A look at the future

How will management at unit level change for nurses? ANTHONY CARR looks at this difficult subject and puts forward his ideas for improvement to the existing management structure.

IT IS human nature to read into documents one's own aspirations and interpretations, which may never have been intended by the authors. By now I suppose we have all transferred our thinking from the "Grey Book" of 1972 to *Health Circular* (80)8 of 1980.

In that circular, paragraph 27 reads: "Authorities should arrange their services into 'units of management'." This is repeated in paragraph 29: "To achieve maximum delegation to 'units of management' there is a need . . .". From the statement 'units of management' has come the concept of unit management teams or hospital management teams.

A recent article, by four administrators in the *Hospital and Health Service Review,* said that in institutional management co-ordination reigns supreme; while I see it, and perhaps many here will, in much wider terms.

Misunderstanding

There is a major assumption, I believe, within the professions that "units of management" is synonymous with "unit management teams". I consider this to be a misunderstanding of considerable proportions. I will admit to reading in the circular about individual or collective responsibility. The word "responsible" or "responsibility" occurs 19 times but "collective responsibility" is only mentioned in relation to health authorities and district management teams, never at unit level. My interpretation of responsibility is "liable to be called into account as being in charge or control; deserving the blame or credit for; answerable".

Perhaps if I turn to another management term it may help clarify my views. "Account", "accountable", or "accountability" is mentioned five times. A definition of accountability is "to give reason or explanation, to answer as one responsible". Perhaps the writers of the circular assume we all know that if a person is made responsible for something, he must account for that something.

Nowhere, however, does the word "authority" appear as relating to individuals, apart from using that word in the title of health authorities. That, to my mind, is a pity, because if I knew what authority a person in a particular post could be given, I could more easily plan a system of management responsibility, both individually and collectively.

My critics would respond and say that this is what reorganisation is about: local decisions on local management structures. My response is, it would have given me some confidence that those drafting the circular really understood the workings of the NHS at local level. As it is, a query remains in my mind. I will return to the subject of "teams" later.

How different it is in the textbook of all textbooks, the Bible. Not only do we have firm hierarchies as in Exodus, chapter 18, so that everyone knows where they are, but in the New Testament we read of authority being given to individuals. Jesus said on one occasion: "All power is given unto me, go you therefore." This shows what delegation of authority can do. The result of that statement turned the world up-side-down and right-side-up.

A successful manager keeps in touch with the ward.

Perhaps the government was too apprehensive about such radical change.

Responsibility can be delegated to a low level in the organisation, but if authority is not co-equal and retained at district level, frustration is the only change reorganisation will bring.

Let us concentrate on one member at "unit" level who is mentioned in the circular: the director of nursing services. To create the new "units", or "divisions of management" as I would prefer to call them, certain principles should be agreed.

First, three major principles in organising or reorganising nursing services and at the same time preserving a balance between them. They are:

- the effective delivery of nursing care to patients;
- providing adequate education and training facilities;
- promoting study and research into the nursing care of patients and its organisation.

Using these principles, the midwifery services need to combine hospital, community and midwifery education. There may be rare exceptions, but in general the delivery of care is more consistent, education and training more easily organised, and subsequent studies and proposed developments can be analysed accordingly.

This proposal does not easily fit into many administrators' ideas of organisation. The circular admits this in paragraph 28(d). This is not a

criticism of administrators. Their job is essentially of administrative co-ordination at district and unit level and provision of support services, while nursing and medicine is treating and caring for patients.

Mental illness and mental handicap services also seem to lend themselves to these objectives. The emphasis in these two specialties is also away from institutional care.

Community services seem a natural service to bring together: that is the district nursing, health visiting and school nursing services and their medical counterparts. To amalgamate this service with hospitals is almost like saying the expertise found in the community, is not sufficient to stand as a high level input to the planning mechanisms in its own right.

There may be some successful combinations of institutional and community services, but I personally have not seen one. One element that may be missing in combined units is the close liaison with social services and education.

A fourth principle emerges then. Where there is a definable community element, try to structure "units" in terms of patient-client care groups rather than institutions.

Of course, there are obvious institutional structures which require management divisions. The large hospital is an example. But one or two small geriatric hospitals may be just as easily managed in a community setting as by being attached to large hospitals.

A fifth principle relates to the advice required by the nurse at district level. To my mind, it is important for the chief nurse to receive advice at a high level of expertise on all the major care groups existing in the district.

If any of that nursing advice is filtered by a third party first (for example, a general nurse trying to interpret the needs of midwifery) the quality of that advice may always be held to be suspect.

Size of units

A surprising statement in the reorganisation circular is: "In the main, authorities should establish units that are smaller than existing sectors and nursing divisions . . ." (paragraph 28).

Is the sixth principle then "smaller is beautiful", irrespective of the situation? The experience of many officers over the past six years has been that adjustments have been made in areas of responsibility. In many cases, an optimum size has emerged already. Surely the last thing anyone wishes to see is artificial divisions created to fulfil some vague philosophy.

Units should be established on the basis that patients have to be cared for in the most effective way to promote their care and discharge.

