



A survey to provide baseline activity in relation to ward sister/charge nurse supervisory roles

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Executive Summary

Background

The aim of the study was to understand the activities that take place as part of supervisory roles for ward sisters/charge nurses. Supervisory roles are when ward sisters/charge nurses work as an additional member of the team, over and above the numbers of staff required to provide direct care to patients. This reflects the time required to effectively lead a team; with more time for activities such as leadership, education, management, interdisciplinary work, patient safety, coordination and planning of care. Whilst policy agendas promote supervisory practice and leadership through the ward sister/charge nurse role, less is known about the nature and extent of its implementation. This study therefore aimed to find out how supervisory roles are working, what is considered important, what the benefits and challenges are, and whether there are any indications of improvement in patient care because of supervisory roles. To do this, we contacted senior nurses, Chief Nurses or Directors of Nursing Services in England, who have responsibility for providing high quality care, and asked them to take part in a survey of activity.

Sample

An online survey was sent to 234 Chief Nurses or Directors of Nursing Services (DNS) in NHS England. Four research and development departments chose not to participate in the study. Community trusts were excluded if their web sites did not indicate that they had community beds. 63 trusts, (27%), responded which included 37 acute, 8 mental health, 5 community and 10 integrated trusts.

Method

The questionnaire was informed by a prior qualitative study of supervisory ward sisters and an additional in-depth interview with a Senior Nurse. The study was approved by the Health Research Authority (HRA) IRAS project ID 184809 and the University of Warwick Biomedical and Scientific Research Ethics Committee No: REGO-2915-1601.

Findings

1) What is a supervisory ward sister/charge nurse?

a) Respondents made additions to existing definitions of supervisory ward sisters, which included

i) a clinically knowledgeable professional and ii) being dynamic, proactive and moving care forward.

b) Key knowledge and skills were required to both lead care and lead developments in care. The key elements identified by participants highlighted the essence of being supervisory as both time 'outside the numbers' but also the principles underlying the leadership approach that are knowing, sharing, directing, involving, engaging, managing, and overseeing.

The strategies used to achieve these principles can be grouped under i) being present ii) knowing and sharing knowledge and skills and iii) developing and sustaining standards of care.

2) Most participants had or were implementing supervisory roles usually as a band 7; five were unable to, due to lack of finance and high vacancy factors. The overall aim for implementing supervisory practice was focused on 6 objectives: to ensure compassionate care was delivered; to provide time for leadership; to improve communication; have visible experienced staff on the ward; develop satisfaction with the role; and to improve patient outcomes. These elements may provide a useful framework to develop a process evaluation for this role. The activities undertaken in a typical day support those identified within the strategies. These were: organising; working alongside; problem solving; liaising; maintaining standards; working with complex patients; managerial activities; working closely with the team; and working clinically.

3) The extent of implementation was varied. The majority had supervisory practice to some degree with most aiming for 5 days a week as an ideal; however, others implemented the role between one to four days a week. One day a week was most often identified as the minimum time for supervisory practice. However the reality of financial constraints and high vacancy factors meant that often it is a struggle to achieve supervisory practice and staff were easily drawn back into the numbers to cover essential care due to sickness, poor skill mix, staff training and vacancy factors.

4) The challenges of practicing in a fully supervisory way were largely focussed on staff shortages, sickness and high acuity. This was compounded by lack of finances, inability to recruit staff with the appropriate expertise and lack of clerical support. Financial support for the role was variable. Some had received a lump sum, others had increased the establishment overall, some had backfilled posts or increased the supervisory time by a small amount. Charitable funds had helped with leadership programmes and clinical teams with support for ongoing supervision. However despite support in some areas the feeling was one of fragility with changes and uncertainty due to ongoing financial constraint.

5) Evaluation of the role through key performance indicators (KPIs) proved to be problematic due to the multitude of organisational variables that influenced these measures. Participants were aware of the data identified in these measures but could not directly link these to supervisory roles alone. Many used a range of measures and activities to judge how wards were developing and sustaining good practice. There were clear areas in which participants felt care had improved, the top six being: leadership; the quality of care; managing staff; being visible within the organisation; patient safety; communication and coordination of care. All of which could be evaluated at ward level using a range of tools and narrative reports. There was a strong perception that care had improved for those who had implemented the roles recently and that it would be difficult to fulfil every day obligations without this role.

6) There was a strong drive to ensure ward leaders had the knowledge, skills and support to undertake and sustain this role.

Many had systems in place and others were developing them. There was a recognition that investment was necessary to produce competent, experienced and effective ward leaders but this would have benefits in terms of staff retention and creating leaders for the future. Some were already reaping this benefit. The complex nature of the role and the need to juggle different elements and get a balance between them was identified as challenging and requiring support. There was also recognition of the differing expectations of the role and the importance of clarifying expectations with staff and key stakeholders when moving through a process of change.

Conclusions

Key conclusions from the study were:

- i) The key driver for supervisory practice was time to lead created by the current fast paced, high pressured, safety driven health care environment.
- ii) Two key elements of the leadership approach were a knowledgeable professional and proactive dynamic forward moving care. These elements were supported by principles of the leadership approach and strategies for enacting these principles in practice. The strategies highlighted the importance of: 'being present' being available and visible to others; being knowledgeable and skilful and being able to facilitate the development of others; and having a strong focus on developing and maintaining standards of care.
- iii) The underlying change in ways of being was to encompass time to think, clear lines of responsibility and accountability in addition to a proactive, dynamic approach to care.
- iv) Six objectives for implementing supervisory roles were identified and the activities identified in a typical day supported the leadership strategies for enacting the leadership principles
- v) Supervisory roles have been implemented to a varying degree depending on financial support and high vacancy constraints.
- vi) Supervisory roles are an ideal well supported by senior staff but in reality they are difficult to implement and sustain due to high vacancy factors, skill mix, and sickness cover.
- vii) KPIs were too broad as a measure to be useful and more locally important measures related to the role were required to evaluate its utility. More research is needed on how to assess the impact of supervisory roles.
- viii) Knowledge and skills through education and ongoing support was necessary for the development of these roles.
- xi) Financial support was essential as was a low staff vacancy rate. If these are not present it is debateable whether this role is sustainable.

x) A conceptual framework provides the core elements of the leadership approach identified by senior nurses that underpins ward sister/charge nurse supervisory roles (see fig 1p27).

The Study

Background

The role of the ward sister has always contained aspects of management, but over time this management role seems to have become more prominent. This management role can include being responsible for meeting targets and human and financial resource management. The ward sister title has been changed to ward manager in many settings. These type of changes have been described as resulting in loss of professional role and control, and there have been calls for a focus on delivering higher standards of care and removing the management role, Ball (1998).

The demands of being a leader, a manager and a clinical expert may result in tensions and job related stress. In addition effective management may be challenging when there is a lack of autonomy, power and authority (Menzies-Lyth 1988, Hay Group (2006).

The Francis Report (Francis, 2013) recommended that ward sisters should operate in a supervisory capacity. The ward sister should be visible and accessible to both staff and patients. The ward sister should also know about the care of every patient on their ward. Ward sisters should be a role model and mentor and enable a caring culture. As they work alongside staff, they develop clinical competencies and leadership skills within the team. Both the RCN (2009) and the Prime Minister's Commission (2010) state that the ward sister role should be central to patient experience and that the role, once vital to nursing, is now confused and should be reclaimed.

In 2009, the RCN recommended that the ward sister role should be made supervisory. The RCN (2011) went on to develop a framework for the supervisory role. As a result of the RCN recommendations, the increasing focus on the pivotal role of the ward sister and the recommendation made by the Francis Inquiry Report, some NHS Trusts have implemented this supervisory status for ward sisters.

Previous research on the role of supervisory ward sister has examined: i) supervisory ward sisters' views in relation to moving towards a supervisory role, their expectations, interpretations and evaluation of that role; ii) senior nurse and the wider clinical teams view of the supervisory role; and iii) an examination of views on the impact and benefits of the role on patient care and staff outcomes. This research suggests there are real benefits for ward sisters in the provision of: leadership through driving improvements in care, education and empowerment of others and being pivotal in terms of being able to step in, step out or step up as required by the wide ranging needs of patients and the organisation (Watterson, Currie & Seers 2015). Other evaluations of supervisory roles suggest improvement in quality indicators and the ability of staff to lead care (Russell & McGuire 2014).

However despite recommendations that supervisory status should be widely adopted, NHS Trusts may not always be able to move towards this aim and may struggle with competing agendas. What we need to know is what is happening in practice and what the challenges and benefits of the implementation of the supervisory role are, in order to provide a basis for directing future policy and practice agendas. In order to do this a survey of senior nurses in NHS Trusts in England has been undertaken to obtain an understanding of the extent of implementation of supervisory roles and the challenges and benefits associated with these roles.

Methods

The research questions were:

- What are the key challenges, enablers, potential benefits and the extent of the implementation of supervisory ward sisters/charge nurses in NHS Trusts in England?
- How are NHS Trusts evaluating supervisory practice and what are their findings?

