



Royal College
of Nursing

Breaking down barriers, driving up standards

The role of the ward sister and charge nurse





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The role of the ward sister and charge nurse

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Foreword

Ward sisters and charge nurses have many roles, but their responsibility is clear – to oversee patient care on a ward.

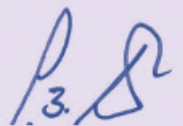
This report looks at how the role is working across different types of hospital trusts in England, including mental health, children and adult wards. The importance of the ward sister role applies universally, and where the role is supervisory, patient care benefits.

The ward sisters who participated in this research are nurse leaders who have to be expert clinical practitioners, the hub of information going between all health care staff, the ward leader, the educator for students and newly qualified staff, and the manager filling in paper work and recruiting staff. Too often, the leadership role has suffered.

Featured in this report are examples that demonstrate what can be achieved where ward sisters are able to supervise shifts, and oversee all aspects of care on a ward, from cleanliness to allocation of staff.

To do this they need to have the resources to develop their skills, the will of their managers to institute a supervisory role, and the rewards to convince talented nurses to take the route of becoming a ward sister. That way, talented nurses can benefit more patients than those they treat directly.

All ward sisters must have the authority and the resources to make their wards run as well as they possibly can. This report outlines the best ways to make this happen and the conclusions and recommendations are drawn from the people who make quality care happen, day in and day out. It has been so rewarding to see the support and collaboration of so many of the Royal Colleges, whose participation and support in the future will be essential to our success.



Dr Peter Carter OBE

Chief Executive & General Secretary

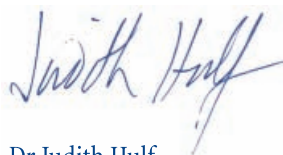
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Supporting statement

Nursing leadership at ward level provided by a sister or charge nurse is vital to the delivery of safe high-quality care to patients. Every ward sister should have the capacity, time, resources and the authority to co-ordinate and deliver patient care in partnership with the rest of the health care team as well as patients and their families. This must be a top priority and the role of ward sister needs to be reviewed urgently.

We are delighted by this Royal College of Nursing initiative to clarify and strengthen this important role so that the quality of care experienced by patients is second to none.

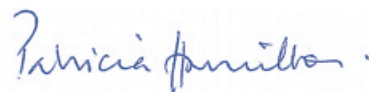
We look forward to working with the RCN on this important issue.



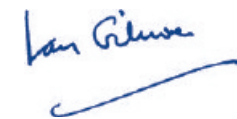
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1

Executive summary

Lord Darzi's NHS Next stage review report, *High quality care for all* (Department of Health, 2008a), heralded a significant change for the NHS in England because it has made the quality of care a central organising principle alongside access, volume and cost of health care. This review defined three dimensions of health care quality as:

1. patient safety
2. effectiveness of health care interventions
3. patient experience.

Subsequent communications from the NHS Chief Executive, David Nicholson, to NHS health care trusts and strategic health authorities have stressed the rapid pace at which the Government expects these dimensions of quality to become core to commissioning and providing NHS services. Some legislative and practical steps are already being put in place to ensure this happens quickly:

- the development of measures or 'metrics' of health care quality so that the performance of NHS trusts can be benchmarked and compared in order to drive forward quality standards
- legislation in early 2009 that will make 'quality accounts' of performance by NHS trusts in care quality mandatory, and open to public and patient scrutiny
- establishment of a national quality board to oversee implementation of policies that embed quality into the NHS.

There is no doubt the Government is very serious about a quality agenda for health services. This agenda will be absolutely essential to the business of every NHS trust and immensely important to them in terms of performance rating, reputation and contestability, and their credibility with patients and the public. Nursing is core to this as it has a demonstrable impact on standards of health care quality. The Chief Nursing Officer for England, Dame Christine Beasley, recently published *Framing the nursing and midwifery contribution: driving up the quality of care* (Department of Health, 2008b), which draws together key

areas of work that will strengthen the nursing contribution. These are:

- the development of measures that identify, quantify and make visible the impact of the nursing workforce on care quality outcomes, beginning with the publication of an evidence base *State of the art metrics for nursing: a rapid appraisal* (National Nursing Research Unit, 2008a)
- a reaffirmation of the responsibility of nurses for care quality with the publication of *Nurses in society: starting the debate* (National Nursing Research Unit, 2008b)
- the development of a framework of clear roles and responsibilities that make accountability for the quality of care from the point of care to the NHS trust executive boardroom explicit ('from ward to board')
- a strengthening of nurse leadership for care quality performance.

As the UK professional organisation for nursing, the Royal College of Nursing (RCN) has a clear mandate for promoting and supporting high-quality standards of nursing care. The RCN is therefore fully engaged with the Department of Health in this work and has chosen to focus particularly on the contemporary role of the ward sister and charge nurse[†] because this role is known to be key. This is because it is:

- the front line management role of the largest group of NHS staff
- the interface between health care management and actual clinical care delivery
- unique in that it combines responsibility for the daily delivery of care and the physical environment in which care is delivered, with managerial responsibility of those who deliver the care (the nursing team) and responsibility for those who receive that care (the patients).

The ward sister role is therefore ideally situated in the hospital system because it is at the centre of the patient experience and can oversee and co-ordinate the different dimensions of service provision to patients.

There is also extensive research evidence that links the impact of the ward sister role to standards of patient care. For example, research by the Hay Group (2006) found correlations between effective ward sister leadership, patient outcomes, and staff performance, such as:

[†]The term 'ward sister' is used hereafter for brevity; it is not meant to imply that the ward leader role is exclusively female or that 'ward sister' is the only suitable title.

- lower rates of medication errors
- higher levels of patient satisfaction
- lower ward staff absence and sickness rates.

Because of the importance of the ward sister role for the delivery of the new NHS quality agenda, the RCN undertook an investigation of its contemporary situation and context, including the experiences of modern day ward sisters, in order to ensure the role has remained fit for purpose. This RCN report details that investigation, findings and recommended actions to strengthen the ward sister role for the delivery of quality patient care.

The RCN investigation took place in the six months between July and December 2008 and was based on the following:

- a literature review of the research and history of the ward sister role
- reanalysis of RCN annual employment surveys undertaken in 2002 and 2007
- focus groups of ward sisters from different types of hospital trusts across England (foundation trusts, district general hospitals, hospitals with tertiary specialities), drawn from mental health, children and adult ward settings. Approximately 90 ward sisters took part.

The findings and preliminary conclusions from the focus groups were subsequently discussed and validated with two further groups of ward sisters, and seven nurse directors, none of whom had been involved in the focus group discussions.

Our findings show a range of issues for ward sisters, on which there was strong consensus and agreement. There was absolute agreement for example that the ward sister role remains fundamental to the organisation and delivery of hospital nursing and to the standards of nursing care on each hospital ward. However, a range of issues were raised about the current organisational, professional and employment context of the contemporary ward sister role and its future and place within the nursing profession. The key headlines from this were:

- the huge breadth of the ward sister role, which encompasses leadership and management, clinical practice, and education and teaching
- the absence of agreed role definitions and clarity about role aims, purpose and functions
- role conflict – ward sisters constantly balance the different aspects of their role

- lack of formal preparation and skills development for the role and lack of support and skills development for ward sisters in post, even though the role requires a significant breadth and depth of knowledge and skills
- theoretical responsibility of the role for key issues that underpin nursing standards, but in reality a lack of authority to assure them (for example, for ward cleanliness and nutrition).

The above issues are reflected in both academic and popular literature that spans at least the last 50 years. This suggests that the nursing profession must take some clear and firm decisions to shape, support and strengthen the role of the ward sister since it is vital, now and for the future policy agenda and patient care. Ward sisters highlighted the urgency of this action as current pressures and competing priorities have rendered their role almost impossible resulting in excessive workloads and extra unpaid hours worked every week.

