The supervisory ward manager's role: Progress on Compassion in Practice action area four

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Paul Regan

Senior lecturer, School of Nursing, Faculty of Health and Wellbeing, University of Central Lancashire, Preston, England

Sarah Shillitoe

Senior lecturer, School of Health Sciences, University of Central Lancashire, Preston, England

Correspondence

PJRegan@uclan.ac.uk

Abstract

In 2012, the Department of Health published Compassion in Practice, which included six areas for action. Action area four suggests that ward managers and leaders should be supervisory, and not included in ward staff numbers. The recommendation has recently been changed to promote black and minority ethnic (BME) leadership in the NHS. This article examines the literature on supervisory nurse leader roles between 2007 and 2017 to identify what, if any, progress has been made. Although supervisory status can improve care at ward level, and was endorsed by the Francis Report, it seems that few care providers in England have invested in this, possibly because it is voluntary, rather than a statutory requirement. The article argues that, rather than focusing on BME leadership, commissioners and providers should consider implementing the original action four to support the lessons learned in the Francis Report.

black and minority ethnic, BME, compassion in practice, leadership, nursing management, supervisory ward manager, trusts

Introduction

In 2012, chief nursing officer for England Jane Cummings and Department of Health (DH) lead nurse and director of nursing for Public Health England Viv Bennett endorsed a new vision and strategy for nurses, midwives and care staff. The strategy is called Compassion in Practice: Nursing, Midwifery, and Care Staff (DH 2012a).

The strategy aimed to restore the public's trust following the inquiry into care failings at Mid Staffordshire NHS Foundation Trust (Francis 2013a, 2013b), commonly referred to as the Francis Report, and the Winterbourne review (DH 2012b). Compassion in Practice includes six areas for action, and action area four (DH 2012a) states the need for supervisory nurse leadership roles, such as ward managers. However, this was later changed to promote black and ethnic minority (BME) leaders in the NHS (Serrant 2016). The Francis Report (2013a) did not identify this as an issue so, although promoting BME leadership is important, this article focuses on the benefits of the original area for action: supervisory status for ward managers.

Background

Compassion in Practice is England-centric, but has international resonance when considering that the supervisory and supernumerary status of ward managers can affect the quality of care. The strategy was informed by several documents, including the NHS Constitution (DH 2012c), the Francis Report (2013a, 2013b) and various engagement activities, while consultations with 9,000 nurses, midwives, care staff, patients, stakeholders and think tanks, contributed to the development of quality improvement initiatives.

Participants in the consultation were asked what the 6Cs meant to people, what steps were needed to embed the principles in healthcare, whether focusing on the 6Cs would deliver the strategy's vision; what factors might be missing, and what national and local initiatives supported the 6cs. From this, six action areas were identified to maximise the benefits of prevention, early intervention and health promotion, inter-professional collaboration, improving health outcomes, effective integrated high-quality care, measurement of effects, positive experiences of care and staff development (DH 2012a, Cummings 2013).

The authors of this article examined the progress of action area four, building and strengthening leadership, which suggested the need for a national programme of leadership and led to the formation of the NHS Leadership Academy, a review of undergraduate and preceptorship courses, and the creation of mentorship programmes for aspiring leaders, as well as leadership teams that reflect local patient and staff groups (DH 2012a).

It also recommended that local trusts should review options for '…introducing ward managers' and team leaders' supervisory status into their staffing structure…' (DH 2012a). This article refers to this as the 'original' recommendation, which relates to the following: '…ward or community nurse/midwifery leaders… [should be] supervisory to give them time to lead… We hope this will be accepted and built into all future workforce tools…' (DH 2012a). This suggests that NHS commissioning boards were expected to support assessment of the potential effects of supervisory and supernumerary leadership roles. However, the lack of literature on implementation of action area four shows that this has not been fully embraced and, therefore, that the lessons highlighted in the Francis Report have not been learned.

Literature review

An initial review of the international literature, between 2007 and 2017 on supervisory and supernumerary leadership roles, was conducted (Table 1). This review identified the evidence that informed the recommendations in Compassion in Practice, and its effects since publication of the strategy. Inclusion and exclusion criteria are shown in Table 2.