Design

The design was a survey and the content of the survey was informed by the first study which undertook a qualitative exploration of supervisory practice (Watterson, Currie & Seers 2015) and an interview with a Senior Nurse. As such the survey represents the second phase of the programme of research focusing on the supervisory role.

Data collection was in the form of an online survey via email. The survey was run by the Centre for Educational Development Appraisal and Research (CEDAR), University of Warwick who have validated systems in place to manage surveys within the University's Governance framework.

The short questionnaire had open and closed questions (see Appendix 1). The questionnaire was sent out via email with a covering email and participant information sheet (PIS, Appendix 2). Two reminders were sent and the participants had 5 weeks to complete the questionnaire. Data analysis was through the use of descriptive statistics and qualitative thematic analysis.

Ethics

The study was approved by the Health Research Authority (HRA) IRAS project ID 184809 and the University of Warwick Biomedical and Scientific Research Ethics Committee No: REGO-2915-1601. The study was explained in the PIS and consent for the study was identified in a question on the questionnaire. The data provided was anonymous, a number was sequentially applied to questionnaires and no names were used. Data is stored securely on pass-worded computers in locked offices in swipe card protected areas of the University of Warwick.

Only the core research team and key members of CEDAR have access to any personal participant information which is held securely. Transfer of data was through secure processes within the University of Warwick. Electronic transfer of datafiles between University departments (CEDAR and RCNRI, WMS) have been via secure sites using password protected files with passwords emailed separately. All personal data will be deleted once feedback of study findings has been achieved. Electronic copies of the anonymised data will be kept on University of Warwick servers for 10 years or encrypted memory stick in a locked cabinet at the RCNRI and then destroyed. All data will be destroyed using the confidential waste disposal system at the University of Warwick.

Sample

Inclusion

The online survey was sent to the Chief Nurse/Director of Nursing in 234 acute/mental health/community/integrated NHS trusts and health providers in NHS England. The lists of contacts were obtained from NHS England and reviewed through internet searches.

Exclusion

Four Research and Development departments declined to participate in the study and were not sent the questionnaire; three due to difficulties with their role in the new Health Research Authority (HRA) process and one trust had an internal finance review. Community trusts were excluded if their web sites did not indicate that they had community beds.

Response rate

63 trusts, (27%), responded which included 37 acute, 8 mental health, 5 community and 12 integrated trusts, one missing data. The integrated trust included: 1 Integrated community mental health and learning disabilities; 1 Independent organisation with primary care, urgent care, and a variety of community services; 4 Community and mental health trust; 1 Specialist Trust; 1 Mental health, learning disabilities & children's community services; 2 Integrated trusts; 2 Integrated acute and community trusts. The trusts were geographically spread with 12 North, 25 Midlands, 7 London, and 19 South.

Schedule

The survey was sent out on the: 7th September 2015 with a first reminder on the 21st September and a second on the 28th September. The participants had 5 weeks to complete the survey. The Chief Nurse had raised awareness of the survey in the CNO Bulletin (August 2015) and sent a letter to all Chief Nurses/Directors of Nursing so potential participants were pre-notified of the survey.

Participants

The questionnaire was filled in by either Chief Nurses/Directors of Nursing/Head of Services (n=34) or other senior nurses such as the Deputy Chief Nurse or Director of Nursing Services/Operations Lead/Chief Matron/Associate Director of Nursing/Head of Nursing and Midwifery Research/Head of Service/Ward Manager/Corporate Senior Nurse/Lead nurse/Staffing Project Facilitator (n=29).

Findings

The findings were analysed based on the questions in the questionnaire and focus on 6 key elements:

- Definition of the supervisory role
 - a) definitions
 - b) key elements of supervisory practice
- The introduction of the supervisory role including
 - a) implementing supervisory roles,
 - b) aims
 - c) banding
 - d) a typical day
- Proportion of time in supervisory practice
 - a) extent of time in supervisory practice
 - b) number of days in a supervisory role
 - c) variation between different weeks
 - d) minimum proportion of time in a supervisory role
 - e) maximum proportion of time in a supervisory role
- Challenges and constraints to practicing in a supervisory way
 - a) constraints to practicing in a fully supervisory way
 - b) challenges of implementing or sustaining supervisory roles
 - c) best things about implementing/sustaining the role
- Evaluation of the role
 - a) extent of role evaluation
 - b) Improvements identified as a result of supervisory roles
 - c) Improvements and their link to supervisory roles
- Support for supervisory practice
 - a) evidence of support
 - b) cost effectiveness of supervisory practice
 - c) evaluation of the impact on ward leaders
 - d) evaluation of the impact on patients
 - e) support or education to enable nurses to fulfil their supervisory role
 - f) other aspects that are considered important
 - g) other factors

1) Definition of the supervisory role

a) Definitions

The participants were asked to define the supervisory role drawing on the three definitions below:

Definitions supplied to participants

Definition 1: “Supervisory is used in preference to supernumery as supernumery implies being extra to the establishment numbers within a clinical team. Whereas supervisory encompasses the purpose for which this time would be used; acknowledgement that time is required to undertake supervision over and above the provision of direct care; and a range of strategies for achieving supervision that may involve the provision of direct care with other team members” (Making the case for ward sisters/team leaders to be supervisory to practice RCN 2011 p3).

Definition 2: “Ward or community nurse /midwifery leaders are supervisory to give them time to lead” (Compassion in Practice DH 2012p22).

Definition 3: The Francis Report (2013p106) states that:

“Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team”.

Definition 3 was found most helpful by 34 participants but they also added to key aspects of the role and nine conveyed their own definition. Nine found definition one useful and one definition 2; five used a combination of 1 and 3, two chose 1, 2 and 3, and 3 participants had missing data.

From the findings the following definition of the supervisory role for ward sisters/charge nurses has emerged.

Supervisory ward leaders have the time to be present in clinical areas, to be visible and accessible to patients, their family/carers, ward staff and the broader multidisciplinary team. They proactively coordinate care finding sensible and innovative solutions to problems. As clinically knowledgeable professional role models they work alongside, supporting, educating and managing staff. To develop and sustain high standards of care they constantly assess and challenge aspects of practice whilst driving forward developments in care.

b) Key elements of supervisory practice

Key elements of supervisory practice were identified as:

i) A supervisory role is ‘outside the numbers’ required to provide direct care although it is recognised that this is an ideal and in reality staff shortages, sickness and resources limit the degree to which this is possible.

ii) Leadership of care is the core element of a supervisory role which is expressed through i) knowing the needs of patients, knowing the ward staff and broader multidisciplinary team; ii) sharing expertise, supporting and developing expertise in others; iii) directing and overseeing the overall quality of care provided by staff; vi)

involving - active involvement in developments in practice; v) engaging in the coordination of care; vi) managing - proactively managing staff; vii) overseeing essential administration.

iii) The strategies used to achieve this were identified as proactively:

a) Being present

- being on the floor available, present and accessible
- being visible so that people know who the ward sister/charge nurse is
- trouble shooting, pre-empting problems, problem solving
- providing innovative and sensible solutions

b) Knowing and sharing knowledge and skills

- being knowledgeable about patient needs without disempowering other staff involved in the care
- working alongside staff to develop their knowledge and skills
- actively supporting staff
- providing support for junior staff
- meeting with staff and reviewing patient care plans
- mentoring/coaching staff
- teaching and training staff
- advocating for the team
- role modelling professional behaviour

c) Developing and sustaining standards of care

- sharing leadership skills
- line managing staff with regular appraisals
- assessing care
- challenging issues around patient safety
- investigating and responding to complaints
- discussing care with patients/relatives
- attending board rounds & ward rounds
- attending trust management/leadership events
- keeping on top of things
- completing administrative tasks that must be done
- undertaking office based work
- driving forward changes

The following three quotes provide an example of the comments provided by participants that underlie the above definition and elements.

Quotes from participants

P11: Not having a patient caseload • Being clinically present so that you are available and accessible for staff, patients, carers and other colleagues as needed • Being sufficiently visible so that staff, patients and carers know who the ward sister/charge nurse is • Providing support and development when needed, including trouble-shooting, advocating for the team, teaching and training • Being able to keep on top of things and challenging any issues relating to patient safety and ward quality standards • Being able to drive forward changes • Having time to oversee administrative tasks that are delegated and complete the ones you must do.

P14: The supervisory ward sister/charge nurse has capacity, through being excluded from the ward rota, to undertake key leadership activities that support clinical quality. Supervisory ward sisters/charge nurses spend their time coordinating care, discussing care with patients, assessing the quality of care that is being delivered, supervising junior staff, providing support for junior staff, problem solving and providing innovative and sensible solutions to issues that arise in the ward. Throughout all of their activities they role model professional behaviour to their team and are highly visible to both staff and patients.

P58: Supervisory status enables the ward manager to be on the floor, supervising & observing standards of practice & quality of care, attending board rounds & ward rounds and being visible and accessible to patients and relatives.