Some pressures are relatively recent and stem from whole system issues within modern day hospitals which require rapid patient turnover and patient throughput, and high levels of bed occupancy. These have resulted in high levels of patient acuity – that is, most patients on the ward will be acutely unwell. Taken together these issues add up to increased demands on nursing time.

Another modern day pressure has been changes to the organisation of medical education which have meant junior doctors are no longer attached to consultant firms and wards. This has resulted in a clinical ward team that is less well defined and less stable. These combined factors have made it more difficult for ward sisters to maintain their leadership role for clinical care quality, to supervise and organise patient care, especially continuity of that care.

But the most significant finding from the RCN investigation was the pressure placed on ward sisters from looking after and nursing a group of allocated patients on every working shift, in addition to their ward leader responsibilities. This has made it impossible for them to appropriately lead, manage and *supervise* clinical practice and the ward environment. This is not acceptable to the RCN and needs to be swiftly remedied. Ward sisters must become supervisory to shifts so that they are enabled to oversee standards of care delivery and the ward environment and become visible to patients, ward staff, doctors and other ward visitors as the ward nurse leader and the person in charge of the ward. This will allow them to set appropriate standards, know their patients and their health care needs, teach clinical practice and procedures, and be a role model for good professional practice and behaviours.

Another effect of modern pressures on the ward sister role has been their low morale. Some ward sisters said they were demoralised because they did not feel valued by their NHS trusts. Others described their frustrations in trying to achieve simultaneous high-quality standards in a wide range of areas – such as, ward hygiene practices, clinical care or teaching – coupled with a lack of time, a lack of authority and inappropriate ward staffing levels to achieve this.

Lack of clarity about the ward sister role and purpose has exacerbated this and means ward sisters find it difficult to delineate their role and control the demands and pressure on it. This is compounded by the varying expectations of different stakeholders, such as patients, doctors and health care managers, of the ward sister role.

Management is one of the key areas of role conflict and pressure in the above. Ward sisters viewed their management work as *one* component of their role alongside clinical expertise, leadership and teaching, but perceived health care managers to view them *primarily* as managers of staff and ward resources. Motivation was an issue that underpinned this, for ward sisters were motivated to manage their ward and ward team by a passion for *nursing* rather than an aspiration or desire to be ‘a manager’ *per se*.

This view was reflected in their unanimous rejection of the title ‘ward manager’. All ward sisters who took part in the focus groups wanted a title that identified them as the lead nurse in charge of the ward.

Another area of conflict related to the *authority* of the ward sister role to actually manage the ward and ward staff. In theory, ward sisters hold responsibility for the management of the ward and ward staff, yet many said they did not actually have the adequate authority to effectively carry that out. So, in effect, they were being held responsible for ward management issues that they could not control, because the responsibility had not been fully devolved to them and they still needed the signature and agreement of line managers for even small-scale decisions or change. Even for very minor matters such as ordering batteries for ward electrical equipment for example.

The absence of support roles and support functions for the ward sister role was highlighted as a further related issue. This was about capacity and support roles such as clerical and housekeeping support, but extended to support functions for issues such as clinical governance and data management. The support function of the human resources (HR) departments was a particular issue for many ward sisters, as they managed ward teams of an average of thirty ward staff. They said they were often unsupported when managing complex performance

issues, such as sickness absence policies and disciplinary procedures, but also even recruitment processes from writing job descriptions, placing advertisements, through to the selection process. Ward sisters viewed such work as poor use of their time and skills, since others with a more appropriate qualification could undertake this. They also perceived the lack of non-clinical support and the expectation that they would absorb such work as an indication that their role was not valued.

Pay and salary, which is one expression of how much a role is valued, was an area of considerable disgruntlement. The RCN was surprised and concerned to find that some ward sisters appeared to be inappropriately banded and paid at Agenda for Change (AfC) band 6 instead of the minimum AfC band 7 that correlates to the ward sister profile. However, we are not certain how widespread inappropriate banding of ward sisters is and will be investigating this further. A related area of concern for many participants was that their take home pay had actually decreased on their appointment to a ward sister post since some no longer worked ‘unsocial hours’ and therefore earned less than they had previously as staff nurses.

Focus group discussions also touched on nursing career pathways for ward sisters. This revealed that many felt trapped in their role because they did not want to progress down a managerial or nurse specialist career pathway yet felt there were no other options or opportunities that would allow them to be ward based yet develop their skills and improve their salary. Some resentful comparisons were made between their role and that of clinical nurse specialists at bands 7 and above. It was felt that specialist posts attracted similar or better salaries but with better working hours and conditions, and a lot less responsibility. Some suggested the ward sister role was no longer seen as attractive by many staff nurses, because they could achieve the same pay and a perceived higher status by becoming a nurse specialist. Implicit within this was a feeling that specialist posts were valued more by NHS trusts but also more by the nursing profession itself. The conclusion was that ways needed to be found to reward and value the role of the ward sister with commensurate professional status so that nursing excellence can be recruited, retained and developed at ward level.

The RCN believes the findings of our investigation strongly suggest work urgently needs to happen in several areas in order to strengthen and support the ward sister role for the delivery of high-quality nursing and the new health policy agenda. This will be important for nursing, for patients, and for NHS trusts that will be judged on the

quality of care they provide. The RCN has therefore put together a set of recommended actions (for England only) to this end. These aim to gain **recognition and acknowledgement** of the value and impact of the ward sister role for high-quality care, and put in place the necessary measures to **strengthen and support** the ward sister role for care quality. Our recommended actions are for a variety of stakeholders to take forward including the executive board teams of NHS trusts, government health policy advisers, nurse leaders, nursing organisations and ward sisters themselves. The RCN will develop an action plan to support and monitor implementation of these.

The value of the ward sister role

- The RCN will support nurse directors to promote discussion and a strategy to recognise the importance of the ward sister role for high-quality care in every NHS trust.
- The RCN will compile a short fact sheet of high-quality research regarding the importance of the ward sister role for ward standards of patient care.
- The RCN expects all ward sisters who match the ward sister profile to receive the minimum AfC band 7 salary.

Strengthening the ward sister role for care quality

- The RCN recommends that all ward sisters become supervisory to shifts so that ward sisters can: fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; role model good professional practice and behaviours; oversee the ward environment; assume high visibility as the nurse leader of the ward.
- The RCN therefore recommends ward sisters and charge nurses assume a title that conveys a clear identity as the nurse leader of the ward.
- Nurse directors need to review the remit of ward sisters in each NHS trust to ensure they have the appropriate authority for key issues that underpin care quality – such as ward cleanliness and nutrition – and the appropriate administrative, housekeeping, and HR support to enable them to manage the ward team and ward environment.
- The RCN will host a joint summit with the Chief Nursing Officer for England of key stakeholders to clarify and agree the purpose and key functions of the ward sister role; the skills, competencies and

knowledge needed to fulfil this role; the requirements for education and skills support to achieve these; career pathways for ward sisters.

- The RCN will host joint events with the Chief Nursing Officer team for England in every strategic health authority to enable ward sisters and matrons to discuss the policy and professional context for care quality, the measures that can be used to improve it, and receive feed back on how to develop this further.
- The RCN will work with the Chief Nursing Officer for England to develop frameworks for care accountability that can support messages on care quality from ‘ward to board’.

2

Introduction

“The ward sister remains the key nurse in negotiating the care of the patient because she is the only person in the nursing structure who actually and symbolically represents continuity of care to the patient. She is also the only nurse who has direct managerial responsibilities for both patients and nurses. It is this combination of continuity in a patient area together with direct authority in relation to patients and nurses which makes the role unique and so important in nursing.”

(Susan Pembrey, 1980)

The above quotation conveys the very essence of why the ward sister role is so important for nursing, for patients and for health care. For ward sisters are the front line managers of the largest group of staff in the NHS, and the interface between health care management and actual clinical care delivery. The role combines managerial responsibility for the daily delivery of care with managerial responsibility of those who deliver that care, as well as responsibility for the patients who receive care. The ward sister role is therefore uniquely placed in the hospital system because it is, quite literally, at the centre of, and able to oversee, these different dimensions of service provision.

