Nurse executives are underpaid and undervalued

June Girvin, Assistant Editor of Nursing Management, reports on the implications for the future careers of senior nurses arising from the Royal College of Nursing’s recent survey on nurse executive pay in National Health Service trusts.

In January 1997 the RCN published its survey of nurse executive pay, publicising results that have been causing concern to those in senior positions for some time. There is little information available on trust board executive pay generally and, until now, information on nurse executive pay has been particularly scant. In spite of the media’s fascination with ‘fat cat’ chief executive salaries, nurses’ salaries at this level have raised little interest, and this report is timely and of critical importance in planning for the future.

The survey provides some interesting information about the role that nurse executives have. Nurse executives reported 56 different job titles, half of them had more than one title, reflecting a huge range of responsibilities. Most acted in a largely strategic management capacity, though 40 per cent felt that their role was a combination of operational and strategic working. There appears to still be an issue surrounding operational involvement. How involved should nurse executives be in the day-to-day running of nursing services? Interestingly, many nurse executives reported managing various groups of staff and functions, including paramedics, chaplains, porters and so on, yet only 22 per cent said they managed nursing services. Many had additional operational management responsibilities added to their remit without any increase in salary.

Probably the most predictable results were those surrounding nurse executive pay. Half of all nurse executives reported that they were the lowest paid member of the trust board. The average differential was around £6,000, but there were reports of differentials up to £20,000. Not surprisingly, 48 per cent of nurse executives felt that they were not paid fairly in relation to other board executives. From comments received, some nurse executives saw these discrepancies as undermining nursing, and reflecting the fact that the nurse executive role is not well understood or appreciated.

Susan Dickson, joint chair of the South and West Region Nurse Executive Group commented: ‘the findings are not at all surprising. Executive nurses can add such value at board level, and this should be properly and fairly rewarded. Nurse executives are particularly concerned that such disparity causes disenchanted and could lead to difficulty with retention and succession planning’.

The profile information gathered on nurse executives bears out Susan Dickson’s concerns and has clear implications for the future. The average age of nurse executives is 46 years, and 11 per cent of those studied were at or over minimum retirement age. The majority had been in post for three years or slightly less, and there is a suggestion that turnover rates may have slowed marginally from the 38 per cent recorded in 1995 (Ball et al 1995). When asked where they expected to be in two years time, 70 per cent expected to be continuing to work in provider organisations, 45 per cent in their existing post, 12 per cent in another executive nurse post, and 13 per cent aspired to be chief executives.

This leaves 43 per cent of current nurse executives who do not expect to be working as nurse executives in NHS trusts in two years’ time. In relation to the sample, that means 135 nurse executive positions will need to be filled in the near future. This raises further questions about nurses in management generally and, on the basis of this survey, about how attractive nurse executive positions are as a career.

Christine Hancock, RCN General Secretary, is also concerned about the implications. She feels very strongly that: ‘nurses in senior management are not an optional extra. Nurse executives deserve to be rewarded fairly and their contribution to patient care and good management recognised. Becoming a nurse executive ought to be a goal for more nurses. I am worried that too many do not see it as a good career move.’

The RCN is calling specifically for:

- The establishment of a clear and fair pay review system for nurse executives, where nurse executives are allowed to present their own case for a fair pay package to trust remuneration committees, as well as being able to make a formal submission to chief executive nurses. Currently 55 per cent are unaware of the criteria used to determine their salary, and 32 per cent felt that the process of determination was secretive and unfair.

- Job evaluation systems to give greater recognition to the contribution nurse executives make when they advise on the.

Manual handling is source of most injuries

A recently published study by the Royal College of Nursing reports on the nature of personal injuries suffered by nurses at work. The findings in Hazards of Nursing – Personal Injuries at Work show that manual handling incidents are the most common (52 per cent), followed by slips, trips and falls (30 per cent). D and E grade nurses are predominant in the findings, probably reflecting the level of ‘hands on’ care that they are involved in.

More accidents were reported during morning shifts than at any other time, and accidents occurred at the start of shifts, rather than later on in the working pattern. Frequency of reported incidents was highest in NHS hospitals and highest in elderly care clinical areas.

This is a fair snapshot for middle managers looking to identify areas for scrutiny in their own workplace, and is available free from the Royal College of Nursing.
The nurse executive role is a tough one, but a crucial one if trust boards are interested in the patient/client's experience and quality of care. This report should be finding its way onto the agenda of every trust board remuneration committee, and should be informing human resource strategies throughout the UK. Nurse executives themselves should be finding ways of publicising the enjoyable and rewarding aspects of their job to the wider profession and looking to the development of colleagues for the future. But, as we are seeing at the entry point to the profession, if nursing isn't attractive, and salary has a large part to play in that, then we won't get the calibre of nurses or of nurse executives that the patient and the profession needs.

Reference

Cautious welcome to extra NHS funding

The Institute of Health Services Management welcomed the Chancellor of the Exchequer's budget pledge to provide an extra £1.6 billion of funding for the National Health Service and was particularly pleased to hear Kenneth Clarke's warm support for the efforts of NHS managers in promotion efficiency and better patient care.

IHSM Director Karen Caines said: 'I hope, however, that when further details of the settlement and the accompanying targets for efficiency savings and management costs are made public, the settlement will be one which supports the progress which the NHS has made towards providing a more efficient service.

In particular the Government needs to appreciate the link between investment in good management and the delivery of efficient, high quality care'.

The IHSM is a membership organisation for UK healthcare managers. It has a membership of around 8,500, and is based at 39 Carlton Street, London NW1 1JD, Tel 0171 388 2626.

Registered nurses are cost effective

National Health Service trusts can increase their effectiveness by boosting the number of registered nurses they employ, says a new report from the Royal College of Nursing.

Caring Costs Revisited, commissioned by the RCN and undertaken by the Institute for Employment Studies and Queen Margaret College Edinburgh, provides convincing evidence that care from registered nurses not only means that patients get better faster, but makes sound economic sense too.

Caring Costs Revisited reviews research from the period mid-1991 to Spring 1995 which evaluates the costs and benefits of employing registered nurses.

It shows that employing registered nurses leads to better quality care, with patients spending less time in hospital and lower mortality rates. Where nurses are given responsibility and independence, there is often less need to employ agency staff, which leads to lower administration costs for the National Health Service.

Key findings in the report include:

- Investment in qualified nurses and nurses with additional qualifications had a pay-back in terms of a higher level of quality care
- Evaluation of pilot studies in South Thames RHA showed high patient satisfaction with the care from nurse practitioners
- When nurse consultants for minor injuries in a GP group practice were introduced, 86 per cent of patients required no contact with their doctor.

The report points out that it can be difficult to get a comprehensive view of research into the benefits of employing registered nurses, as there is a lack of commonly agreed evaluation standards.

The research is often fragmented, and can be difficult to compare.

Christine Hancock, RCN General Secretary, said: 'Improvements to patient care must be the driving force behind change in the NHS, and registered nurses are best placed to deliver this care. These improvements bring their own cost benefits to the NHS.'

'Caring Costs Revisited provides a comprehensive overview of the research which is currently available. What we need now is a clear framework for future nursing research. This would fill gaps in our current knowledge, set common standards, and would make sure that research is available for everyone to draw on.

'There needs to be a clear, national picture of the innovative work which is taking place throughout the UK. We hope that the Department of Health will take the lead in this valuable project.'

The report also includes a survey of executive directors of nursing, which asks how they determine nursing staffing levels.

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