Table 1. Search strategy			
Databases searched 2007-2017	Search terms	Rationale	Number of retrieved papers
Cinahl complete, Cinahl Plus Fulltext, AMED, Nursing Index, ERIC, Medline, Psychinfo, PsychArticles. Only full text and the date range above were ticked to widen the search	Ward manager and nurse manager	Initial broad search to identify background reading. Synonymous terminology (Hewison 2013)	114
	Ward manager	Broad search to identify background reading	185
	Ward manager and supervisory	Terms used in Compassion in Practice. Inclusion and exclusion criteria used (Table 2)	11
	Ward manager and supervisory and UK	UK publications to broaden the search	0
	Ward manager and supervisory and England	Terms used in Compassion in Practice to focus the search. Inclusion and exclusion criteria used to identify relevance	2
	Ward manager and supervisory	Returned to previous search. Of the *n*=11, two were relevant, 9 had no full text or abstract, and were irrelevant	11
A hand search of reference lists used	Ward manager and supervisory	Inclusion and exclusion criteria used, three more papers found adding to the 2 identified above	5

Table 2. Inclusion and exclusion criteria	
Inclusion criteria	Exclusion criteria
• Peer-reviewed papers • England • English language • Ward manager • Supervisory • Workforce centred	• Opinion papers, blogs, reflective accounts • International, other UK countries • Non-English • Nurse managers in general

The terms ‘ward manager’ and ‘nurse manager’ were used first to identify published papers and background reading. The terms were found to be synonymous (Hewison 2013) and 114 papers were identified when both were used. To relate the search terms to Compassion in Practice, the term ‘ward manager’ was used, which identified 185 papers, and adding ‘supervisory’ and applying the inclusion and exclusion criteria, retrieved 11 published papers.

The search term ‘UK’ was applied to try to identify a wider scope of published papers, but none were found. Of the 11 papers previously identified, nine did not meet the inclusion and exclusion criteria, did not have abstracts, or full text, or relevance to the aim of the review. However, two papers were identified when the term ‘England’ was included, Duffin (2012) and Kendall-Raynor (2013).

This was followed by a hand search of reference lists, which identified another three totalling five relevant papers, Royal College of Nursing (RCN) (2011), Duffin (2012), Snow (2012), Fenton and Phillips (2013), and Kendall-Raynor (2013). The retrieved literature indicates there has been some interest in the notion of supervisory ward managers, sisters and leaders, but progress is hard to assess because of the lack of research. However, the search also identified that action area four has been changed, and now promotes BME leadership (NHS England 2014a, 2014b), which restricts the original action.

Better patient care and financial benefits

RCN (2011) guidance on making a business case for supervisory ward managers suggests that high-quality leadership and supervision are vital for improving care, and that including ward managers in staffing numbers is a false economy. The guidance identifies several benefits to supervisory status, including being visible and accessible, working alongside teams in different ways, monitoring quality of care so that it is safe, effective and person centred, providing regular feedback, and creating a culture of learning and development. The RCN (2011) suggests that the business case would be proven by the transformation of care and services, achievement of goals and action plans, and a reduction in the number of patient safety incidents.

One case study in the guidance, at Medway NHS Foundation Trust, Kent, highlights the importance of defining supervisory roles clearly in job descriptions and describing the relevant key performance indicators (RCN 2011). Medway found that implementing supervisory ward managers reduced medication errors and staff sickness, and increased patient satisfaction and staff morale. Costs were higher when ward managers were counted as direct care givers, because they could not focus on both their clinical and managerial duties (RCN 2011).

Despite this, however, Snow (2012) identified that only ten out of 50 English trusts that responded to a survey of NHS organisations had implemented supernumerary managerial posts. Of the other 40, three allocated no supervisory time and 37 allocated only a portion of supervisory time, between one and four days a week, to nurse leaders. This suggests that, at the time, trusts were unconvinced of the need for supervisory ward manager roles, and might have viewed them as a cost burden (Snow 2012), even though trusts already used performance measures of patient experience, safety and clinical outcomes, which demonstrate the potential benefits of these roles (Kendall-Raynor 2013).

Fenton and Phillips (2013), writing after the publication of Compassion in Practice, found that ward managers used only 40% of their time to provide front-line clinical leadership in a non-supervisory capacity. They concluded, therefore, that supervisory roles were given less attention

than they deserved, and perhaps it was unrealistic to expect leaders to combine management and clinical tasks effectively.