2) The introduction of supervisory roles

a) Implementing supervisory roles

All but five Trusts had introduced supervisory roles. Three of the areas identified lack of financial support and two identified high vacancy factors as their reasons for not implementing supervisory roles. One of these trusts identified poor finances and a high vacancy factor. Three trusts felt supervisory roles would be implemented in the next 6-12 months and two felt it would be more than 12 months. Three felt the most important change required was financial support, one felt it was executive support and one having a low vacancy factor. Two felt there were other issues as well but did not specify.

b) Aims of Supervisory Roles

Overall the participants hoped to achieve a higher nursing profile (n=54, 89%) followed by providing leadership for others through role modelling (n=49, 80%), improved team relationships (n=44, 72%) and the development of professionalism (n=41, 67%). Nineteen participants provided further information on what they would like to achieve:

- i) Ensure compassionate care was delivered in a safe efficient way where there are high standards of care that includes an in-depth understanding of patient/relative/carer experience; to oversee the quality of care provision.
- ii) Provide time for leadership and management of staff including appraisal, performance review, supervision, support and education of new staff.
- iii) To improve communication and develop cohesive ways of working within the team and help with succession planning.
- iv) Have visible, experienced staff readily available on the wards.
- v) Develop a greater satisfaction with the role and improve standards of care.
- vi) Improve patient outcomes.

The following three quotes provide an example of participants' views underlying the introduction of supervisory roles.

Quotes from participants

P32: A supervisory role is about ensuring good clinical care and practice is achieved for patients, it is about staff feeling supported, being provided with direction, role modelling and that the whole of the multidisciplinary teams (MDT) works cohesively together to meet patient need.

P46: In addition to the above, having the ability to proactively support patients and their carers to provide direct feedback, both positive and negative including raising concerns, directly with the ward leader.

P61: Ensuring compassion in practice and that care is delivered in a safe, efficient and professional way placing patients at the centre of care planning.

In addition it was noted that these roles were not necessarily new, one trust had them for five years.

c) Banding

Most supervisory roles were band 7 although a few were 8a or b, or band 6. Some areas did not use the term ward sister/charge nurse, one area had ward managers on band 7 and charge nurses (deputy to the ward manager) on band 6.

d) A Typical Day

In general there was an overview that a typical day included patient care followed by an array of coordinating, problem solving, managerial, educational and administrative activities. The following three quotes provide an insight into a typical day.

Quotes from participants

P11: Being present at ward/board rounds, handovers at key points during the shift. Being aware of the overall dependency and needs of patients and staff. Delegating appropriately administrative tasks to ward administrators. Maintaining a finger on the pulse with regards to quality and safety issues, including staffing, reporting and escalating in a timely manner. Working closely with Matron to troubleshoot/pre-empt problems. Supporting ward staff with complex decision making, including issues relating to patient experience, staff training, appraisals etc.

P19: The senior sister greets each patient, is part of the ward board huddle and safety briefing, reviews staffing allocation, supports junior staff undertaking clinical roles, manages sickness, performance, budget, undertakes audit. Daily visible and present during visiting times to speak to all family/carers. Involved in complex case conferences.

P34: A ward manager would start their day by gaining an in-depth overview of all the patients on the ward, potential admissions and discharges and the nurse staffing for the shift. They would oversee and work alongside their staff, supporting, role modelling and teaching. They would ensure all patients are progressing through their agreed pathway of care, have a knowledge of the organisation's status relating to capacity, staffing and priorities. In addition to this they would ensure all key performance indicators are met within their ward area.

The activities of a typical day included providing leadership through:

i) Organising and coordinating using knowledge of patient care gained from ward rounds, handover or board rounds; bed management determined from information about admissions and discharges; assessing staffing and taking action.

ii) Working alongside staff providing supervision/support/education/training/developing competencies of staff; focus on new staff/juniors/students reviewing careplans and observing care; supervising meals/role modelling good practice.

iii) Problem solving, pre-empting problems, trouble shooting.

iv) Liaising closely with patients/families/carers to ensure good experiences of care; being available at visiting time for families/drop in sessions.

v) Maintaining standards of care including patient safety, performance, budgeting, managing pathways of care.

vi) Working with complex patients or complex pathways, assessing mental capacity.

vii) Managerial activities such as administration/meetings/audits/safety briefings/staff rotas/sickness monitoring/reporting activities/quality and safety metrics/patient feedback/errors and near misses/environmental checks/appraisals/liasing with HR/mentoring or coaching/quality improvement reports/service development/root cause analysis/complaints/linking into developments at trust level.

viii) Working closely with other team members, conflict management, multidisciplinary team work, challenging the team, acting as a central contact for medical teams.

ix) Working clinically to fill in gaps in staffing due to sickness, high vacancy as required or allow others to develop leadership skills; providing opportunities for support and reflection.

3) Proportion of time in supervisory practice

a) Extent of time in supervisory practice

The majority of participants (n=41, 67%) aimed to have supervisory practice 100% of the time. However there was a spread of time with some only managing 10%. (2 participants had missing data)

Table 1 to show the proportion of time staff are in supervisory practice

% Time	100	90	80	70	60	50	40	30	20	10
% Responded	67%	8%	6%	3%	0%	0%	3%	3%	2%	6%
Number of responses	41	5	4	2	0	0	2	2	1	4

There were some areas that participants identified as not having supervisory roles these were: outpatients; women including maternity and antenatal wards; Paediatrics; Renal Unit; Stroke Units and older people; and some community teams. The reality of having supervisory time was limited by a high vacancy factor, some areas such as intensive care had collective time and shifts such as night duty had no supervisory time; community teams that were non nurse led did not have supervisory roles.

b) Number of days in a supervisory role

The number of days a week spent in supervisory practice varied, with n=26, 42% in the role 5 days a week. (2 participants had missing data)

Table 2 to show the number of days in a week staff are in a supervisory role

Days in supervisory role	Less than one day a week	One day a week	Two days a week	Three days a week	Four days a week	Five days a week
% responded	2%	5%	23%	16%	11%	42%
Number of responses	1	3	14	10	7	26

c) Variation between different weeks

Variation was reported in the number of days in supervisory practice between different weeks by 66% (n=40) of participants. No variation between weeks was reported by 25% (n=15) and 8% (n=5) did not know. (3 participants missing data)

The main variation between weeks was because of staffing which included skill mix, sickness absence, a high vacancy factor, staff training, patient numbers, dependency and acuity. Often it was difficult to fill these shifts with agency or bank staff. Staff were expected to use their time flexibly to cover the ward to maintain safety, standards of care and key performance indicators. The three quotes below provide examples of these factors.

Quotes from participants

P55: Currently it is dependent on staffing numbers & sisters may be pulled back into a purely clinical role.

P57: Whilst the intention and our staffing templates permit our ward leaders to be 100% supervisory the reality is that with currently significant vacancies and operational pressures they are invariably pulled into the numbers.

P61: It is dependent on activity in specific ward areas, how well the sister manages their roster planning and if the ward area has vacancies or sickness which then impacts on the ability to support the supervisory role. The sister will be pulled into the staffing numbers to support and manage patient safety. There is no way of accurately capturing how this impacts on individual sisters currently as the way sisters record their supervisory time is not consistent despite providing an electronic rostering system to support this.

How the weeks varied was based on staffing needs as staff may be in the numbers one week and unable to take their supervisory time and then supervisory the following week. The underlying tenet is one of flexibility and filling gaps in daily service whilst maintaining the full range of activities. The three quotes demonstrate this element.

Quotes from participants

P8: Can be from 1 day per week to 5 days per week "in the numbers" if acute staffing issues or escalation of wards.

P32: All of our ward managers/ charge nurses are supernumerary to shift numbers however there are times due to very short notice absence or emergency situations where they have to step in to work within the expected shift numbers this does not happen frequently but is possible. There are times when the ward managers/ charge nurses are off the wards in meetings, this varies from week to week.

P50: If the ward is busy, short staffed, the supervisory time gets subsumed into the provision of direct care.

d) Minimum proportion of time in a supervisory role

The minimum time spent in a supervisory role was reported by 26% (n=16) as one day a week. However there was a variation with other participants as table 3 shows. (2 participants missing data).

Table 3 to show minimum proportion of time in a supervisory role

Minimum days per week in a supervisory role	Less than one day a week	One day a week	Two days a week	Three days a week	Four days a week	Five days a week	Don't know
% responded	10%	26%	11%	16%	13%	11%	11%
Number of responses	6	16	7	10	8	7	7

e) Maximum proportion of time spent in a supervisory role

There was variation between 1 and 5 days, as table 4 revealed. (2 participants missing data)

Table 4 to show maximum proportion of time in a supervisory role

Maximum days per week in a supervisory role	Less than one day a week	One day a week	Two days a week	Three days a week	Four days a week	Five days a week
% responded	0%	3%	8%	16%	8%	63%
Number of responses	0	1	5	10	5	39

4) Challenges and constraints to practicing in a supervisory way

a) Constraints to practicing in a fully supervisory way

The constraints to practicing in a fully supervisory way were largely focussed on staff shortages (n=57, 93%), sickness (n=49, 80%) and high acuity (n=39, 65%). (2 participants missing data, participants could select more than one response)

Table 5 to show the constraints to practicing in a fully supervisory way

Constraints	Staff shortages	Sickness	High acuity	Low skill mix	Lack of financial resources	Lack of clerical support
% responded	93%	80%	65%	44%	43%	39%
Number of responses	57	49	40	27	26	24

For some supervisory roles have been embedded for a long time others struggled to achieve them.