I think this sixth principle is a better one than "small is beautiful". It should not be about power struggles between administrator, nurse or doctor. It should be primarily about assisting people who need professional help, advice and skilled care, to maintain or restore a measure of positive health.

Let me return to the "team" problem. A great deal of the understanding of teams comes from paragraph 27. It indicates that the unit administrator and director of nursing services discharges an individual authority in conjunction with a senior member of the medical staff. How does this affect the relationship of the respective senior officers at district level? I believe that once individual responsibilities are shared, responsibility becomes blurred.

Co-ordination also looms large in this debate. As I see the unit administrator's position, he or she will be or should be managing catering, domestic services, medical records, personnel, and possibly works services. If he or she is not managing, but only co-ordinating, who is to manage? that is, set objectives and evaluate results. The likelihood of a high level of service being received at ward level will inevitably be poor if these areas are not sorted out now.

Matters that require collective views range from patients' visiting times to proposed developments of new clinical departments. These discussions and views are going to be easier to conclude for single units, such as mental illness, than two general hospital units in the same district.

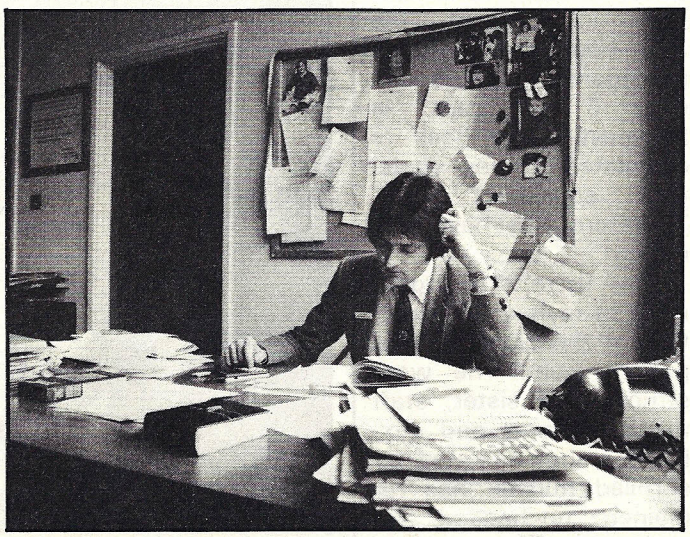
Interaction

The first question in the latter situation is, how do one hospital's proposals affect the other's services? Should those two or even three hospital units in a large district not make joint decisions? Or perhaps the district should undertake that task, but that is not what reorganisation is about, is it?

Delegation of responsibility to units will also include decisions such as who attends what conference.

It may be much more effective to agree a budget for each senior manager and let him or her make the decisions. What I want from reorganisation is someone who has the management authority to make decisions so that linen is at the bedside seven days a week, the food is appetising and delivered on time, and so on. I need a manager for that, not just a co-ordinator. Yet the word "manage" is rarely used in the circular at unit level. Apart from "management accountability", paragraph 27, it is a banned word.

The other drawback of viable formal unit teams is that the unit administrator and director of nursing ser-



Form-filling is part of a nurse manager's job.

vices have senior officers to report to – and the senior medical member a committee to report back to. These constraints should be considered seriously.

Apart from these proposals, perhaps what the district management team should be looking for from units is collective views and proposals, not concerted management action already taken.

There is much collective work to be done at unit level. If the work of the existing divisional nursing officers is compared with the new directors of nursing services, what differences emerge? This will depend on what services are delegated to units.

If all personnel services are to be devolved to units, then workable policies have to be formulated conforming to district policy. If the works' organisation is essentially at unit level, much more collective discussion will have to take place.

The evaluation of all services operated at unit level will need to be undertaken by the director of nursing services and unit administrator with the presence of a senior medical member. Regular reviews will be made of the unit's budgets and spending and of developing new services and revitalising others.

Effects on the new person at unit level will result in more work in group situations and analysis of services across the unit. How this will match with the individual responsibilities of accountable officers I do not know. Already the existing divisional nursing officer has a right to monitor all those services that are offered at ward level, such as catering, domestic and linen services. Whether she does so is a different matter.

Differing views of what a satisfactory service is could be challenged in this new world of "units".

While an administrator may be very pleased that the laundry services performed first class for 49 weekends last year, the nurse judges the performance of the service on three weekends when some patients had no sheets or bottoms to their pyjamas. Administrators may find this unfair, but nurses judge the service from the patients' point of view. However, in most areas individual officers are accountable to a more senior officer. A most effective mechanism, I believe, for no change.

If a nurse spends less time managing her service, what happens to that service? Remember the director will be able to use her budget on nurses of her choice. No longer can the response to a request for more nurses on the intensive care unit be "the district will not give the money".

Management costs reductions will give her fewer subordinates to do different work. Those who are to be involved in the management costs exercise, should remember that in nursing the 37½-hour week reduced management hours by over 6 per cent. In Newcastle, the loss is calculated at three whole-time equivalent staff. Therefore, we have had our cut.

Now there is an urgent need to review the structure of the ward team at patient level. The ward structure of sister, staff nurse, learners and auxiliaries, supplemented by enrolled nurses, has remained unchanged for many years □