However, this statement is neither new nor a revelation. The importance of the ward sister role has been known for years. Its impact has also been demonstrated in numerous research studies. For example, in the 1980s the RCN published the following research studies:

- Pembrey (1980) – regarding the impact of the management style of ward sisters
- Redfern (1981) – on the different components of the ward sister role and role conflict
- Ogier (1982) – about the impact of ward sisters on student nurse learning and education
- Stapleton (1983) – on the educational needs of ward sisters.

The RCN subsequently led an action research study in the 1990s to identify the key factors for high standards of hospital ward nursing care. This study confirmed the role and leadership of the ward sister as absolutely fundamental (Cunningham and Kitson, 2000). As a consequence, the RCN developed a Clinical Leadership Programme (see appendix 1) which focuses on effective leadership development and support for the ward sister level of nursing.

However, the role of the ward sister has not, of late, received the same level of professional attention. Recent focus has been more on the contribution of new roles in nursing, such as clinical nurse specialists and matrons, and on the contribution of advanced nursing practice to patient care. These nursing roles are both valid and necessary for contemporary nursing practice, but the time is right for the RCN to revisit the ward sister role once more and take stock.

Lord Darzi’s NHS Next Stage Review report, *High quality care for all* (Department of Health, 2008a), was a further impetus to this report because it has made care quality a central organising principle of the NHS in England alongside access, volume and cost of health care. This review defined three dimensions of health care quality as:

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immensely important to them in terms of performance rating, reputation and contestability, and their credibility with patients and the public.

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3

A short history of the ward sister role

Central to nursing

A review of the literature from 1947 onwards provides a fascinating portrait and history of the ward sister role and highlights consistent themes, issues and tensions over the past 50 plus years. One consistent theme is the central importance of the ward sister role for quality standards of nursing and patient care. This is reflected in a range of different types of literature, from opinion to government reports. For example:

- In 1972, the Briggs report (Department of Health and Social Security, 1977) singled out the ward sister role for particular mention: “The key figure in the ward team is, and will continue to be, the ward sister”.
- Twenty years later, in 1992, a report by the Audit Commission (1992) stressed: “The ward sister holds the key to the ward: her management style determines the ethos and the direction of the ward and its response to change”.
- Sixteen years on, in 2008, Minister of Health, Ann Keen, stated: “The key to patient care is the nurse in charge of that ward” (Harrison, 2008).

The research literature confirms the centrality of the ward sister role to quality patient care. It has two main strands:

1. **Leadership factors:** these relate to leadership style and qualities and their influence on the nursing team ethos, work culture, work behaviour and subsequent impacts on ward standards of care. A synopsis of this research is set out in Appendix 2.
2. **Structure and process factors:** these are factors that affect the functions, authority and span of control of the ward sister role, and their impact on delivery of quality nursing and patient care. Pertinent research studies within this theme are referenced throughout the text that follows.

What is the ward sister role?

The literature suggests there are three key components of the ward sister role:

1. clinical nursing expert
2. manager and leader of the ward staff team and the ward environment
3. educator (of nursing and nurses, other health care professionals, patients and carers).

The broad scope of this role has led to some issues and challenges and the literature from the past 50 plus years makes frequent reference to role conflict and role pressures. For example:

- Goddard, as far back as 1953, notes the tension within the ward sister role for being a hands-on nurse and clinical expert whilst also a leader and manager of nurses and the care environment
- this is echoed in Redfern’s 1981 study of 134 ward sisters, which found 75 per cent were experiencing moderate to high levels of role conflict and job-related stress
- fourteen years later, a study by Bowles (1995) reported role conflict related to a contrast in the perceptions of the ward sister role: doctors perceived it primarily as a clinical expert and clinical leader role, while health care managers perceived it primarily as a staff management role.

There have also been shifts in emphasis for the role at different points in time. For example, more emphasis has recently been put on the management component of the ward sister role. Ward sisters have always been expected to manage the delivery of care by nurses but now they have broader general management responsibilities, such as:

- for human resources management such as staff recruitment, staff sickness absence management and disciplinary procedures
- meeting hospital targets, for example, waiting times and audit of infection rates
- budgetary and resource management and control.

A ward manager?

The relatively recent title change from ‘ward sister’ and ‘charge nurse’ to ‘ward manager’ reflects the above shift in emphasis. Ball (1998) charts the policy drivers that led to

this change, which include the 1983 Griffiths report that led the way for general rather than clinical management of health care. However the title change and its implications were not without criticism, or indeed opposition, from the nursing profession. For example, Lewis (1990) expresses concern because he believes the title ‘ward manager’ implies a loss of professional role and control. Roberts (1993) also decries the change which she describes as “veering towards middle management”.

Research by Brunel University (Kinston, 1987) concurs and states that in order to achieve high standards of quality care the primary responsibility and focus of the ward sister role must be to lead nursing and nursing care, rather than to undertake broader managerial and administrative functions. A more contemporary study by Macleod (1994) adds further weight to this and states that the critical caring and compassion aspects central to nursing practice demand a clinical leadership role that can be “frequently overlooked and taken for granted” in favour of a broader management role.

Ball (1998) raises the whole issue of evidence in relation to a more managerial function for ward sisters, both in terms of whether there is evidence of positive or negative impacts, and whether greater management authority has actually been devolved to the ward sister role in reality. She concludes there is little evidence on both counts; for example, little evidence that ward sisters across England have direct control of their ward budgets. Yassain’s (1996) admittedly small, study of 15 ward sisters found that while ward sisters were “made to feel accountable for the (ward) budget” in practice their decisions had to be scrutinised and agreed by their line manager. Menzies Lyth’s (1988) much larger survey of 200 ward sisters reached the same conclusion, stating that although the ward sisters had large workloads with increased responsibilities for management and teaching, they lacked the autonomy, authority and power over resources to carry through a role as manager. East and Robertson’s (1994) study of ward sisters concurs and reports ward sisters stated they had little control over the key issues necessary to manage their wards effectively, including the inability to influence appropriate ward staffing levels for patient safety.

But a paradox currently exists for the managerial role of the ward sister. For while the role is lauded as central to patient care and service delivery with a theoretically increased managerial function for ward organisation and services, ward sisters state they lack real authority or control to carry out managerial aspects of their role. A concrete example of this paradox was the gradual removal from ward sisters of the authority and line management responsibility for ward domestic staff. This originated

with the Salmon report (Ministry of Health and Scottish Health and Home Department, 1966) but was accelerated by the contracting out of non-clinical hospital services in the 1980s, whereby cleaning and catering services were largely transferred to external companies and no longer provided in house. Ward sisters therefore lost direct control of the provision of food and a clean environment, even though both are essential to quality nursing care and the care environment (Black, 2005). These factors are also extremely important to patients and how they rate health care quality, a factor consistently demonstrated in patient research and opinion. The ward sister role has therefore been put into something of a management conundrum, with responsibilities for management that ward sisters do not have the authority or control to fulfil.

The role in context

The relationship between the ward sister role and other clinical and managerial roles in the hospital structure has an impact on a ward sister’s ability to be effective. A range of government health policies in the 1980s and early 1990s changed hospital management structures so that there were fewer clinical managerial posts. This meant ward sisters were no longer a *de facto* part of a chain of nurse managers and many reported directly to a general management structure[†]. Despite the requirement that all NHS hospital trusts have a nurse director at executive board level, these posts do not necessarily have managerial line responsibility for nurses or nursing services. Research by Newchurch Company in 1995 found that 75 per cent of nurse directors did not have line management responsibility for nurses and nursing.

