwhillie Hospital. There is no medical superintendent.

---

GRADE 9
PRINCIPAL NURSING OFFICER

GRADE 8
SENIOR NURSING OFFICER

GRADE 7
NURSING OFFICER

GRADE 6
CHANCE NURSE

PARTICULARS OF HOSPITALS

<table>
<thead>
<tr>
<th>TYPE</th>
<th>NUMBER OF BEDS</th>
<th>NAME</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

UNIT
(TUTOR)

CLINICAL INSTRUCTIONS

UNIT

SECTIONS

WARDS AND DEPARTMENTS

UNIT

SECTIONS

UNIT

SECTIONS

UNIT

SECTIONS

TEACHING DEPARTMENT BASED AT KILWHILLIE HOSPITAL WITH 40 STUDENT NURSES IN TRAINING AT KILWHILLIE, ARROCHBURN AND LOCHEVEN GENERAL HOSPITAL.

ACUTE 160
KILWHILLIE HOSPITAL

ACUTE 80
ARROCHBURN HOSPITAL

ACUTE 55
LOCHEVEN GENERAL HOSPITAL

MATERNITY 25
LOCHEVEN MATERNITY HOSPITAL

TRAINING 45 PUPIL NURSES AT SKERRYMORE, GLENGARRY AND TARNOCK HOSPITALS

GERIATRIC 240
SKERRYMORE HOSPITAL

ISOLATION 70
GLENGARRY HOSPITAL

ACUTE 40
TARNOCK COTTAGE HOSPITAL

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APPENDIX 7

Job Descriptions

NOTES

1. The job descriptions are to be read in conjunction with the chapters shown in brackets in the list below.

2. Although the underlying principles are intended to be of general application, these job descriptions (except that for the Regional Hospital Board Nursing Officer) relate specifically to the organisation shown in Chart A of Appendix 6 (for a management group consisting of a large district general hospital and a large psychiatric hospital).

3. There are shown in square brackets, [ ], alternative local abbreviated titles for some posts, when held by men, and functions which may or may not be appropriate according to local arrangements.

A. Posts in Grade 10 (Chapter 6)
   1. Regional Hospital Board Nursing Officer.
   2. Chief Nursing Officer.

B. General nursing posts
   1. Grade 9—Principal Matron [P.N.O.] (Chapter 6).
   2. Grade 8—Senior Matron [S.N.O.] (Chapter 5).
   3. Grade 8—Senior Night Superintendent (Chapter 5).
   4. Grade 7—Night Superintendent (Chapter 5).
   5. Grade 7—Matron [N.O.]: surgical unit (Chapter 5).
   6. Grade 7—Matron [N.O.]: out-patient unit (Chapter 5).
   7. Grade 6—Night Sister/Night Charge Nurse (Chapter 4).
   8. Grade 6—Ward Sister/Charge Nurse (Chapter 4).

C. Midwifery posts
   1. Grade 9—Principal Matron (Chapters 6 and 7).
   2. Grade 8—Senior Matron (Chapters 5 and 7).
   3. Grade 8—Senior Midwife Teacher (Chapters 5 and 7).
   4. Grade 7—Matron (Chapters 5 and 7).
   5. Grade 7—Midwife Teacher (Chapters 5 and 7).
   6. Grade 6—Midwifery Sister (Chapters 4 and 7).

D. Psychiatric nursing posts
   1. Grade 9—Principal Nursing Officer (Chapters 6 and 7).
   2. Grade 8—Senior Nursing Officer (Chapters 5 and 7).
   3. Grade 7—Nursing Officer (Chapters 5 and 7).
   4. Grade 6—Ward Sister/Charge Nurse (Chapters 4 and 7).

E. Teaching posts
   1. Grade 9—Principal Tutor (Chapters 6 and 7).
   2. Grade 8—Senior Tutor (Chapters 5 and 7).
   3. Grade 7—Tutor (Chapters 5 and 7).
   4. Grade 6—Clinical Instructor (Chapters 4 and 7).

F. Staff post
   1. Grade 8—Senior Nursing Officer in the central nursing office (Chapter 5).
Top management

Role: Regional Hospital Board Nursing Officer
Grade: Chief Nursing Officer (Grade 10)
Responsible to: Regional Hospital Board
Reports to: Senior Administrative Medical Officer or Secretary

Minimal qualifications: Experience in Grade 9 or its equivalent

Functions:

A. Professional
1. Advising the Regional Hospital Board (and its Committees) on all nursing matters, including nursing recruitment and publicity.
2. Participating in the Area Nurse Training Committee, as member or adviser.
3. Advising on plans of hospital buildings in the region.
4. Promoting research and studies relating to nursing practice.

B. Administrative
5. Advising Chief Nursing Officers (Grade 10) in the region on nursing matters (including nursing establishments).
6. Subject to the Principal Administrative Officer's responsibility to the Board for co-ordinating its activities, taking measures to have nursing policy implemented in the region.
7. Arranging provision of information on nursing as a career.
8. Organising post-certificate training of nurses.
9. Participating, as member, in the regional nursing staff committee.
10. Arranging for senior nurses in the region to learn of major policy changes and to exchange views.
11. Promoting recruitment and training of members of the National Hospital Service Reserve.

C. Personnel
12. Participating as member of selection panels, in the appointment of assistants (Grades 7 or 8).
13. Introducing assistants (Grades 7 or 8) to their duties.
14. Co-ordinating leave for assistants (Grades 7 or 8).
15. Completing annual reports on assistants (Grades 7 or 8), and giving merit-rating according to the established procedure.
16. Developing the management skills of assistants (Grades 7 or 8).
17. Acting as assessor in the selection of senior nursing staff in the region.
Role: Chief Nursing Officer
Grade: Chief Nursing Officer (Grade 10)
Responsible to: Hospital Management Committee or Board
Reports to: Group Secretary
Minimal qualifications: Experience in Grade 9 or its equivalent

Functions:

A. Professional
1. Reviewing and preparing nursing policy and organisation, in consultation with other officers.
2. Advising the Hospital Management Committee or Board (and its Standing Committees) on all matters affecting nursing service and nurse education.
3. Participating in conferences relating to nursing.
4. Undertaking public relations work, both locally within the community and generally on behalf of the nursing profession.
5. Promoting research and studies relating to nursing practice.

B. Administrative
(Subject to the Principal Administrative Officer's responsibility to the governing body for co-ordinating and reviewing the medical, nursing and other services in the group).

6. Taking the measures to have the nursing policy implemented in the group.
7. Controlling or co-ordinating the nursing and nurse education services.
8. Preparing estimates of the establishments and equipment required for the nursing services and subsequently containing expenditure within approved allocations.
9. Representing nursing interests at meetings and committees of chief officers of the group.
10. Planning arrangements for health and welfare of staff and of student and pupil nurses (the appropriate functions to be assigned).

C. Personnel
11. Participating, as member of selection panels, in the appointment within the group of Principal Nursing Officers (Grade 9) and Senior Nursing Officers (Grade 8).
12. Introducing Principal Nursing Officers (Grade 9) to their duties.
13. Determining leave for Principal Nursing Officers (Grade 9).
14. Completing annual reports on Principal Nursing Officers (Grade 9) and giving merit-rating according to the established procedure.
15. Examining and endorsing reports on Senior Nursing Officers (Grade 8) and Nursing Officers (Grade 7).
16. Acting as assessor in the selection of senior nursing staff in other groups.
17. Exercising leadership in the hospital group.
18. Developing the management skills of immediate subordinates.
**Job description: B.1**

*(district general hospital)*

**Top management**

**Role:** Principal Matron [P.N.O.] in control of the Nursing Division

**Grade:** Principal Nursing Officer (Grade 9)

**Responsible to:** Chief Nursing Officer (Grade 10)

**Reports to:** Chief Nursing Officer (Grade 10)

**Minimal qualifications:**
- Registered on the general part of the Register
- Experience in Grade 7
- Top-management course

**Functions:**

**A. Professional**

1. Informing the Chief Nursing Officer (Grade 10) of nursing matters affecting policy and necessary to implement the agreed policy.

2. Studying, setting and reviewing standards and procedures of nursing care, including basic cleanliness of wards and ward equipment.

3. Participating [as member, in the Nursing Committee; and] in meetings of officers.

4. Contributing information and advice to assist in implementation of policy in matters affecting nursing, e.g., catering, cleaning.

5. Participating in in-service training.

6. Investigating serious mishaps and complaints and reporting as laid down in policy.

7. Advising the Principal Tutor (Grade 9) on the selection of student and pupil nurses.

8. Publicising nursing as a career.

9. Advising on structural alterations and new buildings and equipment.

**B. Administrative**

10. Controlling staff of the *division*.

11. Reporting requirements of staff and nursing equipment.

12. Organising in-service training within the *division*.

13. Convening meetings of staff of the *division*.

14. Settling the plan of practical training for student and pupil nurses in consultation with the Principal Tutor (Grade 9).

