Responding to Francis: clinical leadership
Developing skills in clinical leadership for ward sisters

In this article...
- Historical development of the ward sister’s role
- Why nursing needs to modernise the role of the ward sister
- How ward sisters’ time can be freed up for clinical leadership

5 key points
1. The ward sister role is vital for consistent, high-quality care
2. Lack of clinical leadership is a factor in poor care
3. The Francis report has called for a strengthening of the ward sister role
4. A critical analysis of healthcare organisations and a whole-systems approach to change is required to modernise this role
5. The role needs to be clearly defined and sisters need ongoing development

Ward sisters need time to work in a supervisory capacity and provide clinical leadership; organisations need to ensure this can happen.

The Francis report has called for a strengthening of the ward sister’s role. It recommends that sisters should operate in a supervisory capacity and should not be office bound. Effective ward leadership has been recognised as being vital to high-quality patient care and experience, resource management and interprofessional working.

However, there is evidence that ward sisters are ill equipped to lead effectively and lack confidence in their ability to do so. University College London Hospitals Foundation Trust has recognised that the job has become almost impossible in increasingly large and complex organisations. Ward sisters spend less than 40% of their time on clinical leadership and the trust is undertaking a number of initiatives to support them in this role.

In 1980, Sue Pembrey described the ward sister as “the key nurse in negotiating the care of the patient because she/ he is the only person in the nursing structure who actually and symbolically represents continuity of care to the patient. She/ he is the only person who has direct managerial responsibilities for both the patients and nurses. It is the combination of continuity in a patient area together with direct authority in relation to patients and nurses that makes the role unique and so important to nursing” (Pembrey, 1980).

While this quote is more than 30 years old, it remains as pertinent today as when it was written. Ward sisters (also known as charge nurses and ward managers) are the glue in the system, negotiating the boundaries of healthcare in increasingly complex hospitals. The ward sister is responsible for everything that happens on the ward 24/7, but often has little or no control over many of the staff who work on the ward or with patients.

The work of Pembrey and her peers in the early 1980s demonstrated that ward sisters have a complex role with three parts: clinical expert; educator; and manager. In reality, these elements are interrelated and interdependent, as illustrated in Fig 1.

Skilled leaders manage these overlaps, defining the boundaries and setting the priorities. However, many struggle to balance the complexity and competing demands of the role and this is reflected in research by the Royal College of Nursing (2009). This found that ward sisters are often unclear about expectations of them and believe they lack the time, resources and authority to lead effectively. National and international studies suggest ward leaders do not believe they have the power to set priorities and are often merely responding to the demands of the system (Fealy et al, 2011; McNamara et al, 2011; Regan and Rodriguez, 2011; RCN, 2009; Gould, 2001; Aroian et al, 1996). This can lead them to focus on management tasks
rather than providing clinical leadership.

A number of high-profile cases, most recently Mid Staffordshire Foundation Trust (Francis, 2013), have demonstrated failures to deliver safe and compassionate care. These failures have contributed to a lack of public confidence in healthcare providers and particularly the nursing profession. A lack of public faith in nursing is evident in high-profile reports by charities such as the Patients Association (2011), as well as the popular press.

These concerns have led to calls to review and strengthen the role of the ward sister (Department of Health, 2012; 2010; Nursing and Care Quality Forum, 2012; RCN, 2009). Arguably, this will help to restore public faith in both the profession and our hospitals. However, any such efforts must not only include learning from these heartbreaking stories but also focus on the core values of nursing, taking the best from our past and our present.

The 6Cs strategy, recently launched by the chief nursing officer (DH, 2012), seeks to do just this. It aims to reaffirm the core values of nursing and suggests these be delivered through six action areas based on initiatives such as Energise for Excellence (NHS Institute for Innovation and Improvement, 2010) and the High Impact Actions (NHS Institute for Innovation and Improvement, 2011), as well as the popular press.

The strategy calls all nurses to action to improve care, identifying the need to strengthen nurse leadership at all levels and proposes a values-based ward leaders’ programme.

