employer in the country but also provides hotel accommodation for a clientele not noted for its fitness. Engineering staff with the right knowledge and skills are in short supply within the NHS, a point which was emphasised during the inquiry into the Stafford outbreak.² The sheer number of hospital buildings (more than 2000 in England and Wales), each with its own water storage and heating systems, also raises questions on the adequacy of staffing levels. A DHSS code of practice to be issued later this year will make recommendations concerning the maintenance and operation of hot and cold water systems. In the interim NHS management and engineering staff should give the memorandum from the building service engineer careful consideration and follow the principles outlined—and so should the BBC and others responsible for public buildings.

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Nurses make the grade

The nurses' review body must be congratulated for this year's review—not only for recommending sensible pay rises that might help to recruit and retain nurses but also for wheedling the long promised clinical grading review out of the Nursing and Midwifery Staffs Negotiating Council.¹ Such a review was never going to be easy: the current grading structure for nurses, midwives, and health visitors is as old as the National Health Service. Despite past reviews and recommendations it has changed little. Why should it now?

The simple answer is because nursing has changed. With increased specialisation nurses have needed to acquire further skills and qualifications, which have gone unrewarded. Few nurses now regard what they do as a vocation; most come into nursing expecting a career, comparable with other careers. There have been no financial incentives to keep nurses at the bedside—to progress they have had to move into management or teaching.

The new grading structure is meant to remedy this: to keep nurses at the bedside by providing "a sensible career

progression for clinical staff and a proper recognition of the qualifications, skills, and wider responsibilities of those who progress to higher grades now or in the future."

Grades between nursing auxiliaries and senior nurse 7 will be affected by the new changes. Staff in these grades will be allocated to one of nine new levels: auxiliaries to A or B; state enrolled nurses to C or D; state registered nurses to D or E; sisters to F, G, or H; and senior nurses to F, G, H, or I. Each level will contain from five to seven annual salary increments.

The level to which nurses from a particular existing grade will be allocated will depend on their qualifications, responsibilities, and skills. Incentives will be provided within the grades by paying those on the higher levels about 13-30% more than those on the lower levels. Encouragement to remain in direct patient care will be given by increasing the maximum salary of sisters from £12 000 to £15 350, which means that some will be paid more than some of those in teaching or administration.

The problems posed by implementation have probably been exaggerated. The new grading structure was proposed by a joint submission of management and staff on the negotiating council, which presupposes some agreement. Their only major disagreement is over the starting level for midwives, with the management arguing that it should be the same as that for staff nurses. As midwives have usually completed an 18 month course to become midwives in addition to their training to become staff nurses, and as the philosophy underpinning this grading review is to reward further qualifications, then management should surely abandon its niggardly position.

Few problems should attend the classification of auxiliaries, state enrolled nurses, and state registered nurses (who comprise three quarters of those covered by the review). Each grade has to be allocated to one of only two levels and how to do this is clearly explained in the pay review body's report. The Department of Health and Social Security will soon be providing health authorities (which will have to allocate staff to the new levels) with more detailed advice.

The review body wants the regrading completed by 31 October and warns that prolonged uncertainty would damage morale. Whether the DHSS, whose most recent detailed figures on nursing manpower date from 30 September 1986, can coordinate the regrading of 400 000 nurses in less than six months remains to be seen. (At least the exercise will provide it with up to date figures.) Publishing the figures by which the new grading structure has increased the pay bill (say region by region) will reassure those who worry that health authorities will seek to limit expenditure by downgrading their staff.

With the salary and clinical career structure settled, education is next on nursing's agenda. The government has before it Project 2000, prepared by the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting. Its main proposals are for a new division of nursing labour, a new pattern of preparation, and an enhanced educational standard—making registration in nursing of equal standard to other advanced educational qualifications. If the government accepts the UKCC's recommendations as it has those of the pay review body then much will have been done to reduce the damaging division that has opened up between it and the nurses.

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¹ Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine. *Fifth report on nursing staff, midwives and health visitors 1988*. London: HMSO, 1988.