15. Conferring with heads of other *divisions* and with medical and other senior staff.
16. Checking by inspection and reports that work is carried out in accordance with policy and a satisfactory service is provided.

17. Reporting to the Chief Nursing Officer (Grade 10) on the work of the division.

18. Promoting good relations between the hospital and the community, and encouraging voluntary help.

C. Personnel

19. Appointing Charge Nurses (Grade 6), in consultation with Senior Matrons (Grade 8).

20. Participating, as member of selection panels, in the appointment of Matrons (Grade 7); and assisting in the appointment of Senior Matrons (Grade 8).

21. Introducing Senior Matrons (Grade 8) [and Matrons (Grade 7)] to their duties.

22. Counselling Senior Matrons (Grade 8) and Matrons (Grade 7).

23. Co-ordinating leave for Senior Matrons (Grade 8) and Matrons (Grade 7).

24. Reporting to the Chief Nursing Officer (Grade 10) on Senior Matrons (Grade 8) and Matrons (Grade 7) and giving merit-rating according to the established procedure.

25. Acting upon reports on Charge Nurses (Grade 6).

26. Recommending specific courses for members of staff in the development of their efficiency.

27. Exercising leadership of the division.

28. Developing the management skills of immediate subordinates.
Job description: B.2
(district general hospital)

Middle management

Role: Senior Matron [S.N.O.] in control of an area in the Nursing Division

Grade: Senior Nursing Officer (Grade 8)

Responsible to: Principal Matron [P.N.O.] (Grade 9)

Reports to: Principal Matron [P.N.O.] (Grade 9)

Minimal qualifications: Registered on the general part of the Register
Experience in Grade 7

Functions:

A. Professional

1. Acting as consultant to unit Matrons (Grade 7) on implementation of nursing policy.

2. Initiating and developing new ideas and methods in her area and encouraging unit Matrons (Grade 7) to do the same.

3. Participating in in-service training.

4. Controlling a unit in the absence of a suitable deputy to the unit head.

5. Co-operating with medical staff and other officers in research and general care of patients within her area.

6. Participating in meetings of officers.

B. Administrative

7. Co-ordinating work of unit Matrons (Grade 7), including allocation of staff between units.

8. Making requests to Principal Matron (Grade 9) for staffing support when necessary.

9. Working out plans to implement nursing policy, in consultation with unit Matrons (Grade 7).

10. Checking by inspection and reports that plans are carried out and a satisfactory service is provided.

11. Arranging programme for visitors and trainees (in hospitals administration) within the group of units.

12. Conferring with medical staff, Hospital Secretary (or equivalent) and heads of departments.

13. Reporting to the Principal Matron (Grade 9) on the possible effects of nursing policy and the results of the programme.

14. [Deputising for the Principal Matron (Grade 9).]
C. Personnel

15. Appointing Staff Nurses (Grade 5) and enrolled nurses in consultation with unit Matrons (Grade 7).

16. Participating as member of the selection panel, in the appointment of Matrons (Grade 7).

17. Selecting and appointing nursing auxiliaries.

18. Introducing Matrons (Grade 7) to their duties.

19. Counselling Matrons (Grade 7) and Sisters (Grade 6).

20. Co-ordinating leave for Matrons (Grade 7) and Sisters (Grade 6).

21. Taking all steps possible to safeguard the welfare and safety during working hours of staff in the area.

22. Reporting to the Principal Matron (Grade 9) on Matrons (Grade 7) and endorsing or amending reports on Sisters (Grade 6), and giving merit-rating to both according to the established procedure.

23. Recommending specific courses for members to staff in development of their efficiency.

24. Exercising leadership of the area.

25. Developing the management skills of immediate subordinates.
Job description: B.3
(district general hospital)

Middle management

Role: Senior Night Superintendent in charge of the Nursing Division at night.

Grade: Senior Nursing Officer (Grade 8)

Responsible to: Principal Matron [P.N.O.] (Grade 9)

Reports to: Principal Matron [P.N.O.] (Grade 9)

Minimal qualifications: Registered on the general part of the Register

Experience in Grade 7

Functions:

A. Professional

1. Acting as consultant to Night Superintendents (Grade 7) on implementation of nursing policy at night.

2. Investigating mishaps and complaints and reporting as laid down in policy.

3. Taking charge of an area in the absence of a suitable deputy to a Night Superintendent (Grade 7).

4. Co-operating with medical staff in the general care of patients at night.

5. Communicating with relatives of patients and arranging for hospitality, as required.

B. Administrative

6. Co-ordinating the work of Night Superintendents (Grade 7), including allocation of staff between areas.

7. Co-operating with administrative and other staff working in the division at night.

8. Checking by inspection and reports that work is carried out in accordance with policy and a satisfactory service is provided.

9. Reporting to the Principal Matron (Grade 9) on the management of the division at night.

C. Personnel

10. Introducing Night Superintendents (Grade 7) to their duties.

11. Taking all steps possible to safeguard the welfare and safety of staff in the division at night.

12. Counselling staff on night duty.

13. Reporting to the Principal Matron (Grade 9) on Night Superintendents (Grade 7).
Role: Night Superintendent in charge of an area in the Nursing Division.

Grade: Nursing Officer (Grade 7).

Responsible to: Senior Matron [S.N.O.] (Grade 8) in control of the area.

Reporting to: Senior Night Superintendent (Grade 8)

Minimal qualifications: Registered on the general part of the Register
Experience in Grade 5
Course in middle management

Functions:

A. Professional

1. Acting as consultant to night staff in the area on nursing practice and on relations with patients, relatives and medical staff.
2. Controlling introduction, within the area, of agreed procedures for nursing care at night.
3. Participating in tests of new equipment in the area at night.
4. Taking charge of a group of wards (unit) in the absence of a suitable deputy to the Night Charge Nurse (Grade 6)
5. Co-operating with medical staff in the general care of patients at night.
6. Communicating with relatives of patients and chaplains as required.

B. Administrative

7. Co-ordinating the work of Night Charge Nurse (Grade 6), including allocation of staff within the area.
8. Reporting requirements of night staff to Senior Night Superintendent (Grade 8).
9. Working out plans to implement nursing policy within the area at night, in consultation with the Senior Night Superintendent (Grade 8) and the Senior Matron (Grade 8) in charge of the area.
10. Co-operating with administrative and other staff working in the area at night.
11. Checking that a satisfactory nursing service is provided within the area.
12. Reporting to the Senior Night Superintendent (Grade 8) on the management of the area at night and to the Senior Matron in control of the area on its general condition.

C. Personnel

13. Introducing Night Charge Nurses (Grade 6) to their duties.
14. Taking all steps possible to safeguard the welfare and safety of staff in the area at night.
15. Counselling staff on night duty.
16. Reporting to the Senior Matron (Grade 8) on Night Charge Nurses (Grade 6).
Job description: B.5
(district general hospital)

Middle management

Role: Matron [N.O.] in control of a surgical unit

Grade: Nursing Officer (Grade 7)

Responsible to: Principal Matron [P.N.O.] (Grade 9) or to Senior Matron [S.N.O.] (Grade 8)

Reports to: Senior Matron [S.N.O.] (Grade 8)

Minimal qualifications: Registered on the general part of the Register
Experience in Grade 5
Course in middle management

Functions:

A. Professional

1. Acting as consultant to Ward Sisters/Charge Nurses (Grade 6) on surgical nursing practice.

2. Acting as consultant to unit staff (at the request of Ward Sisters/Charge Nurses (Grade 6)) on relations with patients, relatives and medical staff.

3. Controlling tests of new equipment in the unit.

4. Controlling the introduction to the unit of agreed procedures for the improvement of the nursing service and reduction of infection.

5. Initiating and developing new ideas and methods in the unit, and encouraging staff to do the same.

6. Participating in in-service training and in the teaching of student and pupil nurses.

7. Advising and informing the Teaching Division on the organisation and supervision of the training programme for student and pupil nurses allocated to the unit.

8. Communicating with relatives of patients as required.

9. Co-operating with medical staff in solving problems of patient care, and in medical research.

10. Controlling a ward in the absence of a suitable deputy to the Ward Sister/Charge Nurse (Grade 6).

B. Administrative

11. Organising staff and student and pupil nurses allocated to the unit.

12. Organising, within the unit, the in-service training of all unit staff.

13. Arranging, in consultation with Ward Sisters/Charge Nurses (Grade 6), duty rota for unit staff.

14. Reporting requirements of staff and asking for support when necessary.
15. Working out plans to implement the nursing policy within the unit.
16. Checking the day-to-day cleanliness of the unit in consultation with the Domestic Superintendent.
17. Advising and informing other units, departments and services (e.g., admissions, catering officer, medical records, medical social workers, pathology, pharmacy, physiotherapy, transport, X-ray) on matters within the unit’s competence, other than those which can be dealt with by unit staff directly.
18. Reporting to the Senior Matron (Grade 8) on the results of the programme and the affairs of the unit.