There were many constraints around the budget allocation and being drawn back into the numbers due to staffing and vacancy issues. Supervisory practice may be seen as a leadership approach that is a way of working that is used regardless of whether the ward sister/charge nurse is in the numbers or supervisory on any particular day.

Quotes from participants

P29: As mentioned earlier the ward sister is not included in the numbers on all the wards however there are times with sickness, acuity of patients and vacancies where ward sisters are pulled into the numbers and have to take patients. This happens regularly.

P40: The benefits of the supervisory role are massive and if they are not managing a caseload the quality of care will increase due to the supervision, team morale will improve as staff will feel valued as appraisals etc will be done in a timely way. The impact on quality from improved flow through the wards, is massive as length of stay will decrease.

P63: I found these questions quite difficult to answer. We have approached supervisory status as an ethos and a way of working. There are times when it is difficult to be fully supervisory in its purest sense but we have adopted an approach that our ward leaders are supervisory and even if they do have to work in the numbers due to staff shortages they still approach this from a supervisory perspective in that they may not take charge but may still work alongside a staff member whom they want to do some work with etc. We have therefore blurred the lines and actively tried to dispel the 'I'm supervisory today' - this may not be right but I wanted this to be a way of working and thinking for them.

b) Challenges of implementing or sustaining supervisory roles

There are real challenges with supervisory roles, the most often reported being staff shortages (88%; n=52). Lack of financial resources, lack of ward sister/charge nurse expertise and inadequate skill mix were also reported in around half of responses as table 6 shows. (There were 4 participants with missing data and participants could select more than one response).

Table 6 to show key challenges of implementing or sustaining supervisory roles

Key Challenges	% responded	Number of responses
Staff shortages	88%	52
Lack of financial resources	52%	31
Ward sisters/charge nurses lacking expertise	47%	28
Inadequate skill mix	47%	28
Lack of clinical leadership	27%	16
Lack of other resources	27%	16
Lack of executive support	15%	9

Some Trusts reported being unwilling to commit to supervisory roles due to staff shortages. It can take a long time to recruit, there was a lack of skilled ward leaders and it took time to develop their knowledge and skills. Loss of unsocial pay and lack of funding for administrative support can be challenges. Difficulty evaluating the role from existing evidence which is affected by other organisational factors was also highlighted as a challenge.

Quotes from participants

P7: There is no lack of skill, commitment or desire from a nursing perspective from ward level up to a Director level. Unfortunately there is a lack of support from executive colleagues who are a) concerned about the financial impact and b) state that whilst we can't recruit enough nurses there is no point in increasing the supervisory status of existing staff.

P54: Having undertaken an evaluation of the implementation of supervisory roles in another organisation and having a mix of full supervisory roles and those that are 3 days per week there is little evidence to support the supervisory role, it does not necessarily lead to better patient outcomes, experience, staff satisfaction. What does impact on the above is the knowledge and style of the ward leader and the leadership abilities of the individual.

P63: I was very lucky in that my Board supported us to go fully supervisory across all ward leaders across the Trust at the same time. It would not have been possible without this Board's buy in. It has proven difficult to show tangible benefit though (some members of my Board would say) so this research is welcomed. It is tricky changing how people work - fair to say that some of our Band 7s have struggled with the concept.

Implementation was helped by administrative support and engagement in the role by ward sisters/charge nurses and key stakeholders. Clarity over expectations and leadership support and training were seen as essential and having full board support was a facilitator. However within the role some aspects such as sickness management could dominate leaving less time for other activities.

Quotes from participants

P11: Administrative support, an evaluation programme that has engaged ward sisters in determining what supervisory means for them. Engaging with other key stakeholders to understand their expectations and perspectives. Gaining understanding of how visible ward sisters are from a patient/carer perspective and whether this is increasing over time.

P24: Moving between a Band 6 to Band 7 - managing a team of staff can be daunting. The NHS does not typically allow people time or provide training to empower them to deal with this. It is this area where people struggle - having those difficult conversations - not the clinical role model.

P43: Our sisters find that a lot of their time is spent on sickness management. Whilst this is an appropriate role as a manager, it does impact on the time that sisters can spend in supervision of clinical care.

c) Best things about implementing/sustaining the role

The best things about implementing and sustaining supervisory roles were that they have time to lead. There is time to focus on standards of care by supervising practice; supporting new staff particularly European Union (EU) recruits. Staff support, mentoring and where necessary performance management can help to sustain standards of care. Staff feel valued as the pivotal role they play is acknowledged and supported. They report that they feel empowered, have autonomy and increased knowledge and skills. There is consistency across wards, an eagerness to take part and a clear path for future leaders. Staff seem happy with the role, can 'nip things in the bud' before they escalate and have the time to sort things out quickly. They can be supported by leadership programmes and coaching courses and buddying systems. For some there was evidence of improved care from the Care Quality Commission (CQC). Others suggest staff recruitment and retention has improved, as has incident reporting, patient experience and quality indicators. As a group the ward leaders can feel more committed and able to make changes in practice and the role has become more attractive to staff. Overall there is a sense that staff were growing and developing within the role and learning to lead.

Quotes from participants

P19: The clear role modelling for the leaders of the future to follow.

P25: Improved staff satisfaction both from those undertaking the role and for the ward teams. Improved standards of care on the ward. Sisters have time to tackle issues quickly (eg capability and patient concerns).

P30: It has given senior nurses the capacity and permission to supervise practice within their wards. It has allowed us to develop KPIs (Key performance indicators) by which we will assess the capability of the ward manager in ensuring delivery of safe and effective care. They have the time built into the establishment to do this.

P32: There has been clear support from board down with regard to ward managers/charge nurses being supernumery to the daily staffing establishment and therefore in a supervisory role - leadership at ward level is seen as key to achieving safe effective care for patients and an effective ward team. Support is required to foster effective leadership skills to achieve this.

P34: Ward managers have gained more autonomy, had time to work with staff and develop their own skills and knowledge. Initial feedback is positive. Ward managers have reported feeling empowered and are positive about the role.

P40: The visibility of these leaders has been really important. We have changed their uniform so they now have red epilates on their shoulders and the patients really do know who is in charge. We are working with the Super 7s (as they are known here) to be confident and challenging, to really be in charge so to welcome visitors or consultants "Good morning Mr.... Welcome to my ward, how can I help you?"

P43: The Sisters feel empowered...seen as strong, visible, accessible and supportive... supervisory status has also enabled Sisters to develop their leadership skills. Three Sisters have recently acted up as Matrons and so it has given the Trust good succession planning.

5) Evaluation of the role

a) *Extent of role evaluation*

Evaluation of the role proved to be a complicated issue. Evaluation of the role was reported by 34% of participants (n=21). Of these only 15 felt that performance indicators were used. The role was not being evaluated by 62% (n=38) of participants, with 3% (n=2) not knowing if the role was being evaluated. (2 participants had missing data) Of the 15 who used KPIs the following were the most useful and other KPIs were identified.

Table 7 to show KPIs used to evaluate supervisory roles

KPI	Number of responses
Mandatory training; Complaints; Patient experience	15
Staff sickness; Pressure ulcer prevention; Falls	14
Single sex compliance	13
Malnutrition Universal Screening Tool	12
Pressure ulcer risk; Hand washing audit;	11
Dementia screening; Cleaning scores; Track and trigger Scores	9
Essence of care benchmarks; nursing dashboard; staff satisfaction; quality assurance framework; length of stay; patient dependency; occupancy; delayed discharge; budget position; appraisal rates; staff survey results; use of bank and agency; vacancies; turn over; harm from falls; incidents; engagement at ward sister/charge nurse meetings; intentional rounding compliance; response to call bells; clinical incidents; observations done on time; healthcare associated infections (HCAI), medications on time; friends and family test (FFT); appraisal rates; staff fill rates; red flags staffing alerts; budget, rostering within agreed parameters; hydration, venous thromboembolism (VTE) screening; nurse led discharge; bank & agency usage; variance against budget; friends & family compliance and feedback; serious incidents.	Other

Of those 15 participants using KPIs, seven felt that KPIs had improved in some way. Some participants were evaluating the role in other ways (n=17, 28%). A range of measures and activities were being used which included: ward assessment documentation; focus groups; NHS survey items; intention to stay; stress; staffing and roles, ward accreditation process; ward quality and workforce indicators; student experience; skill mix; ward quality and workforce indicators; away day discussions; nurse sensitive indicators; staff staffing; appraisal; staff surveys; and time in supervisory role.

