

LAST MONTH in *Nursing Mirror* (January 29) I suggested it was important to establish effective advice for the district nursing officer so that the health authority could be properly informed about its own services in an effective manner. This time, I would like to discuss three principles concerning size of units and their organisation, middle-management positions and the support posts necessary both at district and unit level.

Third principle – Determining size of units

The question that will face almost all district nursing officers at the beginning of reorganisation is "What is the minimum, and maximum, size of a general unit?" It is inevitable that the Nurses and Midwives Whitley Council is likely to link salaries of directors of nursing to unit size with the appropriate higher and lower limits.

Let me first look at the large unit. The health circular (80)8 presents a difficulty here. It states very clearly in paragraph 27 that "in the main, authorities should establish units that are smaller than existing sectors or nursing divisions".

The whole concept of the new organisation is smaller units of administration with more authority delegated to them. I do not see any evidence in nursing that suggests to me that smaller is more beneficial, and that larger is necessarily more incompetent.

Perhaps experience is often the reverse of this. Larger divisions often attract more competent people or, alternatively, they become more competent because of the larger job.

As a principle, size should be determined by what is feasible in terms of receiving professional advice from units and how effectively units can be managed. The terms "managed" and "manager" are confusing terms in that there seems to be so many different interpretations of those words. Are the health ministers saying that only small units will produce good, effective, sensitive management? Where is their model?

In business it seems to me that it is the large organisations that produce both the financial returns required and the necessary good staff management. Size has to do with people and how they are organised. It has to do with effective communication systems. It has to do with clear definitions of delegation of responsibility and authority.

I would suggest that a unit can be large or small and still achieve its basic aims and objectives. What is often forgotten is the potential of people. Create small units everywhere, and even with the most extensive delegation procedure, very able people will become frustrated and bored – or at least work below their true potential.

I would propose that the size of units should be determined on the job to be done, the advice to be received, and reorganised accordingly. I would not see a general unit of 1,400 beds too large, or 300 beds too small.

A question this raises is, what if the client group which has advice to give is



New units for the new NHS (2)

In the second of two articles on the reorganised Health Service, Anthony Carr, Area Nursing Officer for Newcastle-upon-Tyne, looks at unit size, organisation and staffing.

small in terms of clients, patients or beds? There is this great temptation just to parcel everything up together into a larger unit. This may indeed be the answer, but the specialist advice in the form I have mentioned must be retained.

One way to receive advice direct from a small specialist group, which is integrated in a large unit, is to so arrange committees and working groups where the most senior in a particular specialty is the acknowledged spokesman for that specialty. Direct communication and meeting with the district nursing officer could also be encouraged and planned.

Fourth principle – Review of middle-management positions

What might be off-putting to the ministers is what they regard as excessive middle-management grades. Even allowing for them misunderstanding the structures, there may be some truth in what they believe. The answer may be not to reduce the size of the large unit, but rather think much more imaginatively of how grades and numbers should be used.

It is the management courses of the 1960s and early 1970s which suggested limits to the "span of control" – ie, six to eight subordinates – yet forgot what is called the "span of managerial responsibility". This latter definition is much broader in its application and can embrace more people. It means that if the sister/charge nurse post is much more clearly defined, then there is a chance that the work and responsibility of the nursing officer can be enhanced.

I am very attracted to the proposal contained in the *Report on General*

Nursing in Ireland (1980). It is recommended that team nursing should be the normal arrangement in all hospitals. To facilitate this change it is proposed that the head of a 30- to 40-bedded ward called a "nurse administrator" should be supported by two deputy nurse administrators.

The nurse administrator would bridge the two shifts. In turn the deputies would be supported by staff nurses. With this arrangement, more management responsibility could be given to the head of the ward and the role and function of the present nursing officer could be redefined and considerably extended.

Fifth principle – Support services

The support posts required at district and unit level must be decided by those involved in the local situation. If directors of nursing reorganise their middle-management structures effectively, then they may be able to produce staff support posts necessary to give them the sort of support and advice necessary in taking on their new roles.

Service planning and development must be an area for earnest consideration. At present there is a lot of development of the medical and nursing care to the patient that is unnoticed by those in higher authority. The future senior nurse has to have a full intelligence service on any potentially significant change in the delivery of care so that services can be planned, replanned and organised effectively.

In large units this may require a full-time appointment. In smaller ones either a part-time nurse, or the less satisfactory arrangement of sharing a person may be thought necessary. In the personal arrangements delegation of this function to units – which is encouraged in the health circular – may well mean the establishment of nursing personnel positions at unit level.

The question will be asked "Do these posts need to be duplicated at district level?" This will depend upon what departments are retained at the district. A possible danger of the dispersal of all expertise to unit level is that there could be a tendency for each unit to develop its own policies which may, or may not, accord with another unit in the same district.

I would understand that the district nursing officer may well wish to have an adviser on child care. I do show concern for those present authorities, particularly large ones, which believe the community divisional nursing officer can adequately combine these two duties.

In larger districts – and particularly in teaching districts – service planning may well need district co-ordination in terms of a senior nurse. If a major personnel element remains at district level then a nurse may also have a role to play in that department.

What must not happen is for nurses just to stand by and to say nothing, but become furious when the new proposals are not to their liking. Please speak now – or accept the consequences of the decisions made by administrators and doctors □