C. Personnel
19. Introducing new Ward Sisters/Charge Nurses (Grade 6) to their duties.
20. Taking all steps possible to safeguard the welfare and safety of unit staff during working hours.
21. Counselling unit staff.
22. Co-ordinating leave for Ward Sisters/Charge Nurses (Grade 6) and Staff Nurses (Grade 5).
23. Reporting on Ward Sisters/Charge Nurses (Grade 6) and endorsing or amending reports on Staff Nurses (Grade 5) and giving merit-rating according to the established procedure.
24. Recommending specific courses for members of staff in the development of their efficiency.
25. Informing Tutors (Grade 7) of the progress of student and pupil nurses.
26. Exercising leadership of the unit.
27. Developing the management skills of Ward Sisters/Charge Nurses (Grade 6).
Job description: B.6
(district general hospital)

Middle management

Role: Matron [N.O.] in control of an out-patient unit

Grade: Nursing Officer (Grade 7)

Responsible to: Principal Matron [P.N.O.] (Grade 9) or Senior Matron [S.N.O.] (Grade 8)

Reports to: Senior Matron [S.N.O]. (Grade 8)

Minimal qualifications: Registered on the general part of the Register
Experience in Grade 5
Course in middle management

Functions:

A. Professional

1. Acting as consultant to section Sisters (Grade 6) on nursing practice.

2. Acting as consultant to unit staff (at the request of section Sisters) on relations with patients, relatives and medical staff.

3. Controlling the introduction to the unit of agreed procedures for the improvement of the nursing service and reduction of infection.

4. Initiating and developing new ideas and methods in the unit, and encouraging staff to do the same.

5. Participating in in-service training and in the teaching of student and pupil nurses.

6. Advising and informing the Teaching Division on the organisation and supervision of the training programme for student and pupil nurses allocated to the unit.

7. Communicating with relatives of patients as required.

8. Co-operating with medical staff in solving problems of patient care, and in medical research.

9. Controlling a section in the absence of a suitable deputy to the section Sister (Grade 6).

B. Administrative

10. Organising nursing staff and all staff under nursing control (also voluntary workers) to meet the needs of a variety of clinics.

11. Organising within the unit the in-service training of all unit staff.

12. Reporting requirements of staff and asking for support when necessary.

13. Arranging, in consultation with Sisters (Grade 6), duty rota for unit staff.

14. Working out plans to implement nursing policy within the unit.

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15. Controlling drugs, equipment and dressings if kept centrally for the unit.
16. Requisitioning, with due economy, supplies and repairs and replacements of equipment.
17. Checking the day-to-day cleanliness of the unit in consultation with the Domestic Superintendent.
18. Co-operating with administrative staff working in the unit.
19. Advising and informing other units, departments and services (e.g., pharmacy, physiotherapy, transport, X-ray) on matters within the unit's competence, other than those which can be dealt with by the unit staff directly.
20. Advising administration on the arrangement of patients' appointments and follow-up with doctors and medical records officer.
21. Reporting to the Senior Matron (Grade 8) on the results of the programme and the affairs of the unit.

C. Personnel
22. Introducing new members of staff to their duties.
23. Taking all steps possible to safeguard the welfare and safety of unit staff during working hours.
24. Counselling unit staff.
25. Co-ordinating leave for section Sisters (Grade 6) and Staff Nurses (Grade 5).
26. Reporting on section Sisters (Grade 6) and endorsing or amending reports on Staff Nurses (Grade 5) and giving merit-rating according to the established procedure.
27. Recommending specific courses for members of staff in the development of their efficiency.
28. Informing Tutors (Grade 7) of the progress of student and pupil nurses.
29. Exercising leadership of the unit.
30. Developing the management skills of section Sisters (Grade 6).
First-line management

Role: Night Sister/Night Charge Nurse for a unit in the Nursing Division

Grade: Charge Nurse (Grade 6)

Responsible to: Matron [N.O.] in control of the unit (Grade 7)

Reports to: Night Superintendent (Grade 7)

Minimal qualifications: Registered on the general part of the Register Charge Nurses’ preparatory course

Functions:

A. Professional

1. Supervising professional work of nursing staff at night.
2. Preparing reports for and receiving reports from day staff.
3. Maintaining custody of dangerous drugs: checking and witnessing administration of drugs.
4. Assisting medical staff and ascertaining medical treatments.
5. Reporting condition of patients to medical staff, and receiving instructions.
6. Carrying out some nursing procedures and treatments.
7. Training qualified nursing staff.
8. Teaching student and pupil nurses.
9. Communicating with relatives of patients as required.

B. Administrative

10. Organising all staff under nursing control to meet the needs of the group of wards (unit).
11. Directing domestic and other staff.
12. Organising routine for basic and technical nursing in the group of wards (unit) in accordance with any standing instructions.
13. Reporting requirements of staff to Night Superintendent (Grade 7).
14. Co-operating with other nursing units and other hospital departments, e.g., C.S.S.D., pharmacy, X-ray, in providing a satisfactory service at night; and with outside authorities, e.g., general practitioners, police.
15. Checking by inspection that a satisfactory nursing service is provided in the group of wards (unit).
16. Reporting to the Night Superintendent (Grade 7) on the affairs of the group of wards (unit).

C. Personnel

17. Introducing staff under nursing control to their duties.
18. Counselling ward staff and nurses in training.
19. Reporting to unit Matrons (Grade 7) on the performance of the nursing staff on night duty; and informing Tutors (Grade 7) of the progress of student and pupil nurses.
First-line management

Role: Ward Sister/Charge Nurse in control of a surgical ward

Grade: Charge Nurse (Grade 6)

Responsible to: Matron [N.O.] (Grade 7)

Reports to: Matron [N.O.] (Grade 7)

Minimal qualifications: Registered on general part of the Register Charge Nurses' preparatory course.

Functions:

A. Professional
1. Supervising professional work of nursing staff.
2. Preparing reports for and receiving reports from the night nurse.
3. Maintaining custody of dangerous drugs: checking and witnessing administration of drugs.
4. Assisting medical staff and ascertaining medical treatments.
5. Reporting condition of patients to medical staff and, when necessary to unit Matron (Grade 7), and receiving instructions.
6. Carrying out some nursing procedures and treatments.
7. Teaching of student and pupil nurses.
8. Training qualified nursing staff in nursing and ward management.
9. Directing the training of other ward staff.
10. Maintaining personal contacts with patients through ward rounds, conversations, etc.
11. Arranging for patients' meals and special diets and participating in meal service.
12. Communicating with relatives of patients and with visitors as required.

B. Administrative
13. Organising reception of patients and nursing in accordance with any standing instructions.
14. Maintaining good order in the ward.
15. Directing domestic and other staff.
16. Arranging systematic practical instruction of student and pupil nurses in accordance with the requirements of the General Nursing Council.
17. Controlling drugs and dressings kept in the ward.
18. Maintaining ward stores and equipment; and requisitioning, with due economy, provision and other supplies [if no Imprest System] and repairs and replacements of equipment.
19. Arranging care of patients' property and distribution of mail.

20. Assisting medical staff in the discharge of patients and their after-care.

21. Co-operating with other nursing units and other hospital departments (and where necessary co-ordinating their activities at ward level), e.g., admissions, catering officer, chaplains, medical records, medical social workers, pathology, pharmacy, physiotherapy, transport, X-ray.

22. Rendering returns required by any branch of the hospital administration, including notification of patients' deaths and mishaps.

23. Reporting on ward affairs to unit Matron (Grade 7).

C. Personnel

24. Introducing new members of staff to their duties.

25. Counselling ward staff and nurses in training.

26. Reporting on qualified and other nursing staff to unit Matron (Grade 7).

27. Recording progress of student and pupil nurses and reporting thereon to unit Matron (Grade 7).
Job description: C.1
(district general hospital)

Top management

Role: Principal Matron in control of the Midwifery Division
Grade: Principal Nursing Officer (Grade 9)
Responsible to: Chief Nursing Officer (Grade 10)
Reports to: Chief Nursing Officer (Grade 10)

Minimal qualifications: State Certified Midwife
Registered on the general part of the Register
Experience in Grade 7
Top-management course

Functions:
A. Professional
1. Informing the Chief Nursing Officer (Grade 10) of midwifery matters affecting policy and necessary to implement the agreed policy.
2. Studying, setting and reviewing standards and procedures of nursing care, including basic cleanliness of wards and ward equipment.
3. Participating, as member, in the Local Maternity Liaison Committee [and the Nursing Committee]; and in meetings of officers.
4. Participating in in-service training [and obstetric nurse training].
5. Investigating serious mishaps and complaints and reporting as laid down in policy.
6. Publicising midwifery as a career.
7. Advising on structural alterations and new building and equipment.

B. Administrative
8. Controlling staff of the division.
9. Reporting requirements of staff and nursing equipment.
10. Co-ordinating the work of the Senior Matron (Grade 8) and the Senior Midwife Teacher (Grade 8) in training pupil midwives [and obstetric nursing students].
11. Organising in-service training within the division.
12. Convening meetings of staff of the division.
13. Conferring with heads of other divisions with medical and other senior hospital staff and with the non-medical supervisor of midwives.
14. Checking by inspection and reports that plans are carried out and a satisfactory service provided.
15. [Co-ordinating activities relating to early discharge schemes].