The interview with a Senior Nurse undertaken to direct the content of the questionnaire highlights the problems of KPIs not being sensitive enough to evaluate outcomes but could provide a broader overall sense of standards and any changes in those standards. It also highlighted the difficulty of knowing that supervisory roles were working well from less tangible 'soft' data but the financial staff wanting it in 'black and white'. It was noted how frustrating it was for staff and how difficult it was to gauge its effect when in reality the staff were constantly covering gaps in the workforce.

Quotes from Senior Nurse Interview

But looking at the results in areas where they've had more supervisory time there are better outcomes. Whereas those that have struggled because of vacancies, etc, and have had to go back into clinical numbers, in some of those areas there was less improvement.

So trying to train our finance and performance people that they're not going to see A = B = £1 million ... they want to see it in black and white.

There are loads of things that if you saw a really good supervisory ward sister at work that makes your heart sing, but you can't put it down on paper.

You can implement a role but then if they can't do it, it's frustrating and like every Trust we have got a qualified nursing gap in terms of vacancies.

b) Improvements identified as a result of supervisory roles

Table 8 to show improvements identified as a result of supervisory roles

Improvements	% responded	Number of responses
Leadership	72%	41
The quality of care	72%	40
Managing staff	67%	38
Being visible within the organisation	63%	36
Patient safety	58%	33
Communication	56%	32
Coordination of care	49%	28
Audit	44%	25
Managing adverse incidents	42%	24
Education of staff	40%	23
Clinical governance	38%	22
Interdisciplinary work	35%	20
Bed management	28%	16
Promotion of continuity of care	25%	14

Data was missing from six participants; participants could select more than one category. The top six improvements were: leadership; the quality of care; managing staff; being visible within the organisation; patient safety; and communication. It was expected that all these would improve with experienced educated leaders and a full complement of staff. However the reality was that high vacancy factors limit improvements. Others had been supervisory for many years so they could not identify change and for some it was too soon. Improvements in recruitment and retention rates, personalised care planning and evaluation, micro coaching, quality assurance, communication with families were also identified. It was recognised that this was a difficult area and impossible to directly attribute improvements to supervisory practice. However it was noted that many of the activities required to run a ward could not be achieved without this supervisory role.

Quotes from participants

P14: This is difficult to answer as we have not undertaken a formal evaluation and not all of the sisters are working at the level that I would expect, mainly due to the fact that we need to develop them into this role. Where the role works well, I would expect most of the list above would be achieved, but this requires more than simply having someone in post, they need to be effective. That involves recruiting the right people, developing them and having clear role expectations.

P32: For the trust ward managers being supervisory is not a new concept so it is not about seeing improvements however the reason that we have the ward managers in a supervisory role is for all of the above reasons.

P53: It is difficult to align improvements to the supervisory role as at the same time the Trust have had significant programmes of work on falls and pressure ulcer reduction. The Trust has also implemented a ward accreditation programme and that may be a contributory factor rather than the supervisory role.

c) Improvements and their link to supervisory roles

The key element that was reported as enabling improvement was time. Having the time to lead, think and work as a cohort of leaders had enabled developments in practice. The leadership activities that facilitate developments were: clear responsibility and accountability as a leader and for others in the team which helped to generate a team approach to care; gathering a broader understanding of organisational pressures therefore being able to drive through actions; being able to monitor standards; a focus on coordination of activities; working within the multidisciplinary team to improve patient flow and facilitate timely discharges; being able to experience the status of the ward first-hand and being visible to others; being proactive; being able to provide an oversight to developments in practice. It was noted that these activities were just as relevant for other disciplines and the focus need not just be on nurses. The benefits were increased retention of staff, increased patient flow, and better patient experience.

Quotes from participants

P8: Ward managers have been released to think and actually lead as opposed to being in the "thick of it".

P25: Sisters have the protected time to undertake tasks that otherwise slip when direct patient care is the priority and are able to supervise and ensure these standards are maintained consistently.

P36: The role is enabling a holistic view of the clinical area which enables one individual to see the impact of all of these indicators on each other. They are able to coordinate the response for the whole team and feed back to the team. They also acts as a role model.

P39: More effective leadership. National policy focus on inpatient Mental Health (MH) care. Review of skills needed for MDT, including Occupational Health (OT) and Psychology - plus use of Mental Health workers and alternative roles, it's not just about nursing!

P46: Seeing and hearing first-hand the status of the ward, being visible to patients relatives and staff and able to respond quickly; being proactive in quality improvement work and patient safety/patient experience work - a credible example given 'hands on' experience rather than office based, or counted in the numbers - having a 'helicopter view' of their area and being able to develop strategically in the organisation.

6) Support for supervisory practice

a) Evidence of support

Most participants had financial support for the role (n=41, 77%), whereas 23% did not (n=12); data from 10 participants were missing.

The financial support for the supervisory role varied, participants identified the following: 500K; savings from implementing 12hr shifts; 2 days a week backfill at Band 5; setting a standard of 40% minimum clinical practice; 40% (2days) uplift; 80% not included in direct care numbers; initial financial investment to increase establishments; band 5 backfill for all band 7s; invested £1.7 million in nursing services overall in 2013, this included making the Sisters wholly supervisory from a position of 50% previously; fully funded Band 7s; 60% supervisory status; additional day per week taking the ward leaders from two days to 3 days per week - £105,000; backfill to allow 60% time supervisory; £3m investment; £1million; £970 000; investment in ward administrators. Other investments included charity funded time out days, leadership and development programmes; clinical unit support for a collective group of clinical areas, and regular supervision as “they have hugely responsible roles and high performance expectations in a pressured system” (P29).

Table 9 to show support for supervisory practice

Support	%Yes	Yes – number of responses	%No	No – number of responses	Missing data
Regular meetings for supervisory ward sisters	95%	53	5%	3	7
The provision of admin/clerical support	47%	21	53%	24	18

b) Cost effectiveness of supervisory practice

In general participants felt this was a complex area and difficult to attribute outcomes to costs. Six (10%) participants were undertaking a cost effectiveness analysis and 51 (85%) were not, three (5%) didn't know (3 participants had missing data). Some were still in progress or part of bigger efficiency drives or safety reviews.

c) Evaluation of the impact on ward leaders

A small number of participants (n=3, 5%) were evaluating the impact on ward leaders, but most 96% had not (n=58). (2 participants had missing data) Findings of these evaluations were still in progress, there were ongoing regular meetings to discuss clinical and professional issues and discussion of improvements in the KPI set.

d) Evaluation of the impact on patients

Most, 97% (N=59) had not evaluated the impact of the role on patients. Just 3% (n=2) had evaluated the role using patient satisfaction surveys and patient complaints. (2 participants had missing data)

e) Support or education to enable nurses to fulfil their supervisory role

Table 10 to show the support or education supplied to enable nurses to fulfil their supervisory roles

Support or Education	% response	Number of responses
Leadership education	87%	53
Coaching/mentoring;	73%	45
Management skills	69%	42
Supervision	57%	35
Practice development	48%	29
Study time	36%	22
Action learning sets	33%	20
Administrative support	30%	18
No support	3%	2
Other support	2%	1

There was an awareness that more on going work in this area was required and some had development work in the pipeline. Others already had detailed leadership programmes, personal development plans and were working on evaluation and broader metrics. (2 participants had missing data)

f) Other aspects that are considered important

It was felt to be important that time was spent exploring the role, clarifying what is meant by the term supervisory and exploring expectations. It was noted that some staff require more support in this area. Within the role, discussion was required regarding the division of roles between clinical leadership, ward management and administration. Developing effective leaders was seen as crucial and they require help gaining the knowledge and skills. Support for the role was required and help to enable them not to be drawn back into the 'numbers'. It was felt that the provision of expert coordination, mentoring and support to staff was becoming increasingly important in order to manage complex care environments. It was noted that improvements in incident management can be hard to achieve. Current evaluation will include supervisory time taken, satisfaction with role and patient experience.

Quotes from participants

P15: The impact of this status also depends upon the effectiveness of an individual and time management issues.

P28: Inpatient acute wards have an increasing higher acuity and dependency of patients (e.g. demographics, shorter length of hospital stay, use of other settings e.g. Outpatients, Day Units for less complex cases), along with the need to ensure quality standards are being met. This results in very busy and challenging ward areas often with many members of staff to manage on the ward (40 plus). To deliver this well, the Senior Sister/Charge Nurse needs sufficient time and resources.

P30: How they support the assurance framework by working alongside staff in practice which would not occur if they were delivering direct patient care 100% of the time.

g) Other factors

It was emphasised that Trusts were managing under challenging circumstances and it was a battle to make changes in this climate. It was noted that supervisory roles in community and community mental health teams were also of interest. Other factors such as whole pathway working and identifying the disadvantages of supervisory practice were identified as important. The e roster system was useful for monitoring supervisory days but staff were constantly pulled into providing patient direct care. Several participants were running in-house leadership courses and were evaluating the role in a variety of ways.

