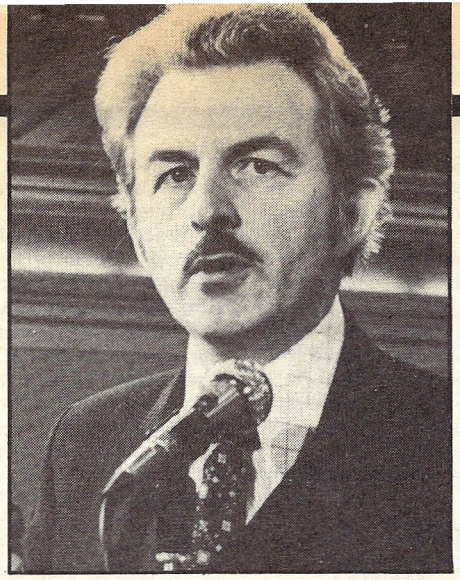
Anthony Carr



Let 'adaptable' be the key word

Anthony Carr, Area Nursing Officer for Newcastle upon Tyne, looks at opportunities offered by NHS changes for making sure the nursing structure is right.

HAND IN HAND with the new reorganisation of the NHS and the passage of the supporting Bill through Parliament, are the equally important proposals yet to be announced on the actual management structures for the various professional and administrative groups employed in the delivery of care and its support services. I would like to gather up the various ideas mentioned recently, and put them together in some sort of order.

Perhaps a look back would be helpful to see how the nursing services could be reorganised if that was seen to be necessary. Anyone who trained in the 1950s and 1960s can remember the matron-type of structure – one senior nurse controlling a 500- to 800-bedded hospital and perhaps up to 70 senior sisters reporting directly to that one person. There is a rather wistful hint about this type of approach in the *Patients First* document.

In the early days of the old structure, nurses worked a 48-hour week with one day off-duty in the week. Patients, even for a hernia operation, stayed three to four weeks – two of those weeks on their backs in bed. A matron going round daily saw the 20 or so new patients admitted the previous day.

How lovely to go back to those days. They are, however, gone for ever. Now, the ward sister of an acute ward, having had two days off, can come back to her ward where one-third or more of her patients are new. To illustrate this more dramatically, a busy, acute hospital a few weeks ago had to limit admissions because of staffing difficulties. It was revealed that 130 admissions would have to be postponed the next day, which was nearly 20 per cent of the total in-patient population!

How, then, can a reorganisation of the health services suggest taking steps backward, when the whole scene has changed forward? Not only has medical treatment and supporting technology changed, but so also has nursing education and the nursing approach to caring for patients. Senior nurses should, and are, looking ahead to the future and I hope that, given this golden opportunity for change, it will be grasped eagerly.

The vogue word used in the content of new structures is "flexibility". I would rather use the word "adaptable". The former word implies being "easily bent"; "pliant"; or "docile". Adaptable means "to make fit", or "suitable" – it indicates a process of change in which there is control by the one being adaptable.

A first step could be to reconsider the structure of nursing, from ward sister upwards. To help in this re-evaluation I would propose a series of at least 30 salary scales. At present rates the lowest grade could be, say, £7,000, moving upwards in £500 steps to £22,000. Under this arrangement there would be no salary increments, just one rate for the job. I do not believe a person is necessarily higher skilled and performing better at the end of a six-year period than in the first year. Motivation and performance have more to do with the working environment, relationships and good management policies.

One approach to this review – which presents certain attractions to some – is to identify at the various levels in the nursing organisation (and separately) clinical and management responsibility; look at the work to be done at the bedside of the patient before deciding on who should do it.

As an illustration of this, take two different types of units – a neurological unit of 120 beds, and a haemophilia unit of four beds. It may be that the larger unit needs eight sisters for night and day cover and a higher grade nurse to co-ordinate essentially the clinical teaching, practical nursing aspects of caring for the patients.

The smaller unit may only require one sister. Perhaps the hardest question of all to answer is whether there is a need for co-ordination of clinical nursing at a higher level than indicated here. Even if the answer is yes or no, the next question is, should those clinically identified staff carry the added responsibility for the more essentially management-orientated tasks?

There are both advantages and disadvantages in separating these functions. By separating them, there is a clear acknowledgment that clinical nursing and management of staff resources are different jobs and separate distinct functions. This is where the debate should, in my opinion, be focused. I am not sure if they are separate or collective. That is why I would ask for each new district health authority to be allowed maximum authority to be adaptable and to experiment. This approach may be unacceptable to trades unions for negotiation reasons, but the idea of creating structures sensitive to the needs of patients and staff is a very attractive proposition.

Let us assume that adaptable structures are allowed. How would an organisation look if it separated these two major functions? Taking the illustrations given previously, the various heads of clinical service could report to the senior nurse designated to have overall responsibility for a medium-sized hospital or to a co-ordinator of clinical services reporting to the senior nurse of a larger hospital. The management tasks would have to be defined clearly and staff at various levels appointed.

The levels may be different in clinical practice to the management responsibility, so the nurse administrator may have management co-ordination responsibility for both units I have mentioned. Having appointed a co-ordinating manager who has authority over all staff in a management role, does she have another level of control, or is the reporting to the senior nurse who is appointed to have overall responsibility? In a larger hospital it may be important to have at least one senior who has overall management co-ordination responsibility.

The result of this structure is that there would be two parallel structures working closely with each other but having different, clearly defined responsibilities. They would meet formally at the top of a nursing divisional structure, but in a large hospital have their own separate co-ordinators immediately below that level. There are, of course, disadvantages, but some of the advantages may be worth looking at, the major one being that clinical nursing could continue up to a level immediately below the most senior nurse.

It may be appropriate in that type of organisation to give nursing education autonomy, because a strong clinical structure would ensure close co-operation between the delivery of care nurses and those with a prime responsibility for nursing education □