However line management of nurses by those who are not nurses does not necessarily mean the ward sister role has been professionally weakened. Indeed, it could be argued that a flatter nursing hierarchy could actually strengthen the professional position of the ward sister as a nursing leader. The real crux for the ward sister role is more to do with the degree of authority devolved to it for patient care, especially the authority to shape policies and practice at ward level. However, care, in the sense of patient and clinical care, does not seem to feature highly on health care trust board executive meetings. Research in 2006 (University of Plymouth/Burdett Trust for Nursing) found an average of only 14 per cent of the total time of the meetings of 60 executive board health care trusts was spent on clinical matters (variance ranged from 7 to 22 per cent). The follow up research (Office Public

[†] Management structures vary between trusts

Management, 2006) suggested that a range of factors influenced the amount of time spent trust board meetings discussed clinical care. These were the:

- skill and persistence of the clinical leaders at board level
- scope and portfolio of the clinical leader roles
- organisational structures and accountabilities for care.

They conclude a critical factor for ‘ward to board’ messages to be heard is a clear framework for care accountability, rather than line management structures.

Whole system issues

Some pressures on the ward sister role are relatively recent and stem from whole system issues within modern day hospitals which require rapid patient turnover and patient throughput, and high levels of bed occupancy. These have resulted in high levels of patient acuity – that is, most patients on the ward will be acutely unwell. Taken together these issues add up to increased demands on nursing time.

Another modern day pressure has been the changes to the organisation of medical education which have meant junior doctors are no longer attached to consultant firms and wards. This has resulted in a clinical ward team that is less well defined and less stable. These combined factors have made it more difficult for ward sisters to maintain their leadership role for clinical care quality, supervise and organise patient care, especially continuity of that care. All these factors relate to much wider issues than roles in nursing and are worthy of separate discussion amongst the Royal Colleges of health professionals.

Preparation for the ward sister role

Lack of formal education to prepare nurses for the ward sister role, and the lack of agreed competences, skills, knowledge and attributes for the role, are consistently referred to in the literature. For example, the Wood Committee as far back as 1947 found little agreement about defined selection criteria for the ward sister role (Ministry of Health et al, 1947). This theme is still apparent in Pembrey’s (1980) study 33 years later, which found newly appointed ward sisters learned their role through experience and observation of other ward sisters, rather than through any formal process that prepared

them to undertake it, despite the requirement for “considerable conceptual ability, the ability to make complex decisions and to pursue priorities as well as social, clinical, teaching and managerial skills” (p.87). A Scottish health department review undertaken thirteen years later in 1993 (Buchan et al.) confirms still little structured preparation for the ward sister role.

Ball (1998) reviewed key documents on this issue from 1966 to 1989 (Ministry of Health and Scottish Home and Health Department, 1966; White and Frawley, 1975; Davis, 1972; Pembrey, 1980; Lathlean, 1988; Stapleton, 1983; Ramprogous, 1989) and her conclusion is that preparation for the role is haphazard and not a planned national or professional requirement. She also notes that many ward sisters perceive the education that is on offer to be of limited use because it does not address the reality of the skills needed; such as, financial skills and resource management skills.

A rewarding role?

The literature about rewards of the ward sister role focuses on the rewards for others; that is, patients, doctors and ward staff, rather than for individual ward sisters. Ball (1998) reanalysed data from 445 ward sisters who took part in the 1995 RCN employment survey and found some ward sisters held negative views about the rewards of their role, in relation to clinical career progression, working hours and pay. Salary had become a particularly negative factor with the advent of the 1988 clinical grading scheme, because only ward sisters defined as ‘having continuous responsibility’ received the higher pay of the G grade.

Career progression was also an issue. Anecdotal stories indicate that the ward sister post is no longer seen as an attractive career option for staff nurses because it is felt to lack the status, defined working hours and conditions, and pay associated with nurse specialist and advanced roles. Wise (2007) undertook research in this area to explore whether the ward sister post is an aspiration for junior nurses and midwives. She identified that this was a career aspiration for only 10 per cent of nurses and midwives and those who wanted career progression favoured the clinical specialist/advanced practitioner route, because the ward sister role was perceived as less attractive (less direct patient contact, the stress involved in managing the portfolio and workload, poor pay and rewards).

4 The RCN investigation

Because of the importance of the ward sister role for the delivery of the new NHS quality agenda, the RCN undertook an investigation of its contemporary situation and context, including the experiences of modern day ward sisters, in order to ensure the role has remained fit for purpose. This RCN report details that investigation, findings and recommended actions to strengthen the ward sister role for the delivery of quality patient care.

The RCN facilitated six focus groups of ward sisters from different types of hospital trusts across England (foundation trusts, district general hospitals, hospitals with tertiary specialities), drawn from mental health, children and adult ward settings. Approximately 90 ward sisters took part. The findings and preliminary conclusions were subsequently discussed and validated with two further groups of ward sisters, and seven nurse directors, none of whom had been involved in the focus group discussions.

The focus groups addressed the following areas:

- the purpose and role of the ward sister, the everyday experience and the context
- the key skills, competences and capabilities of the ward sister
- preparation for the ward sister role.

5 The findings

The purpose and role of the ward sister

All participants highlighted role complexity but there was agreement that the ward sister's main purpose was to lead nursing to deliver safe, quality care to patients at all times. The ward sister role was said to have the following strands.

- **An expert clinical practitioner who leads nursing practice:** all agreed that the ward sister needed to act as the clinical expert in their area of nursing practice. In reality, this means keeping clinically up to date, being able to assess patients thoroughly, plan care rigorously, and audit and evaluate nursing interventions based on evidence and locally agreed protocols and policies.
 - “ I need to know how to deal competently and safely with the treatment and management of care of the patients on my ward ...if I don't know how to do this, then how are my staff meant to learn? ...how will the patients get good care?

I need to lead by example and maintain my clinical creditability ...it can be really frustrating when you can't do this as you are bogged down with managerial things to do and excessive paper work.”
- **To be an effective communicator and be the ward 'hub':** that is, the link between ward staff, patients, patients' relatives and professional visitors to the ward such as doctors and allied health professionals. It included being an advocate for ward staff *and* for patients, and to manage and rectify complaints. This 'go-between' role relies on good communications skills as essential.
 - “ One of the purposes of the role is to make sure everybody knows what is going on ...that is the patient, the nurses, the doctors and others

like the OT [occupational therapist] and physio, dietician ... you have to be able to coordinate the activities of everyone working in the ward, so that each patient gets the best possible individualised care..."

- **To be the ward leader:** set care standards; observe, support, assess and supervise ward staff in nursing practice; be a good role model; demonstrate good nursing practice; develop staff skills and knowledge; communicate effectively; and balance clinical risk and clinical decisions against context .

“... we work with another sister in our directorate to audit nursing care on our wards monthly ... we use these audits to try to continuously improve care. We have been doing this for about a year and we haven't had a complaint on our ward since we started it ... this is really good and we feel very well supported by our lead nurse who helps us to look at our audit results ... this is a really important part of the ward sister's role.”

- **To be an educator:** all participants agreed that they had an educational role. This was about mentoring student nurses, newly qualified staff, and other members of the multidisciplinary team about good clinical practice and the patient experience. Ultimately this was to ensure that high standards of care are delivered.

“... I feel I have to educate everybody on why protected mealtimes is a good idea ... the ward staff, the doctors, the pharmacists and anybody else who thinks it is a good idea to come to the ward at lunch time ... I sometimes think that if I didn't do that nothing would ever change and our patients would starve.”

“If the patients are to receive good care I have a big role to work in a supportive and supervisory way with staff and students...”

- **To be a manager:** ward sisters viewed their role as a combination of good clinical leadership and sound managerial capability.

“We have to lead the whole recruitment process ... writing the letters, sending them out. ... I doing the interviews, everything ... it takes a long time ... I would rather be supporting my staff on the wards, giving patient care ... I don't think I am using my skills as a clinical expert when I am planning interviews.

“I don't really feel confident managing long-term sickness on my own ... but nobody really helps you ... I find it difficult to get the support I need from either the modern matron or from human resources ... and it takes for ever. Things just don't get resolved. I think we should be supported more with certain aspects of the role, like sickness management and managing performance...”