Quotes from participants

P7: Unfortunately many Trusts are desperately trying to do their best with challenging financial and recruitment constraints. Unless supervisory status is mandated, it is going to be very hard for Directors of Nursing to get any headway in terms of increasing the time allocated and funded.

P39: The survey did not allow me to comment on new developments such as whole pathway working with key staff leading this approach which is very different to care in a single environment. There was perhaps insufficient focus on the dis-benefits of the supervisory model - and if you have not evaluated the pre and post, which we had not, the study may not bring this out sufficiently.

P40: I know that as I have not had time to evaluate the role, the agency ceiling now in place, will impact on the time that the supervisory sisters have to lead their areas. We will be asked to put them in the numbers so that the finances balance by reducing the numbers of agency staff. However if they do not have the time to lead , Matrons will again start to act down into their roles with a slowing down of length of stay and staff care, we will lose the benefits that supervisory sisters bring.

Summary

- 1) The key element of supervisory practice is time away from carrying a caseload of patients and not being counted in the numbers to provide direct care. This additional time allows for more work to be undertaken in relation to leadership, education, management and administration. This work was already being carried out to some degree but supervisory roles enable an expansion of this work. The drivers for this change were referred to as highly pressurised environments, with high expectations for performance, high vacancy factors often with low skill mix, high acuity, complex multidisciplinary teams, need to proactively coordinate complex patient pathways, and an increasing focus on patient safety through an eclectic array of measures.
- 2) Respondents made additions to existing definitions of supervisory ward sisters, which included the elements of i) a clinically knowledgeable professional and ii) being dynamic, proactive and moving care forward. Key knowledge and skills were required to both lead care but also lead developments in care. The key elements identified by participants highlighted the essence of being supervisory as both time 'outside the numbers' but also the principles underlying the leadership approach that are knowing, sharing, directing, involving, engaging, managing and overseeing. The strategies used to achieve these principles can be grouped under i) being present, ii) knowing and sharing knowledge and skills, and iii) developing and sustaining standards of care.
- 3) Most participants were implementing supervisory roles usually as a band 7; five were unable to due to, lack of finance and high vacancy factors. The overall aim for implementing supervisory practice was focused on six objectives: to ensure compassionate care was delivered; to provide time for leadership; to improve communication; have visible experienced staff on the ward; develop satisfaction with the role; and to improve patient outcomes. These may provide a useful framework to develop a process evaluation for this role. The activities undertaken in a typical day support those identified within the strategies. These were: organising; working alongside; problem solving; liaising; maintaining standards; working with complex patients; managerial activities; working closely with the team; working clinically.
- 4) The extent of implementation was varied. The majority had supervisory practice to some degree with most aiming for 5 days a week as an ideal; however, others implemented the role between one to four days a week. One day a week was most often identified as the minimum time for supervisory practice. However the reality of financial constraints and high vacancy factors meant that often it is a struggle to achieve supervisory practice and staff were easily drawn back into the numbers to cover essential care due to sickness, skill mix, staff training and vacancy factors.

5) The challenges of practicing in a fully supervisory way were largely focussed on staff shortages, sickness and high acuity. This was compounded by lack of finances, inability to recruit staff with the appropriate expertise and lack of clerical support. Financial support for the role was variable. Some had received a lump sum, others had increased the establishment overall, some had backfilled posts or increased the supervisory time by a small amount. Charitable funds had helped with leadership programmes and clinical teams with support for ongoing supervision. However despite support in some areas the feeling was one of fragility with possible changes due to ongoing financial constraint.

6) Evaluation of the role through KPIs proved to be problematic due to the multitude of organisational variables that influenced these measures. Participants were aware of the data identified in these measures but could not directly link these to supervisory roles alone. Many used a range of measures and activities to judge how wards were developing and sustaining good practice. There were clear areas in which participants felt care had improved, the top six being: leadership; the quality of care; managing staff; being visible within the organisation; patient safety; communication and coordination of care. All of which could be evaluated at ward level using a range of tools and narrative reports. There was a strong perception that care had improved for those who had implemented the roles recently and that it would be difficult to fulfil every day obligations without this role.

7) The underlying change in emphasis in ways of working in supervisory roles were linked to having time to think. This was combined with clear areas of responsibility and accountability combined with a proactive, dynamic, problem solving approach to care. There was also a clear focus on facilitating teams and heightened awareness of having an oversight of the quality of care across the ward. This reflected a professional approach to care that crossed disciplinary and specialist boundaries. As a way of working it can be integrated into care when staff are working with a clinical caseload as identified by one of the participants.

8) There was a strong drive to ensure ward leaders had the knowledge, skills and support to undertake and sustain this role. Many had systems in place and others were developing them. There was a recognition that investment was necessary to produce competent, experienced and effective ward leaders but this would have benefits in terms of staff retention and creating leaders for the future. Some were already reaping this benefit. The complex nature of the role and the need to juggle different elements and get a balance between them was identified as challenging and requiring support. There was also recognition of the differing expectations of the role and the importance of clarifying expectations with staff and key stakeholders when moving through a process of change.

9) Key conclusions from the study were:

i) The key driver for supervisory practice is time to lead created by the current fast paced, high pressured, safety driven health care environment.

ii) Two key elements of the leadership approach were a knowledgeable professional and proactive dynamic forward moving care.

These elements were supported by principles of the leadership approach and strategies for enacting these principles in practice. The strategies highlighted the importance of: 'being present' being available and visible to others; being knowledgeable and skilful and being able to facilitate the development of others; and having a strong focus on developing and maintaining standards of care.

iii) The underlying change in ways of being were to encompass time to think, clear lines of responsibility and accountability and a proactive dynamic approach to care.

iv) Six objectives for implementing supervisory roles were identified and the activities identified in a typical day supported the leadership strategies for enacting the leadership principles.

v) Supervisory roles have been implemented to a varying degree depending on financial support and high vacancy constraints.

vi) Supervisory roles were an ideal well supported by senior staff but in reality they were difficult to implement and sustain due to high vacancy factors, skill mix, and sickness cover.

vii) KPIs were too broad as a measure to be useful to look at the impact of the supervisory ward sister and more locally important measures related to the role were required to evaluate its utility. More research is needed on how to assess the impact of supervisory roles.

viii) Knowledge and skills through education and ongoing support were necessary for the development of these roles.

xi) Financial support was essential as was a low staff vacancy rate. If these were not present it was debateable whether this role was sustainable.

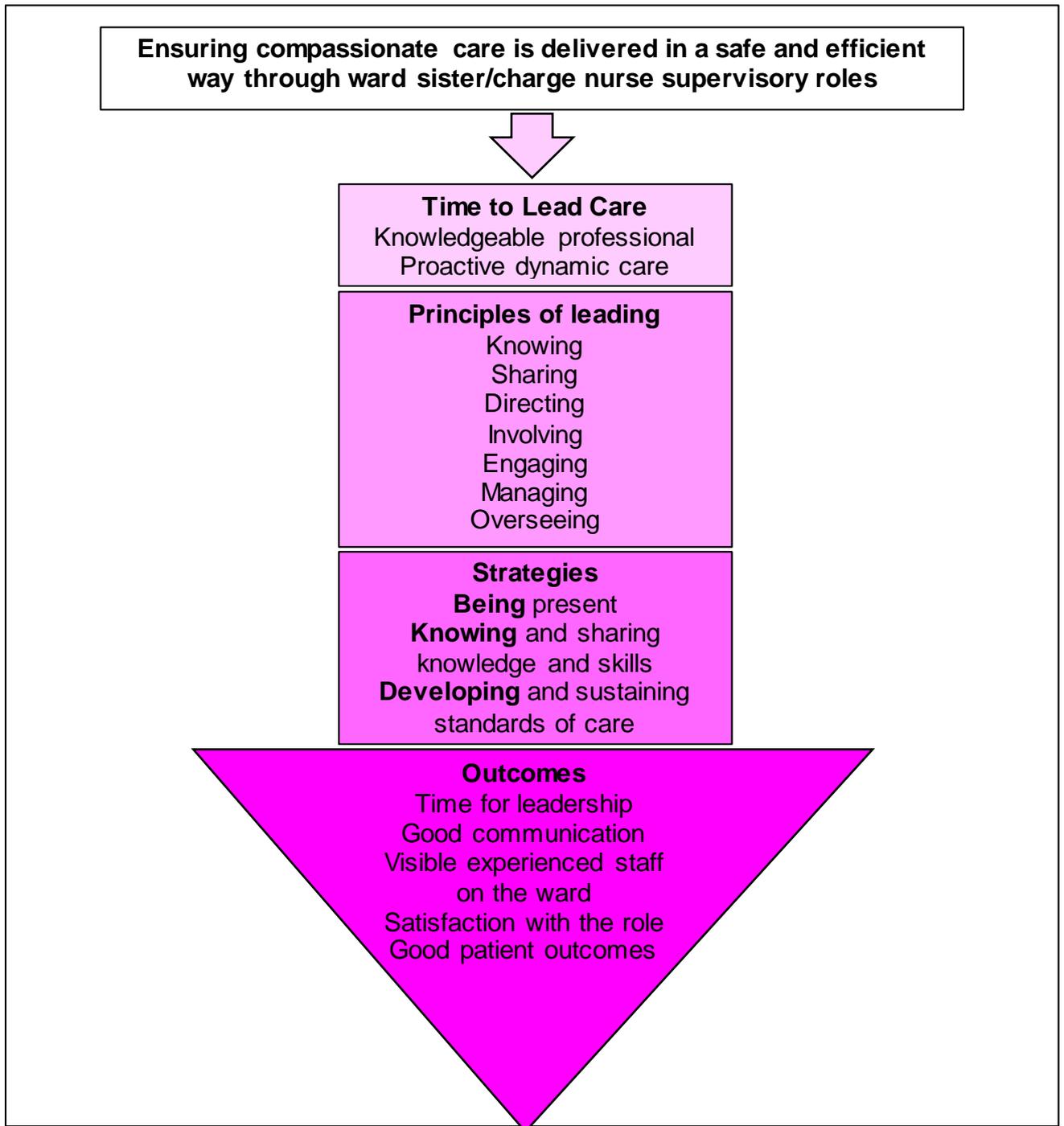
x) A conceptual framework provides the core elements of the leadership approach identified by senior nurses that underpin ward sister/charge nurse supervisory roles. (see fig 1p27)