A historical perspective

The ward sister role has existed since the inception of modern nursing, underpinned by the Nightingale vocational tradition. It developed in a historically hierarchical nursing culture based on military and religious orders, where an autocratic approach was valued and nursing was based on task allocation (Marquis and Huston, 2006; Moiden, 2002; Widerquist, 2000). Key elements of the role were the direct supervision of nursing staff and learners, and the coordination of care delivery (Bradshaw, 2010). Sister had direct control of the entire ward, including staff and resources. These authors suggest a surveillance role, an all-seeing figure revered for her clinical excellence.

Until the 1960s, the role of the ward sister changed little. However, the Salmon report (Ministry of Health and Scottish Home and Health Departments, 1966) and the subsequent Briggs report (1972) resulted in a restructuring of the NHS as a whole and nursing saw some direct management responsibilities devolved to others; this reduced sisters’ direct authority. Responsibility for clinical standards remained key to the ward sister role but evidence suggests the focus on management in these restructures affected both organisational understanding of the sister’s role and the ability of sisters to maintain these clinical standards (RCN, 2009). Changes in title added to this role confusion and it could be argued that the disparity between the title ward sister and ward manager is not simply terminology but concerns the values underpinning nursing. This has contributed to the current nursing leadership crisis (Bradshaw, 2010).

Essentially the role has always and continues to comprise three key elements:

- Clinical nursing expert;
- Manager and leader of the ward staff team and the ward environment;
- Educator (of nursing and nurses, other health professionals, patients and carers).

What has changed is the increasing complexity of the healthcare organisations in which ward sisters operate. These complexities include an increasingly frail and older patient population, a larger number of professionals involved in patient care, multiple ward consultants, and multiple ward rounds that often take place at the same time. All these factors increase the challenge of ensuring effective communication on the ward.

Large and often far-removed corporate services make it difficult to resolve day-to-day issues and necessitate multiple phone calls and emails. High bed occupancy leads to pressure to discharge patients and turn their beds around rapidly for the next patient.

The welcome focus on quality targets has led to a move to understand the unique contribution of nursing to the quality of care (Griffiths, 2008). The development of measures that identify, quantify and make visible the impact of the nursing workforce on care quality outcomes increases the requirement for audits. This also brings additional work as the burden of audit and paperwork increases and many report difficulty in prioritising clinical leadership (RCN, 2009).

All these pressures, along with the demands of managing a budget, ward resources and a large team of nursing staff, make the job almost impossible.

**FRANCIS ON... WARD SISTERS**

Ward sisters and nurse managers should operate in a supervisory capacity and should not be office bound. They should:

- Know about the care plans relating to every patient on their ward and should be visible and accessible to patients and staff
- Work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team
- Ensure that the caring culture expected of professional staff is consistently maintained and upheld

**FIG 1. THE WARD SISTER ROLE**
Recently the complexities and challenges of the role have been recognised by the profession and policy makers, which has led to calls to review and strengthen the ward sister role. However, increased political pressure creates a danger of rebranding without addressing a fundamental element to ward leadership – namely the organisation in which the leader operates.

The culture of traditionally hierarchical and bureaucratic organisations is enshrined in the structure of corporate services and a surveillance culture that does not make the demands of ward leadership easier. Evidence suggests that the way we structure our organisations has an impact on how effectively we can lead (Senge, 1990). Arguably, any efforts to enable sisters to lead must address the complexity of the system they work in. A whole-systems approach to change is required, focusing on all elements of the system (Burke, 2011).

Capacity to lead
Florence Nightingale said: “Let whoever is in charge keep this simple question in her head… how can I provide for the right thing to be always done?”

At UCLH we are asking this question collectively as an organisation. We are considering how to develop individual ward sisters, as well as looking at creating organisational strategy, values, systems and structures that enable ward sisters to lead.

Turnbull-James (2011) noted that “the NHS needs people who think of themselves as leaders not because they are exceptionally senior or inspirational to others, but because they can see what needs doing and can work with others to do it”. This resonates with and builds on Florence Nightingale’s quote of over 150 years ago.