The Heart of England NHS Foundation Trust, Birmingham, made a cost-benefit analysis of supervisory status and consequently invested £1.4 million in an additional 49 band-5 nursing posts to enable ward managers to adopt supervisory roles (Kendall-Raynor 2013). This analysis was important because, since 2010, most trusts have Commissioning for Quality and Innovation (CQUIN) payments, based on achieving key measures with financial benefits, included in their commissioning contracts (DH 2010). Much of the CQUIN performance requirement is nurse led, so the value of supervisory roles should convince trusts that action area four, in its original format, can be beneficial (NHS Commissioning Board 2012).

Reduced staff sickness, improved retention and recruitment

Staff stress and retention, issues identified in the Francis Report (2013a), continue to challenge the nursing profession because of a lack of long-term strategic planning, leading to cyclical shortages of nurses (Marangozov et al 2016). Around 45% of sickness absence in the public sector is attributed to work-related stress, depression and anxiety (Audit Commission 2011). On an average ward budget of £1 million, and an average staffing complement of 35, £75,000 a year can be lost due to staff sickness and this does not include costs associated with overtime or agency nurse cover (Audit Commission 2011). Within 15 months of the introduction of supervisory ward management at East Cheshire NHS Trust, nursing care performance indicators rose by 25%, staff sickness and absence rates fell, access to training improved and staff morale increased (Snow 2012).

Senior management reports from Central Manchester University Hospitals NHS Foundation Trust, where ward managers are supernumerary for about half the time, and Milton Keynes University Hospital NHS Foundation Trust, Buckinghamshire, where ward managers are fully supernumerary, indicate that providing sufficient dedicated time for managing staff attendance has helped address poor staff health and well-being, improved morale, reduced sickness and absence levels, and increased staff retention (Duffin 2012). The supervisory roles have enabled ward managers to allocate time to manage return-to-work interviews, attend human-resource and well-being meetings, and complete occupational health referrals (Duffin 2012).

A reasonable target for reducing sickness absence, of around one third, could save an average ward approximately £25,000 a year, and avoiding one patient fall could save £23,195 (NHS Institute for Innovation and Improvement (NHSI) 2013a). Meanwhile, one grade-four hospital-acquired pressure ulcer costs the NHS an average of £24,214 to treat, money that could go towards funding a staff nurse on a yearly wage of around £30,000 (NHSI 2013b).

Discussion

The lack of literature on implementation of action area four, in relation to supervisory status of ward managers, is concerning, especially when the Francis Report (2013a) endorsed the benefits. The ‘leadership in nursing’ section (Francis 2013a) concluded that delivering safe care and promoting best practice on wards, requires strong, principled leadership, responsibility for budgets and recruitment, as well as empowered staff who feel listened to. The report stated that more needs to be done to develop ward-based leadership and management, to support nurses to supervise other staff, to take initiatives in the limits of their role and competence, and to deal with the public on behalf of their organisations, thus reinforcing the positive benefits of improved staff and patient advocacy, and effective communication with patients, families, carers and the wider community.

Ensuring ward managers operate in a supervisory capacity could help realise these benefits and the Francis Report suggested that supervisory ward sisters should not be office bound, should be expected to know about patients' care plans, act as positive role models, make themselves visible to patients and staff, and coordinate care effectively when required to do so (2013b).

Stating that the 'ward manager's role as leader of a unit caring for patients is universally recognised as absolutely critical' (Francis 2013b) may suggest there are few obstacles to implementation of the role, yet the literature search found otherwise. There is little progress on the original action area four, perhaps because it is voluntary. The DH could have addressed the concerns raised by the Francis Report by making the action area four recommendations statutory, as organisations' duties are in relation to health and safety legislation, for example.

The Francis Report examined systematic failings at Stafford Hospital between 2005 and 2009, and identified lessons to be learned. A first inquiry, published in February 2010 (Francis 2013b), was aimed at identifying what commissioners, supervisory and regulatory bodies had done, or failed to do, to address the culture of management failures. These failures were the result of the market economy mixed with management science practices, which promoted an audit and business culture, and prioritisation of measurement practices, while at the same time failing to listen to patients and staff, or address reports of high mortality rates, neglect and poor standards of care (Berwick 2013, Regan and Ball 2017). These were the same organisational failings identified by the investigation in events at Morecambe Bay, Lancashire, in 2015 (Regan and Ball 2017). Allowing trusts to assess the need for action area four voluntarily suggests a lack of political will to ensure its successful implementation.