10. Limitations of the study were that it focussed on ward based care and has not covered community areas without inpatient beds, some mental health areas, allied health professionals, specialist nurse roles. We do not know if those who did not respond to the survey would have responded differently, but this does capture the experiences of 63 NHS Trusts.

A final comment from one of the participants:

P43: The Sisters feel empowered...they are seen as strong, visible, accessible and supportive... Supervisory status has also enabled Sisters to develop their leadership skills. Three Sisters have recently acted up as Matrons and so it has given the Trust good succession planning.

Figure 1 to show a conceptual framework for the supervisory ward sister/charge nurse role



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Appendix 1 Questionnaire

A survey to provide baseline activity in relation to ward sister/charge nurse supervisory roles

This survey aims to find out more about the activities that are taking place in relation to supervisory roles for ward sisters/charge nurses. A supervisory role conveys the time required to lead a team where the ward sister/charge nurse is not counted in the staffing numbers for the provision of direct patient care. The survey is being carried out by The Royal College of Nursing Research Institute, University of Warwick, and is funded by NHS England.

All the information that you provide will be treated as confidential and will only be used for research purposes.

The survey should take about 30 minutes to complete.

A participant information sheet is available here. Please read this before completing the questionnaire.

I have read the
participant information
sheet

If you agree to take
part in the survey
please tick the box

Please tell us your role. Are you...

- Chief Nurse/Director of Nursing
 Other role

If other role, please specify below

Is your Trust

- Acute Trust
 Mental Health Trust
 Community Trust
 Other

If other, please specify below

To which NHS England regional team do you belong?

(Please tick the **most appropriate** answer)

- North (Yorkshire and the Humber, The North West, The North East)
 Midlands and East (West Midlands, North Midlands, Central Midlands and East)
 London
 South

Introduction

There are a range of definitions of supervisory roles. We have provided key definitions below, but are keen to understand how you define it within your Trust.

Definition 1: "Supervisory is used in preference to supernumerary as supernumerary implies being extra to the establishment numbers within a clinical team. Whereas supervisory encompasses the purpose for which this time would be used; acknowledgement that time is required to undertake supervision over and above the provision of direct care; and a range of strategies for achieving supervision that may involve the provision of direct care with other team members"

(Making the case for ward sisters/team leaders to be supervisory to practice RCN 2011 p3).

Definition 2: "Ward or community nurse/midwifery leaders are supervisory to give them time to lead"
(Compassion in Practice Department of Health 2012p22)

Definition 3: The Francis Report (2013p106) states that:

"Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing critical competencies and leadership skills within the team".

Please tell us how you define the supervisory role

Please write your definition in the box below. If you use one of the definitions above, please tell us which one

Have you introduced a supervisory role for ward sisters/charge nurses in your NHS Trust?

(Please tick the **most appropriate** answer)

- Yes
 No

If no, please explain why you do not have supervisory roles

From your perspective, what are the barriers to implementing supervisory roles?

(Please tick **all** appropriate answers and **add** any more information)

- Lack of financial choice
 Lack of executive support
 High vacancy factor
 Don't know
 Other

If other, please specify below

Do you plan to implement supervisory ward sister/charge nurse roles in the future?

(Please tick the **most appropriate** answer)

- Yes
 No
 Don't know

If yes, when do you plan to implement supervisory ward sister/charge nurse roles?

- Within the next 6 months
 Between the next 6-12 months
 In more than 12 months' time

What is the most important change that would enable a move towards the introduction of supervisory roles? (Please tick **one** answer)

- Increased financial resources
 Other resources (tell us what below)
 Executive support
 Low vacancy factor
 Don't know
 Other

If other, please specify

You have now finished the questionnaire.

Thank you for taking time to complete this questionnaire. Your results will help us understand some of the challenges in implementing supervisory roles.

Please tick this box to submit your answers

Understanding how you are implementing supervisory roles

The questions below look at key characteristics of supervisory roles

We recognise that supervisory roles can be complex and work in a variety of ways, specialities and within NHS Trusts. We aim to capture some of these ways of working to start to gain an insight into current practice. In doing this, we wish to learn more about the benefits and challenges of supervisory roles to provide a basis for developments in practice in the future. With this in mind, we have included open as well as closed questions.

As you are implementing supervisory roles, please tell us what you hope to achieve through their use.

We have included some suggestions. (Please tick **all** appropriate ones and add any others in the comments box.)

- Development of professionalism

- Providing leadership for others through role modelling
- Higher nursing profile
- Improved team relationships
- Other

If other - please tell us below

Do you have any job descriptions for supervisory roles you would be happy to share?

- Yes
- No

If you do have any job descriptions for supervisory roles you would be happy to share, please see the end of the questionnaire for how to send documents, or summarise key aspects in the box below

On which grade, or range of grades, are ward sisters/charge nurses with supervisory roles employed?
(Please record all relevant grades)

To help us understand the ways that supervisory roles are being implemented, can you describe what a typical day involves for a supervisory ward sister/charge nurse? If this is difficult, please provide one, two or more examples of how supervisory roles work in your Trust

Approximately what percentage of ward sisters/charge nurses in your NHS Trust have a supervisory role?
(Please tick the most appropriate percentage)

%	10	20	30	40	50	60	70	80	90	100
	<input type="checkbox"/>									

If less than 100%, which areas do not have supervisory ward sisters?

We would like to find out what proportion of the time is considered to constitute a supervisory role?
(Please tick one box that best summarises this)

	Less than one day a week	One day a week	Two days a week	Three days a week	Four days a week	Five days a week	Don't know
In supervisory roles, ward sisters/charge nurses normally spend:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does the time an individual spends in a supervisory role vary between different weeks?
(Please tick the most appropriate answer)

- Yes
- No
- Don't know

If yes, why does the time an individual spends in a supervisory role vary between weeks?

How does the time an individual spends in a supervisory role vary between weeks?
How does the time an individual spend in a supervisory

Please tell us the minimum proportion of time someone would spend in a supervisory role?
(Please tick one answer)

- Less than one day a week
- One day a week
- Two days a week
- Three days a week
- Four days a week
- Five days a week
- Don't know

Please tell us the maximum proportion of time someone would spend in a supervisory role?
(Please tick one answer)

- Less than one day a week
- One day a week
- Two days a week
- Three days a week
- Four days a week
- Five days a week

Don't know

In your experience or opinion, are there any constraints on practicing in a fully supervisory way?

(Please tick **all** appropriate answers)

- Lack of financial resources
- Lack of clerical support
- Staff shortages
- Sickness
- High acuity
- Low skill mix
- Don't know
- Other

If other, please specify

Please add any further details you think are relevant

Please describe the key challenges of implementing or sustaining supervisory roles.

(Please tick **all** appropriate answers)

- Lack of financial resources
- Lack of other resources
- Lack of executive support
- Staff shortages
- Inadequate skill mix
- Ward sister/charge nurses lacking expertise
- Lack of clinical leadership
- Don't know
- Other

If other, please specify

Are the things that have **helped** with implementing/sustaining supervisory roles the opposites of key challenges from the previous question, or are there other things to add?

- Nothing to add
- There are other things to add

Please give details

What have been the best things about implementing/sustaining supervisory roles?

Are you evaluating or assessing the impact of supervisory roles?

(Please tick **one** answer)

- Yes
- No
- Don't know

If yes, does your assessment use key performance indicators?