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16. Reporting to the Chief Nursing Officer (Grade 10) on the work of the division.

17. Promoting good relations between the hospital and the community and encouraging voluntary help.

C. Personnel

18. Appointing Midwifery Sisters (Grade 6) and Midwife Teachers in training (Grade 6), in consultation with Senior Matron and Senior Midwife Teacher (Grade 8).

19. Participating, as member of selection panels, in the appointment of Matrons and Midwife Teachers (Grade 7); and assisting in the appointment of Senior Matrons and Senior Midwife Teachers (Grade 8).

20. Introducing Senior Matrons and Senior Midwife Teachers (Grade 8) [and Matrons and Midwife Teachers (Grade 7)] to their duties.

21. Counselling Senior Matrons and Senior Midwife Teachers (Grade 8) and Matrons and Midwife Teachers (Grade 7).

22. Co-ordinating leave for Senior Matrons and Senior Midwife Teachers (Grade 8).

23. Reporting to the Chief Nursing Officer (Grade 10) on Senior Matrons and Senior Midwife Teachers (Grade 8) and Matrons and Midwife Teachers (Grade 7) and giving merit-rating according to the established procedure.

24. Acting upon reports on Midwifery Sisters and Midwife Teachers in training (Grade 6).

25. Recommending specific courses for members of staff in the development of their efficiency.

26. Selecting pupil midwives [and Midwife Teachers in training] in conjunction with the Senior Midwife Teacher (Grade 8).

27. Exercising leadership of the division.

28. Developing the management skills of immediate subordinates.
Job description: C.2
(district general hospital)

Middle management

Role: Senior Matron in control of area in the Midwifery Division.

Grade: Senior Nursing Officer (Grade 8)

Responsible to: Principal Matron (Grade 9)

Reporting to: Principal Matron (Grade 9)

Minimal qualifications: State Certified Midwife
Registered on the general part of the Register
Experience in Grade 7

Functions:

A. Professional

1. Acting as consultant to unit Matrons (Grade 7) on implementation of midwifery policy.

2. Initiating and developing new ideas and methods in the area and encouraging unit Matrons (Grade 7) to do the same.


4. Controlling a unit in the absence of a suitable deputy to a unit Matron.

5. Participating in meetings of officers.

B. Administrative

6. Co-ordinating the work of unit Matrons (Grade 7), including allocation of staff between units.

7. Making requests to the Principal Matron (Grade 9) for staffing support when necessary.

8. Working out plans to implement midwifery policy, in consultation with unit Matrons (Grade 7).

9. Checking by inspection that plans are carried out and a satisfactory service is provided.

10. Settling the plan of practical training for pupil midwives, in consultation with the Senior Midwife Teacher (Grade 8).

11. [Consulting with midwifery and nurse teaching staff over arrangements for obstetric nurse training].

12. Conferring with medical staff, Hospital Secretary (or equivalent) and heads of departments.

13. Reporting to the Principal Matron (Grade 9) on the possible effects of midwifery policy and the results of the programme.
14. Organising the work of clerical staff in the division’s office.

15. [Deputizing for the Principal Matron (Grade 9)].

C. Personnel

16. Appointing Staff Midwives (Grade 5) and enrolled nurses in consultation with unit Matrons (Grade 7).

17. Participating, as member of selection panel, in the appointment of Matrons (Grade 7) for the area.

18. Selecting and appointing nursing auxiliaries.

19. Introducing Matrons (Grade 7) to their duties.

20. Conselling Matrons (Grade 7) and Midwifery Sisters (Grade 6).

21. Co-ordinating leave for Matrons (Grade 7) and Midwifery Sisters (Grade 6).

22. Taking all steps possible to safeguard the welfare and safety during working hours of staff in the area.

23. Reporting to the Principal Matron Grade 9) on Matrons (Grade 7) and endorsing or amending reports on Sisters (Grade 6), and giving merit-rating to both according to the established procedure.

24. Recommending specific courses for members of staff in development of their efficiency.

25. Exercising leadership of the area.

26. Developing the management skills of immediate subordinates.
Job description: C.3
(district general hospital)

Middle management

Role: Senior Midwife Teacher
Grade: Senior Nursing Officer (Grade 8)
Responsible to: Principal Matron (Grade 9)
Reporting to: Principal Matron (Grade 9)

Minimal qualifications:
- State Certified Midwife
- Registered on the general part of the Register
- Experience as Midwife Teacher (Grade 7)

Functions:

A. Professional

1. Informing the Principal Matron (Grade 9) of the implications for midwifery training of developments in educational methods and in the content of midwifery training.

2. Classroom teaching; demonstrating nursing and midwifery practices both in training school and in wards and departments; teaching application of theory to practice.

3. Acting as consultant to Midwife Teachers (Grade 7) and Midwife Teachers in training (Grade 6) on implementation of teaching policy.


5. Preparing examinations and tests and assessing results.

6. Participating, as member, in the Nurse Education Committee; and in meetings of officers.

7. Publicising midwifery as a career.

B. Administrative

8. Co-ordinating the work of Midwife Teachers (Grade 7) and Midwife Teachers in training (Grade 6).

9. Organizing the general administration of the midwifery training school, e.g., library, teaching equipment, records of pupil midwives [and obstetric nursing students], arrangements for examinations.

10. Preparing the detailed training programme for introductory periods and study days in consultation with teaching staff and others.

11. Arranging programme of domiciliary visits in consultation with domiciliary midwifery staff.

12. Reporting to the Principal Matron (Grade 9) on the work of the training school.

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C. Personnel

13. Participating, as member of selection panel, in the appointment of Midwife Teachers (Grade 7).

14. Introducing Midwife Teachers (Grade 7) to their duties.

15. Counselling Midwife Teachers (Grade 7) and Midwife Teachers in training (Grade 6).


17. Reporting to the Principal Matron (Grade 9) on Midwife Teachers (Grade 7) and Midwife Teachers in training (Grade 6) and giving merit rating to both according to the established procedure.

18. Recommending specific courses for members of staff in the development of their efficiency.

19. Interviewing, on behalf of the Principal Matron (Grade 9), pupil midwives [and obstetric nursing students].

20. Counselling pupil midwives throughout their courses.

21. Assessing the progress on pupil midwives, as the recognized teacher of the training school, in consultation with unit Matrons (Grade 7) and Midwife Teachers (Grade 7) and reporting thereon to the Central Midwives Board.

22. Exercising leadership of the staff she supervises.

23. Developing the management skills of immediate subordinates.
Job description: C.4
(district general hospital)

Middle management

Role: Matron in control of unit (wards) in the Midwifery Division.

Grade: Nursing Officer (Grade 7)

Responsible to: Principal Matron (Grade 9) or Senior Matron (Grade 8).

Reports to: Senior Matron (Grade 8)

Minimal qualifications: State Certified Midwife
Registered on the general part of the Register
Experience in Grade 5
Course in middle management

Functions:

A. Professional
1. Acting as consultant to unit staff on midwifery practice.
2. Acting as consultant to unit staff (at the request of Midwifery Sisters (Grade 6)) on relations with patients, relatives and medical staff.
3. Controlling tests of new equipment in the unit.
4. Controlling the introduction to the unit of agreed procedures for the improvement of the midwifery service and the control of infection.
5. Initiating and developing new ideas and methods in the unit, and encouraging staff to do the same.
6. Participating in the training of pupil midwives [and obstetric nursing students] and in in-service training.
7. Advising and informing the Midwife Teacher (Grade 7) on the organisation and supervision of the training programme for pupil midwives [and obstetric nursing students] allocated to the unit.
8. Communicating with relatives of patients as required.
9. Co-operating with medical staff in solving problems of patient care, and in medical research.
10. Controlling a ward in the absence of a suitable deputy to the Midwifery Sister (Grade 6).

B. Administrative
11. Organising staff and pupil midwives allocated to the unit.
12. Organising, within the unit, the in-service training of all unit staff.
13. Arranging, in consultation with Midwifery Sisters (Grade 6), duty rota for unit staff.

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14. Reporting requirements of staff and asking for support when necessary.
15. Working out plans to implement midwifery policy within the unit.
16. Checking the day-to-day cleanliness of the unit in consultation with the Domestic Superintendent.
17. Advising and informing other units, departments and services (e.g., pharmacy, physiotherapy, transport, X-ray) on matters within the unit's competence, other than those which can be dealt with by the unit staff directly.
18. Reporting to the Senior Matron (Grade 8) on the results of the programme and the affairs of the unit.

