Anthony Carr

Nursing is a two-sided coin

Anthony Carr, Area Nursing Officer for Newcastle upon Tyne, suggests an entirely new structure for senior nurses in which the clinical and management sides are separated.

MY TASK is to present a possible new structure which would separate clinical supervision from the management of staff which I mentioned last month ("Let 'adaptable' be the key word", *NM*, July 24).

First, it is necessary to identify the highest level of clinical co-ordination which a department or group of wards needs. The question to ask is: "Should wards and/or departments be brought together so nursing policies can be planned and should a senior member of staff be appointed?"

The person appointed should be an expert in the specialty if necessary and should have some direct patient contact. The senior nurse would direct care programmes and prescribe their content.

In a 600-bedded hospital, for example, senior nurses might be appointed to full-time positions in medicine, surgery, psychiatry, and part-time in geriatrics, paediatrics, orthopaedics and gynaecology. A full-time co-ordinator may also be needed to co-ordinate the theatres, accident and emergency and out-patient departments.

The management aspects could be brought together in a different way. One nurse manager could cover surgery, orthopaedics, gynaecology, the accident and emergency department and the theatres.

A second could be responsible for medicine, paediatrics, geriatrics, psychiatry and the out-patient department. A trainee nurse manager would be a helpful addition to this team.

The career structure, designations and salary scales could be:

Grade	Scale	Salary (£)
Ward Sister	0–5	7,000– 9,500
Senior Sister	3–10	8,500–12,000
Unit Director (Nursing)	8–15	11,000–14,500
Area Director (Nursing)	13–20	13,500–17,000
Divisional Director (Nursing)	18–25	16,000–19,500
Director of Nursing	23–30	18,500–22,000

This system would have 31 scales which could be applied to both management and clinical positions. Each grade, except the first, has eight scales and the grades overlap by three scales at each end. The scale which staff would be put on would depend on a number of factors. These might include the number of staff, dependency of patients, throughput of patients, design of ward, number of consultants, input of nursing care required and so on. This overlapping would allow titles to be separated from salary.

The system would allow closer financial integration between grades, and flexibility to differentiate between jobs in the same grade. It would allow, for instance, a divisional director (nursing) of a very large division to be on Scale 25 (£19,500) while the director of nursing (district nursing officer) of a small district would be on Scale 23 (£18,500).

In a 600-bedded hospital, the divisional director (nursing) might have eight senior clinical nurses and two nurse managers reporting to her.

This system would mean the senior nurse would be much nearer to the clinical scene and therefore have a closer understanding of both the developments and difficulties at patient level. The nurse manager's job, on the other hand, would be more difficult to define and even more difficult to put into practice. But if this type of organisation could be made to work, it would mean that two distinct careers would be possible in addition to teaching.

In larger divisions, the area director position could be used in management and clinical positions. In a 1,000-bedded hospital, for instance, it would be difficult to have 20 or more staff reporting to the divisional director. Some of the clinical and/or management unit directors and senior sisters could report to an area director who would be the co-ordinator. Some unit directors could report direct to the divisional director.

The area director (nursing) with clinical responsibility would have to have daily clinical sessions or undertake research at district level.

I have given the title "Director of Nursing" to the district nursing officer. It is a more appropriate title. The director's staff, apart from divisional directors in charge of service, would be other divisional, area, unit directors and senior sisters. These posts could incorporate planning, personnel, research, child health and so on.

The system I have proposed would allow nurses to continue in clinical nursing up to Scale 20. Exceptionally, a district health authority might promote a clinical nurse to divisional director (nursing) (Scale 18–25) if it could prove a need for such a post, particularly in a clinical research situation. The attraction to the clinical nurse would be that Scale 20 is two-thirds to the top of the system (66 per cent), while most clinical posts now stop at nursing officer level, which is only about 39 per cent of an area nursing officer's salary.

Nursing management, on the other hand, would be a good choice for those who enjoy managing people and systems.

The professional may well reject this system, but if this is rejected, what will we put in its place? □