(Please tick **one** answer)

- Yes
- No
- Don't know

We have included a selection of key performance indicators below, please tell us which ones you use and add any others important to you

(Please tick **all** appropriate answers)

- Track and trigger scores
- Malnutrition universal screening tool
- Pressure ulcer prevention
- Pressure ulcer risk
- Hand washing audit
- Cleaning scores
- Dementia screening
- Falls
- Single sex compliance
- Mandatory training
- Staff sickness
- Complaints
- Patient experience

Other

If other, please specify

Have you identified any changes in key performance indicators since implementing supervisory roles?

(Please tick **one** answer)

- Yes
 No
 Don't know

Please specify in which key performance indicators you have identified changes since implementing supervisory roles

(Please tick **all** appropriate answers)

- | | Improved | No difference | Worse | Don't know | Not relevant |
|---------------------------------------|----------|---------------|-------|------------|--------------|
| Track and trigger scores | | | | | |
| Malnutrition universal screening tool | | | | | |
| Pressure ulcer prevention | | | | | |
| Pressure ulcer risk | | | | | |
| Hand washing audit | | | | | |
| Cleaning scores | | | | | |
| Dementia screening | | | | | |
| Falls | | | | | |
| Single sex compliance | | | | | |
| Mandatory training | | | | | |
| Staff sickness | | | | | |
| Complaints | | | | | |
| Patient experience | | | | | |
| Nurse experience | | | | | |
| Other | | | | | |

If other, please specify

Are you evaluating supervisory roles in any other way?

- Yes
 No

If yes, please tell us in which other ways you are evaluating supervisory roles

Please tell us about any improvements you have identified as a result of implementing supervisory roles

(Please tick **all** appropriate answers)

- The quality of care
 Patient safety
 Clinical governance
 Managing staff
 Managing adverse incidents
 Leadership
 Being visible within the organisation
 Coordination of care
 Communication
 Education of staff
 Interdisciplinary work
 Promotion of continuity of care
 Audit
 Bed management
 None
 Don't know
 Other

If other, please specify. Please add any examples to help us understand the improvements

If you have identified any improvements, please tell us why you think this is because of the supervisory role

Please tell us what financial and other resources, if any, you have to support supervisory practice?

Yes

No

Financial

Regular meetings for supervisory ward sisters

The provision of admin/clerical support for the role

Other

None

Don't know

Please specify type and amount of financial resources

Please specify type and amount of other resources

Have you been required to carry out a cost-effectiveness analysis of supervisory practice?

(Please tick one answer)

- Yes
 No
 Don't know

If yes, please provide key conclusions of your cost-effectiveness analysis

Have you evaluated the impact of implementing the supervisory role on the ward sisters/charge nurses?

- Yes
 No

If yes, please give brief details and conclusions of your evaluation of the impact on ward sisters/charge nurses

Have you evaluated the impact of implementing the supervisory role on patients?

- Yes
 No

If yes, please give brief details and conclusions of your evaluation of the impact on patients

Please describe any support or education the Trust provides to enable nurses to fulfil their supervisory role (Please tick all appropriate answers)

- Management skills
 Leadership education
 Coaching/mentoring
 Supervision
 Practice development
 Administrative support
 Action learning sets
 Study time
 None
 Don't know
 Other
If other, please specify

Please tell us about any other aspects of supervisory roles you feel are important for others to understand

Is there something else we haven't asked that you would like to say?

You have finished the survey. Thank you for taking time to complete this questionnaire

The following section will be kept in a separate file to the questionnaire and not linked to your responses to the survey

If you would like a summary of the research project, please provide your contact details below

Are there any policy documents/information that relates to supervisory roles that you feel we should be aware of, particularly in relation to your own Trust?

Please send them to:
Dr Liz Tutton, Senior Research Fellow
Tel: 024761 50620
Liz.tutton@warwick.ac.uk

Participant Information Sheet
**A survey to provide baseline activity in relation to ward
sister/charge nurse supervisory roles**

NHS R&D Form, IRAS No: 184809/818329/14/877
Biomedical & Scientific Research Ethics Committee Ref No: REGO-2015-1601
Version Number: 1.0 1st July 2015

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

Do talk to others about the study if you wish and ask us if there is anything that is not clear.

Why am I being invited to participate?

You are being invited to participate because you are a Senior Nurse, Chief Nurse or Director of Nursing Services working in an acute/mental health/community NHS Trust and are responsible for the delivery of nursing care.

What is the purpose of the study?

We are interested in finding out more about the activities that are taking place in relation to supervisory practice for ward sisters/charge nurses/team leaders. Supervisory practice describes a role where the ward sister/charge nurse/team leader is not counted in the staffing numbers for the provision of direct patient care and deploys themselves to lead, manage and develop their team effectively. We would like to understand what is happening currently, what is important to you, the challenges and benefits of supervisory practice. This work will provide a picture of what is happening across England and produce important evidence on which to base policy and practice developments in the future. We would like to invite you to take part in an online survey which will take approximately 20-30 minutes.

Do I have to take part?

No, it is up to you to decide. If you agree to take part we will take your completion of the questionnaire as formal consent for the study. You are free to withdraw at any time, without giving a reason.

If you agree to participate or not, and if you continue with the study or withdraw from it, this would not affect you or your work in any way.

What will happen to me if I take part?

You will be provided with this information sheet and if you decide to take part we ask you to complete an online survey which will take approximately 20-30 minutes to complete. Most questions provide a choice of answers but some provide the opportunity for you to say what is important from your experience. You would receive a reminder at 2 weeks and 3 weeks and have a total of 5 weeks to complete the survey before recruitment closes.

Expenses and Payments

No expenses or payments are paid if you take part in this study; we do not expect that it will cost you anything other than some of your time.

What are the possible disadvantages and risks of taking part?

We believe that any adverse consequences of taking part in this study are minimal.

What are the potential benefits of taking part?

There is no direct benefit of taking part however we hope the information collected will improve understanding of the challenges and benefits of supervisory practice.

What happens when the research study stops?

Your involvement with the research study will end after completion of the questionnaire. If you wish we will send you details of what we learn as a result of the study.

What if there is a problem?

If you have a concern about any aspect of this project, please speak to Dr. Liz Tutton Tel: 024761 50620 who will do her best to answer your query. If you are still unhappy and wish to complain formally please contact the Director of Delivery Assurance, Registra's Office, University House, University of Warwick, Coventry, CV4 8UW, complaints@warwick.ac.uk, Tel: 02476574774

Will taking part in the study be kept confidential?

All information collected will be kept strictly confidential. You do not need to provide your name, address or the name of your employer in order to participate. You are welcome to provide contact details only if you want to receive communication about the findings of the study. In that case, your contact details would be stored separately and confidentially and would not be linked to your response.

How data is collected, handled, stored and destroyed will comply with the Data Protection Act 1998. Any information included in any reports will be anonymised. We will safeguard confidentiality during this study by:

- keeping any information in a locked cabinet or in a secure electronic database
- not using any identifiable information such as names on any of the documentation or on any publication – we will use a code number instead
- using a separate secure electronic folder to keep personal details. This will be destroyed at the end of the study
- using data only for the reasons stated in this information leaflet

- allowing only researchers and representatives of regulatory bodies, sponsors from the University of Warwick access to the study information. This is so they can check the study is being carried out correctly
- using secure methods of destroying information

The questionnaire responses without identifiable information (anonymised), will be kept, in a secure place, for 10 years and then destroyed. These will be made available to other researchers in the field if required but nothing with names on it will be shown to anyone. We do not use this data for any other purpose without further permission from the Sponsors, Health Research Authority and yourself.

What happens if I don't want to carry on with the study?

If you wish to stop being part of the study you or your work will not be affected. We will only use the data collected up to that time.

Harm

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for compensation against University of Warwick but you may need to pay your legal costs. The normal university complaints mechanisms will still be available to you.

What will happen to the results of the research study?

The results of the study will be published in a report that will be sent to NHS England who funded this study. We will also publish what we learn in healthcare journals and national and international research and health service delivery meetings.

To receive a summary of findings you need to fill in your contact details. At the end of the study the researcher will email or post this summary to you using the personal details you provided, after which your personal details will be destroyed. If you do not wish to receive such a summary you do not have to give your personal details.

How have service users been involved in this study?

The study has been discussed with services users who suggest there is a need to know more about how this role can improve practice. The survey has been piloted with two Directors of Nursing Services.

Who is organising and funding the research?

The sponsors of the study are University of Warwick. The study is funded by NHS England.

Who has reviewed this study?

At the University of Warwick all research involving members of staff are looked at by an independent group of people, called a Biomedical and Scientific Research Ethics Committee (BSREC), to protect your interests. This study has been reviewed and given a favourable ethical opinion BSREC No: REGO-2015-1601.

Contact

Please contact me if you require further information.

Contact: Dr Liz Tutton, Senior Research Fellow, Tel: 024761 50620,

Liz.tutton@warwick.ac.uk

RCNRI Warwick Medical School

University of Warwick
Coventry West Midlands CV4 7 AL

**Thank you for reading this information sheet and considering taking part in
this study**