C. Personnel
19. Introducing Midwifery Sisters (Grade 6) and Staff Midwives (Grade 5) to their duties.
20. Taking all steps possible to safeguard the welfare and safety of the unit's staff during working hours.
21. Counselling Midwifery Sisters (Grade 6) and Staff Midwives (Grade 5).
22. Co-ordinating leave for Midwifery Sisters (Grade 6) and Staff Midwives (Grade 5).
23. Reporting on Midwifery Sisters (Grade 6) and endorsing or amending reports on Staff Midwives (Grade 5), and giving merit-rating to both according to the established procedure.
24. Recommending specific courses for members of staff in development of their efficiency.
25. Informing the Midwife Teacher (Grade 7) of the progress of pupil midwives [and of the progress of obstetric nursing students].
26. Exercising leadership of the unit.
27. Developing the management skills of Midwifery Sisters (Grade 6).
Job description: C.5
(district general hospital)

Role: Midwife Teacher
Grade: Nursing Officer (Grade 7)
Responsible to: Senior Midwife Teacher (Grade 8)
Reports to: Senior Midwife Teacher (Grade 8)

Minimal qualifications:
State Certified Midwife
Registered on the general part of the Register
Midwife Teacher's Diploma
Experience in Grade 5

Functions:
A. Professional
1. Classroom teaching; demonstrating midwifery practices both in training school and in wards and departments; teaching application of theory to practice.
3. Preparing examinations and tests, and assessing results.
4. Participating in meetings of officers.
5. Publicising midwifery as a career.

B. Administrative
6. Arranging clinical teaching for pupils midwives, [obstetric nursing students and medical students] in consultation with Midwifery Sisters (Grade 6) and medical staff.
7. Organizing the work of Midwife Teachers in training (Grade 6) assisting her.
8. Reporting to the Senior Midwife Teacher (Grade 8) on the possible effects of teaching policy and the results of the teaching programme.

C. Personnel
9. Counselling Midwife Teachers in training (Grade 6) and other midwives undergoing courses of instruction under her supervision.
10. Counselling a group of pupil midwives throughout their training.
11. Taking all steps possible to safeguard the welfare and safety of pupil midwives while they are in training.
12. Reporting on pupil midwives to the Senior Midwife Teacher (Grade 8); after consultation with Midwifery Sisters (Grade 6) and/or unit Matrons (Grade 7) and giving merit rating to outstanding pupil midwives according to established procedure.
13. [Reporting to the Senior Tutor (Grade 8) on the progress of obstetric nursing students, after consultation with unit Matrons (Grade 7) and Midwifery Sisters (Grade 6)].
First-line Management

Role: Midwifery Sister in control of a ward.

Grade: Charge Nurse (Grade 6)

Responsible to: Matron (Grade 7)

Reports to: Matron (Grade 7)

Minimal qualifications: State Certified Midwife
Experience as Staff Midwife (Grade 5)
Charge Nurses’ preparatory course.

Functions:

A. Professional
1. Supervising professional work of midwifery staff.
2. Preparing reports for and receiving reports from the night nurse.
3. Maintaining custody of dangerous drugs: checking and witnessing administration of drugs.
4. Assisting medical staff and ascertaining medical treatments.
5. Reporting condition of patients to medical staff and, when necessary to Matron (Grade 7), and receiving instructions.
6. Directing and, as necessary, personally undertaking aspects of, the nursing care of mothers and babies and instructing mothers in care and feeding.
7. Teaching of pupil midwives [and obstetric nursing students].
8. Training qualified midwifery and nursing staff in midwifery and ward management.
9. Directing training of other ward staff.
10. Maintaining personal contacts with patients through ward rounds, conversations, etc.
11. Arranging for patients’ meals and special diets and participating in meals service.
12. Communicating with relatives of patients and with visitors as required.

B. Administrative
13. Organizing reception of patients and nursing in accordance with any standing instructions.
14. Maintaining good order in the ward.
15. Directing domestic and other staff.
16. Arranging in consultation with the Midwife Teacher (Grade 7) systematic practical instruction of pupil midwives.
17. Controlling drugs and dressings kept in the ward.

18. Maintaining ward stores and equipment; and requisitioning, with due economy, provisions and other supplies [if no Imprest System] and repairs and replacements of equipment.

19. Arranging care of patients' property and distribution of mail.

20. Co-operating with other nursing units and departments and other hospital departments (and where necessary co-ordinating their activities at ward level), e.g., admissions, catering officer, chaplains, C.S.S.D., engineers, medical records, medical social workers, pathology, pharmacy, physiotherapy, transport, X-ray; and with outside authorities, e.g., supervisor of midwives, domiciliary midwives, health visitors, general practitioners.

21. Informing mothers of local health authority and other services available.

22. Arranging in consultation with medical social workers for care of patients on discharge [especially where early discharge schemes operate] through the local health authority, general practitioner and domiciliary midwife.

23. Rendering returns required by any branch of the hospital administration or outside bodies.

24. Notifying Registrar of Births and Deaths.

25. Reporting on ward affairs to Matron (Grade 7).

C. Personnel

26. Introducing new members of staff to their duties.

27. Counselling ward staff and nurses in training.

28. Reporting on qualified and other midwifery and nursing staff to Matron (Grade 7).

29. Recording progress of pupil midwives [and obstetric nursing students] and reporting thereon to Matron (Grade 7).
Job description: D.1
(psychiatric hospital)

Top management

Role: Principal Nursing Officer in control of the Nursing Division

Grade: Principal Nursing Officer (Grade 9)

Responsible to: Chief Nursing Officer (Grade 10)

Reporting to: Chief Nursing Officer (Grade 10)

Minimal qualifications: Registered on the appropriate part of the Register for psychiatric nursing
Experience in Grade 7
Top-management course

Functions:

A. Professional

1. Informing the Chief Nursing Officer (Grade 10) of psychiatric nursing matters affecting policy and necessary to implement the agreed policy.

2. Studying, setting and reviewing standards and procedures of nursing care, including basic cleanliness of wards and ward equipment.

3. Participating [as member, in the Nursing Committee; and] in meetings of officers.

4. Contributing information and advice to assist in implementation of policy in matters affecting nursing, e.g., catering, cleaning.

5. Participating in the in-service training of staff.

6. Investigating serious mishaps and complaints and reporting as laid down in policy.

7. Advising the Principal Tutor (Grade 9) on the selection of student and pupil nurses.

8. Publicising nursing as a career.

9. Advising on structural alterations and new building and equipment.

B. Administrative

10. Controlling staff of the division.

11. Reporting requirements of staff and nursing equipment.

12. Organising in-service training within the division.

13. Convening meetings of staff in the division.

14. Settling the plan of practical training for student and pupil nurses in consultation with the Principal Tutor (Grade 9).

15. Conferring with heads of other divisions and with medical and other senior staff.
16. Checking by inspection and reports that work is carried out in accordance with policy and a satisfactory service is provided.

17. Reporting to the Chief Nursing Officer (Grade 10) on the work of the division.

18. Co-operating with the mental health after-care services of local authorities.

19. Promoting good relations between the hospital and the community, and encouraging voluntary help.

C. Personnel

20. Appointing Charge Nurses (Grade 6), in consultation with Senior Nursing Officers (Grade 8).

21. Participating, as member of selection panels, in the appointment of Nursing Officers (Grade 7); and assisting in the appointment of Senior Nursing Officers (Grade 8).

22. Introducing Senior Nursing Officers (Grade 8) [and Nursing Officers (Grade 7)] to their duties.

23. Counselling Senior Nursing Officers (Grade 8) and Nursing Officers (Grade 7).

24. Co-ordinating leave for Senior Nursing Officers (Grade 8) and Nursing Officers (Grade 7).

25. Reporting to the Chief Nursing Officer (Grade 10) on Senior Nursing Officers (Grade 8) and Nursing Officers (Grade 7) and giving merit-rating according to the established procedure.

26. Acting upon reports on Charge Nurses (Grade 6).

27. Recommending specific courses for members of staff in the development of their efficiency.

28. Exercising leadership of the division.

29. Developing the management skills of immediate subordinates.
Job description: D.2
(psychiatric hospital)

Middle management

Role:  Senior Nursing Officer in control of an area in the Nursing Division.

Grade:  Senior Nursing Officer (Grade 8).

Responsible to:  Principal Nursing Officer (Grade 9).

Reports to:  Principal Nursing Officer (Grade 9).

Minimal qualifications:  Registered on the appropriate part of the Register for psychiatric nursing.
Experience in Grade 7.

Functions:

A. Professional

1. Acting as consultant to Nursing Officers (Grade 7) on implementation of psychiatric nursing policy.

2. Initiating and developing new ideas and methods in the area and encouraging Nursing Officers (Grade 7) to do the same.

3. Participating in in-service training.

4. Controlling a unit in the absence of a suitable deputy to the unit head.

5. Co-operating with the medical staff and other officers in research and general care of patients within the area.

6. Participating in meetings of officers.

B. Administrative

7. Co-ordinating work of Nursing Officers (Grade 7), including allocation of staff between units.

8. Making requests to Principal Nursing Officer (Grade 9) for staffing support when necessary.

9. Working out plans to implement nursing policy, in consultation with Nursing Officers (Grade 7).

10. Checking by inspection and reports that plans are carried out and a satisfactory service is provided.

11. Arranging programmes for visitors and trainees (in hospital administration) within the area.

12. Conferring with medical staff, Hospital Secretary (or equivalent) and heads of departments.

13. Reporting to the Principal Nursing Officer (Grade 9) on the possible effects of psychiatric nursing policy and the results of the programme.