“This week we did pressure sore audit, last week was nutritional screening , next week is hand washing ... I know these are all important but we never get anything back ... I want to know if we are worse than anybody else ... how we could improve? But nobody tells you ... it seems a waste of time.”

Many ward sisters bemoaned the lack of adequate ward house keeping and clerical support, which they saw as a major drain on resources that could best be spent in nursing activity.

- **Title** There was a unanimous dislike of the title 'ward manager', and a desire for a title that identified them as the ward nurse leader. Participants felt the title 'ward manager' did not convey this to patients, staff and the public. Indeed, some participants' trusts had formally sanctioned the use of titles like 'ward sister' or 'ward matron'.
- **Supervisory to shifts** Ward sisters wanted to be acknowledged as the visible and identifiable nurse in charge of the ward, with the capacity to know their patients and supervise care delivery and the ward environment. However, many of them regularly looked after a group of patients on their shift. Sometimes this was planned in order to develop the skills of senior staff nurses or to maintain the clinical skills and credibility of ward sisters. Ward sisters also need to role model effective and compassionate nursing care to their staff and student nurses.

However, looking after a group of patients every shift made it impossible for ward sisters to be the ward leader. This point was discussed in each focus group and was a matter for considerable agitation amongst ward sisters, who felt there were real patient safety issues because having a patient workload meant they were unable to oversee clinical risk at a whole ward level. The consensus was that this was not acceptable and ward sisters needed to be supervisory to ward shifts; that is, ward sisters should not be the named nurse for a group of patients.

- **Recognition and pay** A clear message came out of the focus groups that ward sisters felt they were not valued and wanted their nursing expertise recognised. They felt they had not been given the same recognition (and status) accorded to clinical nurse specialists. Pay and salary was a particular grievance, with some being on AfC 6 instead of AfC 7. There was also an issue about ward sisters' take home pay being less than some staff nurses because some rarely worked 'unsocial hours'. However, the deeper message within all this was that ward sisters felt that specialism within nursing was regarded more highly whilst their more generalist role was not recognised or valued, and this was reflected in their pay.
- **Authority and accountability** Although most ward sisters theoretically manage the ward resources, and all juggle staffing and rostering schedules, most felt they lacked any real authority to make and lead changes. They highlighted ward cleaning and nutritional care as areas where they would like improved authority to act and lead change. Most felt that they had to go through long bureaucratic processes to get change and that their concerns were sometimes belittled or fell on deaf ears.

“ We don't have any [weighing] scales that work at the moment ... each day we ring facilities. They just say it will get sorted but it isn't ... meantime the nurses are trawling the other wards to borrow beg or steal some scales ... why can't I just ring up the company and get them to come and repair them?”

Key skills, competences and capabilities of the ward sister

All focus groups were able to supply lists of the skills, competences and capabilities needed to undertake the ward sister role. However, most found it very hard to define these in precise terms, which reflects the lack of agreement and clarity around the role, different expectations they and others had for the role, and that they had rarely been questioned or required to think about these. The following themes emerged that were framed as action descriptors rather than skills and competences.

- **A leader of people and care:** team builder; problem solver; facilitator; multi-tasker; quality and standards setter; a co-ordinator; an advocate; ability to stand up and be accountable 24 hours a day, seven days a week;

be a role model; an influencer; a motivator and inspirer; an effective communicator; good interpersonal skills, including confidence; ability to set goals and lead team to achieve these; context reader.

- **A manager of staff and the care environment:** finances and resources; an investigator; a mediator; ability to set personal and team boundaries; delegation.
- **An educator:** a mentor, supervisor, motivator; staff developer; a graduate; nursing policy and practice awareness.
- **A nursing and clinical expert:** clinical and care risk assessment; interface the clinical with the managerial; interface the generalist and the specialist; demonstrate care and caring.
- **A researcher:** auditor and enact service improvement; IT skills.

Participants agreed there is a real need to clarify and redefine the role because it is currently too broad and unwieldy and the fluidity of the role brings the risk of the addition of further work. They spoke of the different expectations and perceptions held of the role by, for example, doctors for clinical expertise and patient safety, and by health care managers for the management of staff and staff activity.

Preparation for the ward sister role

Most ward sisters said they had little education and training to prepare them for their role, though many had some form of education when they were in post. An exception came from one focus group of ward sisters in an NHS trust that had developed a specific bespoke programme of educational support. The ward sisters who had undertaken this were enthusiastic about its benefits and said the added advantage of an in-house programme was that this engendered peer support and further development amongst colleagues.

Most ward sisters had exposure to some study days about leadership. For example, some referred positively to the RCN Clinical Leadership Programme and the Leading Empowered Organisations Programme. However, there was a feeling that they had not had the preparation and support they required for the ward sister role. The particular areas highlighted included:

- leading a team, team dynamics and different approaches to influencing teams

- human resource processes, including dealing with conflict and difficult situations with staff, sickness absence and disciplinary procedures
- management of resources, especially financial management and understanding
- assessment of clinical risk and associated decision making
- using audit positively
- influencing senior managers and trust policies.

Much of the continuing professional development that ward sisters had undertaken related to either clinical practice – for example, techniques in wound management and palliative care – and/or mandatory training that all staff had to undertake on a regular basis; for example, handling and lifting, and fire procedures. Many participants suggested there should be a required induction period for newly appointed ward sisters that included a structured development plan with coaching and 1:1 mentoring support. This was felt to be appropriate and applicable to all ward sisters, regardless of their length of time in post. Plus, there was agreement that preparation for the ward sister role was vital, important and about ability and skills development to lead and manage a team as well as clinical expertise.

6

Conclusions and RCN recommended action

Focus group discussions confirmed ward sisters have a heavy workload. The key headlines include:

- the huge breadth of the ward sister role, which encompasses leadership and management, clinical practice, and education and teaching
- the absence of agreed role definitions and clarity about role aims, purpose and functions
- role conflict – ward sisters constantly balance the different aspects of their role
- lack of formal preparation and skills development for the role and lack of support and skills development for ward sisters in post, even though the role requires a significant breadth and depth of knowledge and skills
- theoretical responsibility of the role for key issues that underpin nursing standards, but in reality a lack of authority to assure them (for example, for ward cleanliness and nutrition).

The most significant finding from the RCN investigation was the pressure placed on ward sisters from looking after and nursing a group of allocated patients on every working shift, in addition to their ward leader responsibilities. This has made it impossible for them to appropriately lead, manage and *supervise* clinical practice and the ward environment. This is not acceptable to the RCN and needs urgent remedy. Ward sisters must become supervisory to shifts so that they are enabled to oversee standards of care delivery, the ward environment, and be visible to patients, ward staff, doctors and others as the nurse leader in charge of the ward. This will allow them to set appropriate standards, know their patients and their health care needs, teach clinical practice and procedures, and role model good professional practice and behaviours.

Lack of clarity about the ward sister role and purpose has exacerbated this and meant ward sisters find it difficult to

delineate their role and control the demands and pressure on it. This is compounded by the different expectations of stakeholders – such as patients, doctors, health care managers – for the ward sister role.

Management is one of the key areas of role conflict and pressure in the above. Ward sisters viewed their management work as one component of their role alongside clinical expertise, leadership and teaching, but perceived health care managers to view them *primarily* as managers of staff and ward resources. Motivation was an issue that underpinned this, for ward sisters were motivated to manage their ward and ward team by a passion for *nursing*, rather than an aspiration or desire to be ‘a manager’ *per se*.

This view was reflected in their unanimous rejection of the title ‘ward manager’. All ward sisters who took part in the focus groups wanted a title that identified them as the lead nurse in charge of the ward.

Another conflict related to the management component of the ward sister role is the *authority* of the role to actually manage the ward and ward staff. In theory, ward sisters hold responsibility for the management of the ward and ward staff. However many said they did not actually have the commensurate authority to effectively carry that out. So, in effect, they were being held responsible for ward management issues that they could not control, because the responsibility had not been fully devolved to them. They still needed the signature and agreement of line managers for even small-scale decisions or change.