Unhealthy alliance

Critics of NHS reforms suggest there is an 'unhealthy alliance', going back more than 30 years, between the DH, politicians, global management consultancies and pro-NHS marketisation think tanks, to the point of obfuscation (Tallis and Davies 2013). Tallis and Davies (2013) suggest this alliance is due to the crossover of researchers from global management consultancies and think tanks into the DH, and the other way around. Politicians publicly stated they were anti-privatisation of the NHS, yet covertly promoted health service market reforms and private sector involvement.

It has been argued (Regan and Ball 2017) that NHS market reforms resulted in a move away from consensus management to management science, leading to a business, measurement and outcome culture, which coincided with unprecedented failings, including those at Mid Staffordshire (Francis 2013a, 2013b) and Morecambe Bay (Kirkup 2015), and involving the care of older people (Parliamentary and Health Service Ombudsman 2011). These failings might have been coincidental, but they might also explain why NHS commissioning boards were allowed to assess the need for supervisory ward managers voluntarily, despite criticism of management systems' reductive focus on performance and cost efficiency (Bradshaw 2016).

Poor-quality care, therefore, could be related directly to reduction of NHS staffing costs following the 2008 international financial crisis, and the reduction of patient-to-staff ratios between 2010 and 2015 (Marangozov et al 2016). The consequences of these organisational practices are objectification of people and commodification of goods, leading to a lack of transparency (Bradshaw 2016). A good question to ask is: why give local trust providers the option to introduce 'ward managers' and team leaders' supervisory status into their staffing structure' (DH 2012b) after Francis? The authors suggest that faith in this assessment process is wholly unjustified, because

numerous regulators assessed the Mid Staffordshire NHS Foundation Trust, following its application for foundation trust status, as having met Healthcare Commission standards.

Change of focus

Compassion in Practice (DH 2012b) recommended a national programme of leadership, a review of undergraduate and preceptorship courses, mentorship programmes for aspiring leaders and the creation of leadership teams that reflect local patient and staff groups. The strategy's update reports (NHS England 2012, 2014a) have emphasised the need to use products and toolkits, such as the Culture of Care Barometer (Rafferty et al 2015), and implement the 6Cs, compassionate leadership, leadership training and leadership networks, but failed to discuss supervisory roles, or explain why the original recommendation was replaced.

The Francis Report highlighted the need for transparent decision making, yet no explanation is given in Compassion in Practice updates for the omission, or review, of the original action area four. Instead, the updates promote BME leadership through a leadership think tank (NHS England 2014a), despite there being no mention of this as an issue in the Francis Report, and little mention in the original Compassion in Practice strategy (DH 2012b).

The chief nursing officer for England, Professor Cummings (Serrant 2016), suggests the turning point came in the NHSE (2014b) handbook, Building and Strengthening Leadership: Leading with Compassion, which discussed action area four and the leadership characteristics required to ensure Compassion in Practice becomes an organisational outcome. The rationale for the new action area four was that one in five NHS nursing staff is from a BME background, and that nurses from a BME background are under-represented in senior executive posts and experience discrimination in training and recruitment (Priest et al 2015).

In response, the NHS Leadership Academy Next Generation Career Acceleration workshop, held in 2015, focused on BME candidates' leadership aspirations, supported by coaching, mentorship and career guidance (NHSE 2014b). However, this initiative is likely to have been influenced by new indicators for ethnic diversity, against which NHS organisations are now assessed (Priest et al 2015). The lack of success of the original action area four, supervisory ward manager status, which would have had a more significant effect on the healthcare needs of patients has, it seems, been affected considerably by the changed narrative to racialise leadership.

Conclusion

The literature suggests there are cost, quality and developmental benefits for organisations that adopt supervisory ward manager roles, yet the roles are implemented inconsistently. Lessons learned from the Francis Report should have ensured that commissioners and providers prioritise implementation of supervisory manager roles, as outlined in Compassion in Practice, but this has been replaced by concern about BME representation in NHS leadership, under a diversity agenda.

The rationale for this new initiative is based on a literal reading of the Francis Report recommendations in relation to negative institutional cultures, as well as interpretation of the word 'culture' to fit the BME diversity narrative. Implementation of supervisory ward manager roles, therefore, remains uncertain, as are some of the lessons outlined in the Francis Report.

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