14. Communicating with relatives of patients, as required.
15. [Deputising for the Principal Nursing Officer (Grade 9)].

C. Personnel

16. Appointing Staff Nurses (Grade 5) and enrolled nurses in consultation with Nursing Officers (Grade 7).

17. Participating as member of selection panel, in the appointment of Nursing Officers (Grade 7) for the area.

18. Selecting and appointing nursing assistants.

19. Introducing Nursing Officers (Grade 7) to their duties.

20. Counselling Nursing Officers (Grade 7) and Charge Nurses (Grade 6).

21. Co-ordinating leave for Nursing Officers (Grade 7) and Charge Nurses (Grade 6).

22. Taking all steps possible to safeguard the welfare and safety during working hours of staff in the area.

23. Reporting to the Principal Nursing Officer (Grade 9) on Nursing Officers (Grade 7) and endorsing or amending reports on Charge Nurses (Grade 6), and giving merit-rating to both according to the established procedure.

24. Recommending specific courses for members of staff in the development of their efficiency.

25. Exercising leadership of the area.

26. Developing the management skills of immediate subordinates.
Job description: D.3
(psychiatric hospital)

Middle management

Role: Nursing Officer in control of a unit

Grade: Nursing Officer (Grade 7)

Responsible to: Principal Nursing Officer (Grade 9).

Reports to: Senior Nursing Officer (Grade 8).

Minimal qualifications: Registered on the appropriate part of the Register for psychiatric nursing. Experience in Grade 5. Course in middle management.

Functions:

A. Professional

1. Acting as consultant to Charge Nurses (Grade 6) on psychiatric nursing practice, patients' activities and other matters affecting the welfare of patients (e.g., clothing, pocket money).

2. Acting as consultant to unit staff (at the request of Charge Nurses (Grade 6)) on relations with patients, relatives and medical staff.

3. Controlling tests of new equipment in the unit.

4. Controlling the introduction to the unit of agreed procedures for the improvement of the nursing service.

5. Initiating and developing new ideas and methods—both within the unit and with regard to patients' recreational and occupational activities outside the unit—and encouraging staff to do the same.

6. Participating in in-service training and in the teaching of student and pupil nurses.

7. Participating in staff-patient meetings.

8. Advising and informing the Teaching Division on the organisation and supervision of the training programme for student and pupil nurses allocated to the unit.

9. Communicating with relatives of patients as required.

10. Co-operating with medical staff in solving problems of patient care, and in medical research.

11. Controlling a ward in the absence of a suitable deputy to the Charge Nurse (Grade 6).

B. Administrative

12. Organising staff and student and pupil nurses allocated to the unit.

13. Organising, within the unit, the in-service training of all unit staff.
14. Reporting requirements of staff and asking for support when necessary.
15. Arranging, in consultation with Charge Nurses (Grade 6), duty rota for unit staff.
16. Assisting medical staff in observing the legal requirements of the Mental Health Act.
17. Controlling necessary clerical work undertaken in the unit.
18. Co-ordinating arrangements for patients' activities within and outside the unit.
19. Working out plans to implement the nursing policy within the unit.
20. Checking by inspection of reports that plans are carried out, a satisfactory service is provided and the rules of the hospital are observed.
21. Advising and informing other units, departments and services (e.g., admissions, catering officer, industrial and occupational therapy, medical records, psychiatric social workers, pharmacy, transport) on matters within the unit's competence other than those which can be dealt with by unit staff directly.
22. Reporting to the Senior Nursing Officer (Grade 8) on the results of the programme and the affairs of the unit.

C. Personnel:
23. Introducing new Charge Nurses (Grade 6) to their duties.
24. Taking all steps possible to safeguard the welfare and safety of unit staff during working hours.
25. Counselling unit staff.
26. Co-ordinating leave for Charge Nurses (Grade 6) and Staff Nurses (Grade 5).
27. Reporting on Charge Nurses (Grade 6) and endorsing or amending reports on Staff Nurses (Grade 5) and giving merit-rating according to the established procedure.
28. Recommending specific courses for unit staff in the development of their efficiency.
29. Informing Tutors (Grade 7) of the progress of student and pupil nurses.
30. Exercising leadership of the unit.
31. Developing the management skills of Charge Nurses (Grade 6).
First-line management

Role: Ward Sister/Charge Nurse in control of a ward

Grade: Charge Nurse (Grade 6)

Responsible to: Nursing Officer (Grade 7)

Reports to: Nursing Officer (Grade 7)

Minimal qualifications: Registered on appropriate part of the Register for psychiatric nursing.

Charge Nurses’ preparatory course.

Functions:

A. Professional

1. Supervising professional work of nursing staff.

2. Preparing reports for and receiving reports from the night nurse.

3. Maintaining custody of dangerous drugs: checking and witnessing administration of drugs.

4. Assisting medical staff and ascertaining medical treatments.

5. Reporting condition of patients to medical staff and, when necessary, to Nursing Officer (Grade 7) and receiving instructions.

6. Carrying out some nursing procedures and treatments.

7. Teaching of student and pupil nurses.

8. Training of qualified nursing staff in nursing and ward management.

9. Directing the training of other ward staff.

10. Maintaining personal contacts with patients through ward rounds, conversations, etc.

11. Arranging for patients’ meals and special diets and participating in meal service.

12. Communicating with relatives of patients and with visitors as required.

B. Administrative

13. Organising reception of patients and nursing in accordance with any standing instructions.

14. Maintaining good order and cleanliness in the ward.

15. Directing domestic and other staff.

16. Arranging systematic practical instruction of student and pupil nurses in accordance with the requirements of the General Nursing Council.
17. Controlling drugs and dressings kept in the ward.

18. Maintaining ward stores and equipment; and requisitioning with due economy, provisions and other supplies [if no Imprest System] and repairs and replacement of equipment.

19. Arranging care of patients' property and controlling the distribution of patients' mail.

20. Assisting medical staff in the discharge of patients and their after-care.

21. Assisting medical staff in observing the legal requirements of the Mental Health Act.

22. Co-operating with other nursing units and other hospital departments (and where necessary co-ordinating their activities at ward level), e.g., admissions, catering officer, chaplains, medical records, occupational therapy, psychiatric social workers, pathology, pharmacy, physiotherapy, transport, X-ray.

23. Rendering returns required by any branch of the hospital administration, including notification of patients' deaths and mishaps.

24. Reporting on ward affairs to Nursing Officer (Grade 7).

C. Personnel

25. Introducing new members of staff to their duties.

26. Counselling ward staff and nurses in training.

27. Reporting on qualified and other nursing staff to Nursing Officer (Grade 7).

28. Recording progress of students and pupil nurses and reporting thereon to Nursing Officer (Grade 7).
Job description: E.1
(school of nursing)

Top management

Role: Principal Tutor in control of the Teaching Division
Grade: Principal Nursing Officer (Grade 9)
Responsible to: Chief Nursing Officer (Grade 10)
Reports to: Chief Nursing Officer (Grade 10)

Minimal qualifications: Registered on the general part of the Register
Experience as a Tutor (Grade 7)
Top-management course.

Functions:

A. Professional
1. Informing the Chief Nursing Officer (Grade 10) of the implications for nurse training of developments in educational methods and in the content of nurse training.
2. Informing the Chief Nursing Officer (Grade 10) on educational methods for in-service training of nursing staff.
3. Participating, as member, in the Nurse Education Committee; and in meetings of officers.
4. Classroom teaching of some subjects in the syllabus.
5. Participating in in-service training.
6. Giving guidance to Senior Tutors (Grade 8) and Tutors (Grade 7) on teaching methods.
7. Publicising nursing as a career.
8. Acting as an examiner in statutory and non-statutory examinations (or as assigned to other tutors).
9. Advising on structural alterations and new building and equipment.

B. Administrative
10. Controlling staff of the division.
11. Reporting requirements of staff and teaching equipment.
12. Preparing annual school programmes (study blocks/days, etc.) after consultation with nursing and non-nursing staff outside the school.
13. Organizing the preparation of detailed training programmes (lectures, etc.).
14. Preparing annual estimates for the training school for approval.
15. Organizing the general administration of the school, e.g., library, equipment arrangements for examinations.
16. [Organizing the obstetric nurse training scheme.]
17. Arranging the participation of outside authorities and lecturers in the educational programme.
18. Convening meetings of teaching staff.
19. Conferring with the heads of other divisions and with medical and other staff.
20. Reporting to Chief Nursing Officer (Grade 10) on the work of the division
   1. [Arranging prize-givings].