The most memorable illustration of this was the case of a group of ward sisters who needed batteries for ward equipment. In theory, these sisters managed the ward resources and budget, but in practice any decision they made was scrutinised and had to be agreed by a general manager. This not only frustrated and belittled them, it also created difficulties in obtaining battery supplies because there was a lengthy lapse of time between ordering them, the order being agreed and processed, and the batteries arriving on the ward. So the ward sisters bought the batteries themselves, rather than go through the trust process.

The absence of support roles and support functions for the ward sister role was highlighted as a further related issue. This was about capacity and support roles such as clerical and housekeeping support, but extended to support functions for issues such as clinical governance and data management. The support function of the human resources (HR) departments was a particular issue for many ward sisters, as they managed ward teams of an average of thirty ward staff. They said they were often

unsupported when managing complex performance issues, such as sickness absence policies and disciplinary procedures. But also even recruitment processes from writing job descriptions, placing advertisements, to the selection process. Ward sisters viewed such work as a poor use of their time and skills, since others with a more appropriate qualifications could undertake this. They also perceived the lack of non-clinical support and the expectation that they would absorb such work as an indication that their role was not valued.

Pay and salary, which is one expression of how much a role is valued, was an area of considerable disgruntlement. The RCN was surprised and concerned to find that some ward sisters appeared to be inappropriately banded and paid at Agenda for Change (AfC) band 6 instead of the minimum AfC band 7 that correlates to the ward sister profile. However, we do not know with certainty the extent to which ward sisters are inappropriately banded and paid.

A related area of concern for many participants was that their take home pay had actually decreased on their appointment to a ward sister post since some no longer worked 'unsocial hours' and therefore earned less than they had previously as staff nurses.

Focus group discussions also touched on nursing career pathways for ward sisters. This revealed that many felt trapped in their role because they did not want to progress down a managerial or nurse specialist career pathway yet felt there were no other options or opportunities that would allow them to be ward based yet develop their skills and improve their salary. Some resentful comparisons were made between their role and that of clinical nurse specialists at bands 7 and above. It was felt that specialist posts attracted similar or better salaries but with better working hours and conditions, and a lot less responsibility. Some suggested the ward sister role was no longer seen as attractive by many staff nurses, because they could achieve the same pay and a perceived higher status by becoming a nurse specialist. Implicit within this was a feeling that specialist posts were valued more, by NHS trusts but also more by the nursing profession itself. The conclusion was that ways needed to be found to reward and value the role of the ward sister with commensurate professional status so that nursing excellence can be recruited, retained and developed at ward level.

The RCN believes the findings of our investigation strongly suggest work is needed in several areas to strengthen and support the ward sister role. This will be important for nursing, for patients, and for NHS trusts

who will be judged on the quality of care they provide. The RCN has therefore put together a set of recommended actions (for England only) to this end. These aim to gain **recognition and acknowledgement** of the value and impact of the ward sister role for high-quality care, and put in place the necessary measures to **strengthen and support** the ward sister role for care quality. Our recommended actions are for a variety of stakeholders to take forward including the executive board teams of NHS trusts, government health policy advisers, nurse leaders, nursing organisations and ward sisters themselves.

The value of the ward sister role

- The RCN will support nurse directors to promote discussion and a strategy to recognise the importance of the ward sister role for high-quality care in every NHS trust.
- The RCN will compile a short fact sheet of high-quality research regarding the importance of the ward sister role for ward standards of patient care.
- The RCN expects all ward sisters who match the ward sister profile to receive the minimum AfC band 7 salary.

Strengthening the ward sister role for care quality

- The RCN recommends that all ward sisters become supervisory to shifts so that ward sisters can: fulfil their ward leadership responsibilities; supervise clinical care; oversee and maintain nursing care standards; teach clinical practice and procedures; be a role model for good professional practice and behaviours; oversee the ward environment and assume high visibility as nurse leader for the ward.
- The RCN therefore recommends ward sisters and charge nurses assume a title that conveys a clear identity as the nurse leader of the ward.
- Nurse directors need to review the remit of ward sisters in each NHS trust to ensure they have the appropriate authority for key issues that underpin care quality – such as ward cleanliness and nutrition – and the appropriate administrative, housekeeping, and HR support to enable them to manage the ward team and ward environment.

- The RCN will host a joint summit with the Chief Nursing Officer (CNO) for England of key stakeholders to clarify and agree: the purpose and key functions of the ward sister role; the skills, competencies and knowledge needed to fulfil this role; the requirements for education and skills support to achieve these; and career pathways for ward sisters.
- The RCN will host joint events with the CNO team for England in every strategic health authority to enable ward sisters and matrons to discuss the policy and professional context for care quality, the measures that can be used to improve it, and receive feedback on how to develop this further.
- The RCN will work with the CNO for England to develop frameworks for care accountability that can support messages on care quality from 'ward to board'.

7

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8

APPENDIX 1:

Case studies of good practice

This appendix is comprised of four case studies of how good practice in leadership and skills development have been successfully implemented to support the role of the ward sister and strengthen the role for high-quality patient care.

RCN Clinical Leadership Programme

Debbie Dzik Jurasz, Learning and Development Facilitator, RCN

Effective leadership makes a real difference to the quality of health and social care. The RCN Clinical Leadership Programme (CLP) provides a framework to develop leadership and management capabilities and is one of the longest running clinical leadership development programmes for ward sisters and team leaders. Evidence from programme evaluations highlights a positive impact on developing confident and competent ward leaders who can make a positive difference to the experience of patient care.

The CLP was established based on research that identified five themes of leadership development required for patient-centred clinical leaders:

- learning to manage self
- developing effective relationships
- patient focus
- networking
- political awareness.

(Cunningham and Kitson, 2000)

The original research focused on the link between leadership and patient /client outcomes. From this original study, a toolkit was developed and participants are supported by a facilitator throughout the twelve month programme to engage in reflective and experiential learning activities which consider the processes by which

they can effectively lead, empower and enable their team to enhance patient care. The programme interventions include:

Workshops

- personal development – including mentoring, shadowing, 360-degree appraisals and clinical leader profiles
- action learning
- patient-centred activities
- team building
- political awareness and networking
- service improvement projects.

The CLP is continuously evaluated on the difference it has made to the patient experience, patient safety, quality of care and organisational efficiency and this has been positively demonstrated. Specific elements of the CLP have emerged as the main drivers for change, namely the action learning sets, patient-focused activities and the service improvement projects. The service improvement projects have focused around the following areas:

- attitudes of staff
- noise levels
- rest and sleep
- communication
- privacy and dignity
- clinical environment
- nutrition
- ward rounds.

The programme has supported the development of nurses and other health and social care practitioners from a variety of different organisations.

The Charge Nurse Development Programme at Imperial College Healthcare NHS Trust

Jacqueline Fairbairn Platt, Practice Educator and Programme Leader, Imperial College Healthcare NHS Trust

The Charge Nurse Development Programme was developed at Hammersmith Hospitals NHS Trust (which merged in 2008 with St Mary's Hospital NHS Trust and Imperial College Faculty of Medicine to form Imperial College Healthcare NHS Trust). Its genesis came from the identification of needs of charge nurses by a task force which had the prime function of developing an in-house ward management toolkit: the *Charge Nurse Toolkit* (Hammersmith Hospitals NHS Trust, 2004). There was also an organisational need to support charge nurses to deal confidently with all the many complexities of competing priorities, including ward budgets, performance issues, clinical standards and people management.

In March 2006, the trust launched the Charge Nurse Development Programme to support charge nurses to become successful leaders and increase their levels of job satisfaction (Upenieks, 2003). The in-house programme consists of nine one-day events spread over 16 weeks, comprising a mix of tutorials, workshops, work-related learning and e-learning. Participants are assessed on their ability to demonstrate improved ways of working (Hammersmith Hospitals NHS Trust, 2006). The programme is closely linked to the clinical roles of participants and the contexts in which they work, and covers topics and themes normally found in a generic nurse management programme but applied to the context of a charge nurse or midwife manager in the acute hospital environment. The three aims of the programme are to:

1. increase effectiveness of the charge nurse/midwife in managing themselves, their teams and their clinical workloads (taking account of professional and legal frameworks and the strategic direction of the trust)
2. enable the charge nurse/midwife to be solution focused, motivated to implement initiatives, and to apply practical strategies to overcome personal and professional challenges to deliver quality patient care and meet service needs
3. give a greater understanding of resource management and to apply proven techniques to manage resources more effectively and meet budgetary requirements.

Key features of the programme include:

- stimulating and supportive workshops, using a wide range of development approaches and activities
- an introduction to action learning sets and peer support groups focused on relevant topics
- deliberation of professional issues and dilemmas
- assessment directly related to the participant's own role and work settings
- provision of support from peers, direct leads and course facilitators.

The programme themes and content are:

- welcome, introduction, ground rules and a model for reflection in action
- the organisational structure and nursing within the trust
- coaching skills
- time management
- financial management
- recruiting and interviewing skills
- managing your own stress and pressure
- dealing with difficult conversations
- managing poor performance
- using the Knowledge and Skills Framework for appraisals
- health care records on trial: how lawyers use nursing documents in court cases
- how to develop policies, guidelines and procedures
- professional leadership skills: reflecting on styles and skills of self and others
- handling complaints: a workshop
- meeting with and understanding the role of the director of nursing
- role of the duty manager
- managing patients with mental health problems in general settings
- Essence of Care and clinical benchmarking
- presentation skills (including presenting a project at the end of the course)
- evaluation of the course

- introduction to action learning and techniques of reflection
- pain management in general settings.

Feedback from course delegates has been used to evaluate and review the programme content and redesign elements where necessary. Ninety-five per cent of programme evaluations are positive, with 'empowering' being cited as the most frequent positive outcome. The hands-on structure of the programme is also beneficial in providing a supportive environment in which activities such as workshops could be used to change behaviours from a problem orientation to solution focused (Fairbairn Platt and Foster, 2008). Charge nurses have recognised that getting their voices heard more effectively has improved their leadership and management skills and improved co-ordination in delivering care, producing a more cogent and integrated working environment within the trust.

Aspiring Ward Sisters Programme at University College London Hospitals NHS Foundation Trust

Julie Firth, Head of Nursing (Corporate Nursing and Midwifery Education) University College London Hospitals NHS Foundation Trust (UCLHFT)

UCLH recognised prior to the opening of the new Private Finance Initiative (PFI) hospital in 2005 the importance of the ward sister/charge nurse role and their centrality to the management structure of the hospitals of the trust. Studies into the role identified several common themes including role conflict and overload. This coupled with the perception of lack of support and time with conflicting objectives and priorities added to the difficulty in developing the ability to lead (Binnie and Titchen, 1998).

Support and Development of nursing leadership at all levels within UCLH is key to the fulfilment of the UCLH Nursing and Midwifery Strategy (2008-2011), recognising that preparation for such roles is crucial.

Following on from the Leadership Development Programme 2003-2005 prior to the move and the advent of Agenda for Change re-banding it became apparent that there was a developmental gap in the expectations of the Band 7 Ward Sister role and that of a Band 6. The expectation of role for those aspiring to being a Band 7

ward sister was great, and with those in the Band 7 role having undertaken their own developmental programme prior to the move it reinforced the need to prepare those at junior bands for progression.

It was therefore decided that the gap should be addressed with input from ward sisters themselves. A steering group was established to take the project forward including membership from City University, the Trusts' Head of Nursing for Education and ward sisters themselves. The programme was designed for staff at Band 6 level wishing to develop leadership and management skills in anticipation of career progression to ward sister/ charge nurse posts.

Additionally, the programme was developed as leadership development for midwives in the context of a changing organisation. Positive feedback from the first cohort expanded the programme to those aspiring to the full ward sister role. The programme has evolved to meet the needs of non ward clinical areas, and is tailored to be group specific to enable all participants to meet personal learning needs.

Key challenges identified by participants included:

- understanding self and others
- exploring leadership skills and abilities with strategies for becoming an effective leader
- budgeting skills (all ward sisters at UCLH are responsible for their own budgets)
- human resource issues (absence and sickness management, interview techniques)
- risk management
- team building - exploring roles, responsibilities and tensions.
- understanding the wider organisation
- making change happen
- resolving conflict including feedback skills
- negotiating and influencing skills.

Additional activities have been included for different groups, for example, non-participant observation of 'putting patients first' in clinical areas and the application of the 'dignity in care work stream'.

With the assistance of the finance function there have been expanded sessions to include practical activities addressing both management of a budget and budget setting.

Benefits of the programme and consistent in all evaluations are:

- greater confidence in their role
- more clarity of role
- better understanding of the wider organisation
- becoming more proactive rather than reactive
- more likely to be questioning in the work setting
- more likely to be assertive in the workplace
- development of valuable networks.

Participants involved in the steering group also expressed the need for time to reflect and the need to share experiences and frustrations with others. The design of the programme allowed for learning to take place in smaller sets each time the participants met. Sets are six to eight people only which has been perceived as a bonus. These sets have consistently been identified as an important facet of the programme with benefits highlighted as:

- learning from hearing and learning from others
- learning to confront themselves and others
- developing their listening and questioning skills.

The programme has been a resounding success with all ward sisters promoted internally at UCLH subsequent to 2005 having (coincidentally) undertaken the programme.

The course is run twice a year utilising six separate study days. There is always a waiting list. Academic accreditation for the course is currently being sought from our higher education institution partner.

Implementing the Productive Ward Programme

Kerry Bloodworth, Assistant Director of Nursing , Nottingham University Hospitals NHS Trust

The NHS Institute of Innovation and Improvement (2007) found that ward nurses in acute settings spend an average of just 40 per cent of their time on direct patient care. This is supported by research carried out by *Nursing Times* (2007) that shows that nearly three in four ward nurses say that they do not spend enough time on direct patient care, and 90 per cent of those polled say that patient care suffers as a result.

The Productive Ward Programme (NHS Institute of

Innovation and Improvement, 2007) provides tools and guidance to help nurses make changes to their physical environment and working processes that will improve quality of care and heighten safety standards. The approach, which uses improvement techniques from industry, analyses the main tasks taking place on a ward. These tasks, such as medication rounds and meal rounds, are then redesigned to ensure they are patient-focused and easier for staff. Over recent years the NHS has been implementing many changes in an incremental way with the aim of transforming services. There is a need to move from incremental change to accelerated large-scale improvement for NHS patients and staff. The Productive Ward Programme seeks to apply a full range of existing knowledge, at an accelerated pace, in order to deliver measurable high impact improvements at ward level.

The Productive Ward Programme is comprised of 11 modules focused on key activities at ward level. Wards receive approximately half a day's support from a project nurse for 13 weeks to implement the three foundation modules and one other key activity process module; for example, a medicine round. After the 13 weeks, ward teams, under the leadership of the ward manager, are expected to implement the seven other process modules, with much reduced support from the project team, but with the support of the matron and practice development matron.

Three foundations underpin the non-foundation modules:

1. knowing how we are doing (understanding and using measurement to drive improvement)
2. the well organised ward (being able to find things first time, every time)
3. patient status at a glance (using the patient white board to aid communication and discharge planning).

As the programme progresses, a pro-active model of sustainability needed to be developed to enable the changes to be embedded. The sustainability of changes in processes and behaviours will involve the continued maintenance, development and integration of the productive ward lean methodology and measures into trust-wide processes. Progress is measured through an audit tool which has an associated scoring system. The aim of the audit is to score over 79 per cent (green on target) and if scores fall below 79 per cent the ward teams are given action plans to ensure they remain on trajectory. The audit also demonstrates the progress made by ward sisters from their three-month block of coaching and facilitation from the project team, which aims to instill the confidence required to implement the process.