C. Personnel
22. Appointing Clinical Instructors (Grade 6) in consultation with Principal Matron (Grade 9) and Senior Tutors (Grade 8).
23. Participating, as members of selection panels, in the appointment of Tutor (Grade 7); and assisting in the appointment of Senior Tutors (Grade 8).
24. Introducing Senior Tutors (Grade 8) [and Tutors (Grade 7)] to their duties.
25. Counselling Senior Tutors (Grade 8) and Tutors (Grade 7).
27. Reporting to the Chief Nursing Officer (Grade 10) on Senior Tutors (Grade 8) and Tutors (Grade 7) and giving merit-rating according to the established procedure.
28. Acting upon reports on Clinical Instructors (Grade 6).
29. Recommending specific courses for members of staff in development of their efficiency.
30. Selecting student and pupil nurses, in conjunction with the nursing officer nominated by the Chief Nursing Officer (Grade 10), including reviewing applications, interviewing and making a final assessment of candidates.
31. Interviewing student and pupil nurses as necessary.
32. Assessing progress of student and pupil nurses [including obstetric nursing students] and certifying that they have complied with the General Nursing Council's training requirements.
33. Exercising leadership of the division.
34. Developing the management skills of immediate subordinates.
Job description: E.2
(school of nursing)

Middle management

Role: Senior Tutor
Grade: Senior Nursing Officer (Grade 8)
Responsible to: Principal Tutor (Grade 9)
Reports to: Principal Tutor (Grade 9)

Minimal qualifications:
Registered nurse
Experience as Tutor (Grade 7)

Functions:
A. Professional
1. Class room teaching; demonstrating nursing practice both in the training school and in hospital wards and departments; teaching application of theory to practice.
2. Acting as consultant to Tutors (Grade 7) and Clinical Instructors (Grade 6) on implementation of teaching policy.
3. Participating in in-service training.
4. Preparing examinations and tests and assessing results.
5. Participating as member, in the Nurse Education Committee; and in meetings of officers.
6. Publicising nursing as a career.

B. Administrative
7. Co-ordinating the work of Tutors (Grade 7) and Clinical Instructors (Grade 6) teaching a group of subjects.
8. Preparing the detailed training programme for the introductory course and study blocks in consultation with teaching staff, Charge Nurses and others.
9. Undertaking part of the school's administration, e.g., the library, records of student and pupil nurses, arrangements for examinations.
10. [Co-ordinating the activities of nursing and midwifery staff concerned with obstetric nurse training.]
11. Convening meetings of Tutors (Grade 7) and Clinical Instructors (Grade 6) teaching a group of subjects.
12. Reporting the Principal Tutor (Grade 9) on the possible effects of teaching policy and the results of the teaching programme.
13. [Deputising for the Principal Tutor (Grade 9)].

C. Personnel
14. Participating, as member of selection panel, in the appointment of Tutors (Grade 7).
15. Introducing [Tutors (Grade 7) and] Clinical Instructors (Grade 6) to their duties.
16. Counselling Tutors (Grade 7) and Clinical Instructors (Grade 6).
17. Co-ordinating leave for Clinical Instructors (Grade 6).
18. Reporting to the Principal Tutor (Grade 9) on Tutors (Grade 7) and Clinical Instructors (Grade 6) and giving merit-rating to both according to the established procedure.
19. Interviewing (and counselling) student and pupil nurses on behalf of the Principal Tutor (Grade 9).
20. Assessing the progress of student and pupil nurses in consultation with Nursing Officers (Grade 7) and Tutors (Grade 7) [and that of obstetric nursing students, in consultation with the Midwife Teacher (Grade 7)] and reporting thereon to the Principal Tutor (Grade 9).
21. Exercising leadership of the area.
22. Developing the management skills of immediate subordinates.
Job description: E.3  
(school of nursing)

**Middle management**

**Role:**  
Tutor

**Grade:**  
Nursing Officer (Grade 7)

**Responsible to:**  
Principal Tutor (Grade 9)

**Reports to:**  
Senior Tutor (Grade 8)

**Minimal qualifications:**  
As specified by the General Nursing Council*

**Functions:**

**A. Professional**

1. Classroom teaching; demonstrating nursing practices both in training school and in wards and departments; teaching application of theory to practice.

2. Participating in in-service training.

3. Preparing examinations and tests, and assessing results.

4. Participating [as member, in the Nurse Education Committee and] in meetings of officers.

5. Publicising nursing as a career.

**B. Administrative**

6. Arranging clinical teaching for student and pupil nurses in consultation with Charge Nurses (Grade 6), medical staff and others.

7. Reporting to the Senior Tutor (Grade 8) and the Principal Tutor (Grade 9) on the possible effects of teaching policy and the results of the teaching programme.

**C. Personnel**

8. Counselling a group of student and/or pupil nurses throughout their training.

9. Taking all steps possible to safeguard the welfare and safety of student and pupil nurses while they are in training.

10. Discussing the clinical progress of student and pupil nurses with Charge Nurses (Grade 6) and/or Nursing Officers (Grade 7).

11. Reporting on student and pupil nurses to the Senior Tutor (Grade 8) and giving merit-rating to outstanding student nurses according to the established procedure.

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*At present:—
Registered on general part of the Register.
Experience as a Ward Sister.
Sister Tutor's Diploma.

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First-line management

Role: Clinical Instructor
Grade: Charge Nurse (Grade 6)
Responsible to: Senior Tutor (Grade 8)
Reports to: Senior Tutor (Grade 8)

Minimal qualifications: Registered nurse
Experience as a Staff Nurse (Grade 5)
Post-registration course in clinical teaching

Functions:
A. Professional
1. Instructing student and pupil nurses, in conjunction with Charge Nurse (Grade 6) in units, in accordance with the programme.
2. Participating in in-service training.
3. Assisting with hospital examinations and tests.

B. Administrative
4. Keeping records of student and pupil nurses in the unit.

C. Personnel
5. Counselling student and pupil nurses in the unit.
6. Reporting on student and pupil nurses to the Senior Tutor (Grade 8).
Job description: F.1

Middle management

Role: Senior Nursing Officer in the central nursing office
Grade: Senior Nursing Officer (Grade 8)
Responsible to: Chief Nursing Officer (Grade 10)
Reports to: Chief Nursing Officer (Grade 10)
Minimal qualifications: Registered Nurse
Experience in Grade 7.

Functions:
A. Professional
1. Reviewing nursing organisation and procedures in the group, as instructed by the Chief Nursing Officer (Grade 10).
2. Assisting the nursing member of the team planning hospital building schemes.
3. Advising Senior Nursing Officers (Grade 8) and Nursing Officers (Grade 7) on job specification for nursing staff.
4. Informing the Chief Nursing Officer (Grade 10) of developments in nursing administration.
5. Giving guidance on professional matters to the general administrative grade officer in the central nursing office.
6. Publicising nursing as a career.
7. Relieving Principal Nursing Officers (Grade 9) and other Senior Nursing Officers (Grade 8), when necessary.

B. Administrative
8. Working out plans to implement policy for recruitment of qualified and other nursing staff and, in consultation with the Principal Tutor (Grade 9), of student and pupil nurses.
9. Organizing in-service training of all qualified and auxiliary nursing staff.
10. [Organizing a nursing cadet scheme].
11. Reporting to the Chief Nursing Officer (Grade 10) on recruitment and in-service training [and the nursing cadet scheme].
12. Arranging programmes for visitors and for seconded senior nurses on training courses.

C. Personnel
13. Introducing to their duties and counselling Charge Nurses (Grade 6) seconded to the central nursing office for training.
14. [Counselling nursing cadets.]
15. Reporting to the Chief Nursing Officer (Grade 10) on Charge Nurses (Grade 6) seconded to the central nursing office for training and giving merit-rating according to the established procedure.
APPENDIX 8

The Principle of Secondment

1. Scope

In this note the principle of secondment is illustrated by the case of the Domestic Assistant (cleaner) who does cleaning in wards. The object of the arrangement is to relieve the Ward Sister of work which is not essentially part of nursing. An advantageous consequence is that central control of cleaners makes for economy in their organisation and use. The principle applies to activities where there is division of labour such as the serving of meals, which is carried out in some hospitals by catering assistants. It is less readily applicable where a miscellany of functions is combined in a single job, and it cannot be applied in wards to jobs which may include some nursing tasks, as with the Ward Orderly.

2. Definitions

A person is said to be transferred to another sphere of authority when his tasks are co-ordinated with the tasks of others in that sphere of authority by one who exercises structural authority therein. (Structural authority is the right to command and to expect and enforce obedience.)

A person is said to be seconded to another sphere of authority when his tasks are co-ordinated with the tasks of those in that sphere of authority by the use of sapiential authority. (Sapiential authority is the right to be heard by reason of knowledge or expertness.)