Our data demonstrates that there has been a 12 percentage point increase in direct patient care time. This means that direct patient care time has, on average, increased by 30 per cent. The strength of the Productive Ward Programme lies in the real empowerment of ward teams under the leadership of the ward sister. It gives ward staff the information, skills and time they need to regain control of their ward and the care they provide.

The trust has now facilitated the programme on 42 wards and the emergency department. Direct care time is slowly increasing and wards are using performance information to own the issues which prevent them delivering high-quality care.

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APPENDIX 2:**Synopsis of the research: leadership factors and the ward sister**

The role of the ward sister has long been recognised as key to the provision of quality patient care and the efficacy of the ward as a learning environment (Pembrey, 1980; Runciman, 1983; Lathlean, 1988; Brown, 1995; Kitson, 1991). The research literature confirms that leadership style and leadership qualities of the ward sister influence the nursing team ethos, team behaviour, and team and ward culture, all of which subsequently impact on the ward standards and quality of care. However, the degree to which these are attributes and skills of the individual, rather than a consequence of an organisation that enables, develops and supports the same, is a matter of debate. The common themes that emerge from a range of research studies on ward sister leadership include:

- the extent to which ward sisters underestimate their power and impact to influence change
- the ward sister as a positive role model is crucial to ward staff behaviour and practice
- ward sisters who are positive role models hold positive views of the importance of their own role in ‘caring’, and attributes within that, such as kindness, compassion, patient dignity and respect, and communication.

(Pembrey, 1980; Redfern, 1981; Ogier, 1982; Stapleton, 1983; Runciman, 1983; Lathlean, 1988; Brown, 1995; Kitson, 1991)

More recently, as the role of ward leader has developed in response to the growing management agenda of productivity and efficiency, there is increasing concern that we are in danger of seeing managerial functions swamping the clinical leadership agenda. The expert knowledge of nurses that has been identified as so important to quality patient care is in danger of being devalued in favour of general management responsibilities. Aspects of nursing that are central to its practice, such as ‘caring’, demand a considerable

commitment and personal investment in getting to know and understand patients’ needs (James, 1984; Smith, 1992). Such complexities are rarely articulated, yet are central to good nursing. The difficulty in articulating this component has led to assertions that the clinical leadership role is “frequently overlooked and taken for granted” despite being essential in determining standards of care and the overall ward culture (Macleod, 1994).

Several studies have reported on the difficulty many ward leaders experience in trying to juggle the managerial and clinical components of the job. Menzies’s (1988) survey of 200 ward leaders indicated increased workloads and added responsibilities in management and teaching, coupled with inadequate preparation and lack of autonomy and resources. East and Robertson (1993) similarly highlighted lack of control over issues necessary to manage and develop services effectively, as ward sisters in their study identified constraints they perceived as preventing them from achieving their aims to make improvements. Those constraints included inadequate skill mix and disenfranchisement from organisational development. More recently, Wise undertook a study in 2007 to explore whether ward management is an aspiration for junior nurses and midwives in the NHS in Scotland. The research identified that moving into line management was a career aspiration for only 10 per cent of nurses and midwives, and those who wanted career progression favoured the clinical specialist/advanced practitioner route. By comparison, the ward sister (charge nurse) role was perceived to be very unattractive because of less direct patient contact, the stress involved in managing the portfolio and workload, and poor pay and rewards.

There is a paradox in the recognition of the importance of developing and sharing clinical expertise while at the same time effectively removing experts from practice by overloading them with general management responsibilities. There is a need to develop leaders who

can combine management and clinical agendas, and create cultural change to value this. Some progress has been made. Traditional leadership models based on professional hierarchies and positions are no longer appropriate to a rapidly changing health care environment (Dean, 1993; Hunt, 1994). Rigid management structures are declining as the emphasis has shifted towards increased individual accountability for patient care as near to the patient as possible (Pearson, 1989; Smith, 1992; Wright, 1995). Bennis (1992), Bass (1991) and Burns (1974) all argue that traditional hierarchical models of leadership do not maximise outcomes for patients or staff and are not an effective use of resources. The Audit Commission (1992) study confirms that wards which are effective in patient-centred care manage their resources, both clerical and support staff, staff time and equipment, to release nursing time for patients. A recent study by Wise (2007) supports these findings.

There are many other challenges and opportunities for all nursing levels in clinical practice, education, research and management. These are multiple and include developments in pre- and post-registration nurse education, role expansion and autonomous practice within nursing (Woolwich, 1992), changes to the organisation of care and changes in traditional patterns of working across teams (Morgan, 1993; Mullen, 1995; Brown, 1995), skill mix issues and the rise in the support workforce (Carr Hill et al., 1992). Leadership preparation should be introduced across the health care professions at pre registration level, as on qualification all will need to adopt leadership strategies. Appropriate support and development is also needed for existing leaders (Cunningham and Whitby, 1997).

Research studies have focused on different aspects of the links between effective ward sister leadership and patient care. Some, for example, have attempted to link leadership qualities directly to patient outcomes. This link is highlighted in research by the Hay Group (2006), a global consulting firm that works with the private and public sectors on leadership strategies. Their study from 2006 is small, because it only involves 22 ward sisters, but of interest because of its detail. It suggests correlations between ward sisters it categorised as ‘excellent’ and:

- lower rates of medication errors
- higher levels of patient satisfaction
- lower staff absence and sickness rates.

It also identified the key characteristics of ward sisters rated by the study as high performing leaders as:

- an ability to adapt leadership approach and be flexible

to the needs of the situation and the nursing staff

- an ability to set clear, challenging but attainable goals which are communicated and understood by the ward team
- protects staff from the impact of bureaucracy and limits the number of set rules
- gives staff effective motivational feedback and fosters a co-operative environment which enables interaction and instils shared pride.

After reviewing high-quality evidence of relationships between the nursing workforce and trends in health care associated infections (HCAIs), Griffiths and colleagues (2008) suggest that leadership qualities can be traced to patient outcomes, but point out that organisational factors, such as staffing, can inhibit the influence of leadership qualities:

“Positive leadership at ward level and above appears to be a necessary prerequisite of effective action relating to infection control practices. The effects of such leadership are diffused by direct supervision of large numbers of staff, and clear allocation of direct supervision to appropriate management levels is important.”

(Griffiths et al., 2008, p.iii)

The focus of other research has been on *how* the ward sister as leader affects ward staff behaviour and staff morale – the hypothesis being that ward staff behaviour and morale is a key link in the chain to standards of patient care and patient outcomes. For example, one study regarding the impact of *ineffective* clinical leadership links measurable levels of staff stress to care standards (Firth-Cozens and Mowbray, 1997).

The link between leadership and effective team working has long been recognised in research and organisational development, both in the health service and outside of it. In the health care context there is considerable evidence that effective teams enhance the ability to deliver high-quality health care and support innovation in practice, but that effective teams develop as a result of clear leadership (Borrill and West, 2002).

Clarke and Wilcockson (2001) describe the health care leadership role as about the creation of a strong and unified culture that is able to focus on current patient care but also *future* innovations to improve it. The ward sister leadership role in this is multidimensional, since it combines clinical expertise, management of care delivery and the ward environment with education. This is

summarised as follows in a 1993 literature review of ward sister effectiveness:

“ The (ward sister) role is multi-faceted and it is often difficult and/or misleading to focus on only one element of role in discussing effectiveness. Ward sisters have a wide range of responsibilities and they are required to undertake a large number of tasks and activities. They therefore require a broad spectrum of attributes, skills and competencies to fulfil this role.”

(Buchan, 1993)

In conclusion, the research evidence clarifies the importance and complexity of the ward sister role. The role is pivotal to the modernisation of the NHS. However, unless the role, responsibilities and expectations of these experienced nurses are clearly defined, the position may cease to be a promotional aspiration of junior nurses. The negative consequences of this for standards of patient care and recruitment and retention of staff are likely to be significant.



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