3. Cleaning in wards

The function of the cleaner is cleaning and the cleaner uses cleaning operations or methods. The function of the nurse is care of the patient, which includes a function of preserving hygienic conditions. The function 'preserving hygienic conditions' is achieved through a variety of methods, including cleaning methods, in this case carried out by the cleaner. The function of the Ward Sister includes the co-ordination of the various functions in the ward towards the achievement of care. Since nursing care includes hygienic conditions then all those functions that are required for hygiene, including cleaning, must be co-ordinated; hence it is a function of the Ward Sister to co-ordinate the function of preserving hygiene in the ward (including cleaning).

The Domestic Superintendent obtains and trains the cleaners; she is an expert in methods of cleaning and in the recruitment and training of domestic staff. The Ward Sister is an expert in nursing which includes the setting and maintenance of standards of ward hygiene. The Domestic Superintendent is responsible for the cleaning all over the hospital including the chapel, offices, corridors and residences as well as wards. She is not responsible for the preservation of hygienic conditions in the wards; she is responsible for ordering and co-ordinating cleaners in such a way that cleanliness is achieved, which is adjunctive towards the preserving of hygienic conditions. Therefore in the ward, the cleaners must have their tasks co-ordinated by the Ward Sister with those of other staff on the ward, such as nurses; the Domestic Superintendent cannot so co-ordinate having no sapiential authority on this matter of ward hygiene. However, the Domestic Superintendent has sapiential authority on methods, and will have the
right to order her cleaners on the methods that may be used in the ward, that is
to say on questions of operations. She is responsible for training cleaners and so
providing cleaners who can perform operations appropriate to the function of
cleaning in the wards, towards the general function of preserving hygienic
conditions for patients.

4. Responsibility where the cleaner is seconded to the Ward Sister

(a) The cleaner is ordered by the Domestic Superintendent to clean in the
ward, according to the co-ordinating imperatives of the Ward Sister.

(b) Therefore, failure to obey these co-ordinating imperatives of the Ward
Sister is equivalent to failure to obey the Domestic Superintendent to whom the
cleaner is responsible; whence the cleaner can be admonished by the Domestic
Superintendent but not by the Ward Sister.

(c) Should the cleaner fail in operation, i.e., does not use proper cleaning
methods as a result of not having been trained properly, this failure is on the
part of the Domestic Superintendent. The cleaner cannot be ordered to do
that which she is unable to do; therefore, as a result of failure in operational
efficiency of this nature, the Domestic Superintendent is responsible. The
Domestic Superintendent in the hospital is responsible for provision of
adequately trained cleaners as part of her function of serving the patient,
which is the overall function of the hospital staff.

(d) On secondment of the cleaner the Ward Sister can only give co-ordinating
imperatives, that is to say telling the cleaner where to clean, when to clean
and what to clean, within a programme generally agreed between the nursing
administration and the Domestic Superintendent.

(e) If she ‘orders’ the cleaner to use a different method of cleaning, then:

(i) The cleaner has the choice as to whether she uses this ‘ordered’
operation or not, because she has been trained to use particular forms of
cleaning by the Domestic Superintendent and may not go beyond these
unless she is prepared to take the consequences of so doing. This is self-
responsibility in decision on operation.

(ii) If the cleaner obeys this ‘order’ believing it to be a co-ordinating
order, then the cleaner cannot be held at fault should anything untoward
result. The fault is the fault of the Ward Sister.

(f) If the Ward Sister believes that the methods of cleaning employed by the
cleaner are unsuitable for the ward, then she cannot, as under (d) above,
give ‘orders’ to the cleaner; she must use the hypothetical imperative and
leave to the cleaner the choice of operation. If the Ward Sister wants a
particular method to be used in the ward, which method is beyond the
kinds of operation taught by the Domestic Superintendent, then the Ward
Sister must ask the Superintendent that this form of operation be applied.
In practice this request would be made through the nursing officer responsible
for co-ordinating the nursing service of the unit.

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5. The Domestic Superintendent: to whom responsible

Under the arrangement described above the cleaners are in the sphere of authority of the Domestic Superintendent whose duty it then is to obtain, train and supply them. In this she could be responsible either to the head of the nursing service of the hospital or to the hospital administrator. In the view of the majority of the Committee the latter is preferable in order to relieve the head of the nursing service of work that is not fundamentally part of nursing.

However since the head of the nursing service is responsible for nursing care of patients which depends considerably on hygiene in the hospital, it follows that she must be able to use some form of imperative in the use of the cleaners throughout the hospital. She must have the right to be able to say to the Domestic Superintendent that cleaners be supplied where she, the senior nurse administrator believes that cleaners are required in terms of the nursing functions. For instance, should she receive complaints from a Ward Sister about the shortage of cleaning staff then she must have the right to demand that the cleaning on the ward should be upheld by the Domestic Superintendent. If the Domestic Superintendent is responsible to the hospital administrator, the senior nurse administrator has the right to advise (the hypothetical imperative) the hospital administrator that the Domestic Superintendent must provide suitable cleaners of the right calibre and in number appropriate to the needs of the wards. Since the administrator will be responsible for the supply (being in control of the Domestic Superintendent) then he must feel it incumbent upon him so to produce it, if he can, even though he is not perfectly obliged to do so.
APPENDIX 9

Syllabuses for Courses of Preparation for the Three Levels of Management

1. PREPARATORY COURSE FOR FIRST-LINE MANAGEMENT

For Charge Nurse (Grade 6): lasting four weeks—in two Parts.

PART A (two weeks): teaching operational principles of management.

(1) First principles of structural organisation: e.g.
   (a) Division of labour; primary and secondary functions; line and staff structure.
   (b) Communication in an organisation.
   (c) Organisation of a job (task, processes, operations).

(2) Operational principles of organisation of people: e.g.
   (a) Authority, responsibility.
   (b) Delegation and supervision.
   (c) The giving of orders ("instructions").
   (d) Committees, conferences, meetings.

(3) Elementary principles of personnel administration: e.g.
   (a) Training by organising work.
   (b) Training by precept and concept.
   (c) Counselling.
   (d) Reporting.

PART B (two weeks): relating more strictly to nursing and subsequent to Part A.

(1) Hospital organisation including nursing, medical and administrative services.

(2) Elementary hospital economics.

(3) Communication within the hospital and with health and welfare services in the community.

(4) Legal aspects of the care of patients, as affecting nurses.

(5) Management of the ward team (section).

(6) Practical teaching methods.

(7) Reporting for merit-rating ("assessment").

(8) Communication with patients and relatives.
2. PREPARATORY COURSE FOR MIDDLE MANAGEMENT

For Nursing Officer (Grade 7): lasting 12 weeks—in two Parts.

PART A (four weeks): of a kind that could be given at technical colleges, teaching theory, including theoretical principles of management.

2. Human relations—theory and practice of administration—concepts of authority, power and law.
3. Decisions—theory, and training by case method.
4. Effective communication of information in day-to-day work.
5. Elementary occupational psychology (attitudes of staff to their work and the effect on efficiency).
6. Elementary statistics as an aid to management.
7. The law as it affects the hospital and the nursing profession.
9. Principles of production, quality, budgeting, cost and inventory control as practised in industry and their relevance to hospital nursing work.
10. Programme to give effect to policy decisions.

PART B (8 weeks): teaching the application of theory to practice, the content varying according to the kind of unit in which a Nursing Officer (Grade 7) is to work. The following example relates to work in operating theatres.

3. Inspection methods (quality control) and reporting.
4. Office management—records, reference material.
5. Organisation of work in the unit. Use of work study. Planning of duty rotas for nursing staff (qualified and unqualified) and operating theatre attendants.
7. Preparing reports for nursing and hospital administrators and for medical staff.
8. Planning and organising of staff training programme, including in-service training for ancillary staff working in operating theatres. Practical teaching methods.
9. Preparation of staff reports.
3. PREPARATORY COURSE FOR TOP MANAGEMENT

For Principal Nursing Officer (Grade 9).

Course (12 weeks): for further exposition of management theory and for consideration of the nursing function in the context of the health service, with the aid of case studies.

(1) Definition of kinds of policy—financial, professional, recruitment and labour, educational.

(2) Information for policy—the factors affecting different policies, and how to organise required information, work study methods and research techniques; use of statistics including Hospital Activity Analysis.

(3) Methods of determining policy: the roles of committees and conferences.

(4) Government policy—development of health and welfare services in relation to other social services.

(5) Staff relations—joint consultations with management.

(6) Planning—factors and weighting of factors in forecasting, probability estimation. Modern business machines, including computers.

(7) Data processing (including computers) and automation (including control systems).

(8) Techniques of review of policy—implementation—targets and performance appraisal.

(9) Design and layout of hospital buildings—operational policies; reconciliation of the requirements of the nursing functions with other factors; commissioning. Visits for evaluation.

(10) Social psychology of public relations with special reference to the hospital services.
MINISTRY OF HEALTH
SCOTTISH HOME AND HEALTH DEPARTMENT

Report of the Committee on
Senior Nursing Staff Structure

LONDON
HER MAJESTY'S STATIONERY OFFICE
1966
MEMBERS OF THE COMMITTEE

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F. D. K. WILLIAMS (Secretary)
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