Ensuring the right thing can always be done for patients is best achieved by working collaboratively as an organisation to tackle the issues that constrain individual efforts to do the right thing. At UCLH, this has led to a whole-systems approach to a number of projects that address the ward sisters’ capacity to lead, as well as the organisation’s ability to enable effective ward leadership.

Liberating sisters to lead care
In 2009, the RCN called for ward sisters to be supernumerary. These calls have been echoed by many (Francis, 2013; DH, 2010). At UCLH, the term “supervisory to practice” is used. It is in being supervisory that ward sisters can clinically lead using their skills as clinical experts and educators to develop their teams and ensure excellence in care. We found our ward sisters were spending less than 40% of time in clinical leadership, with 35% spent on administrative tasks. Fig 2 illustrates the breakdown of their daily activities; while many are essential to the ward sister role, such as budget and staff management, they are not streamlined to minimise the time away from the bedside. Add in audit and reporting requirements and it becomes apparent that the role has become so vast that it is impossible to dedicate the clinical leadership time necessary to ensure consistency in patient care and experience.

To redress the balance, organisations need to have all their elements aligned to reduce essential but time-consuming non-clinical workloads to free sisters to lead. This has been recognised by the Health Foundation, whose Shared Purpose improvement programme seeks to address organisational design, aligning corporate and clinical services around common quality goals to improve patient experience (Health Foundation, 2013).

We have designed and are undertaking one of these nine Shared Purpose projects, Liberating Sister to Lead. Its objective is to remove the burden of corporate processes on ward sisters, freeing them up to be visible leaders of their wards with a focus on improving all elements of quality. A review of corporate services, such as human resources and finance and estates, from the ward sisters’ perspective led to an objective to increase clinical leadership time to 75% (Box 1). An example of this is the introduction of a concierge service to reduce essential but time-consuming non-clinical tasks. Fig 2 illustrates the breakdown of their daily activities, with 35% spent on administrative tasks, 21% on clinical care, and 4% on development.

A personal capacity to lead
It is evident that the ward sister role of old is not fit for purpose in today’s complex healthcare organisations. To date, much effort has been focused on finding or developing the ideal person to lead, based on this shared outdated image of the all-powerful ward sister, although it has been demonstrated that ward sisters struggle to live up to this image. Despite the challenges, many ward sisters continue to do an excellent job and this suggests personal leadership capacity also has a role to play.
In addition to developing ways of supporting ward leadership, each healthcare organisation and the nursing profession as a whole must seek to identify and nurture people with the capacity and resilience to lead consistently excellent care.

Research conducted by the Hay Group (2006) found that wards where sisters exhibited transformational leadership skills had fewer safety incidents, and staff absences and turnover were lower. The challenge is to ensure this exemplary leadership happens consistently. Studies have suggested role complexity, lack of role clarity and inadequate preparation make it a challenge for ward sisters to do the right thing all the time (Fealy et al, 2011; RCN 2009; Chase, 1994).

To address these challenges, we are working to define clinical leadership and have agreed key elements of the ward sister’s clinical leadership role (Box 1). This will lead to the articulation of clear expectations, competencies and programmes that ensure a shared understanding of the ward sister role.

These developments will be underpinned by the shared organisational values of safety, teamwork, kindness and improving, which are essential for effective leadership. Appraisal and recruitment processes will require ward sisters to demonstrate these values through their interactions with patients and staff, making everyone feel valued. This has been shown to contribute to excellence in patient and staff experience.

While these innovations will support the development of existing ward sisters there is also a need to recognise and nurture future nurse leaders early. University College London Partners has created an accelerated development programme to make this a reality. Thirteen outstanding newly qualified nurses have been through a rigorous recruitment process that includes assessing their values and behaviours alongside clinical competence and academic achievement. Those selected are undertaking a four-year programme leading to a ward leadership role and a master’s-level qualification.

The programme is grounded in practice and underpinned by clinical, educational and leadership competencies reflecting all elements of the role. These nurses will have had the opportunity to work across all hospitals in the UCLP alongside excellent ward sisters before taking up their leadership positions. This is a significant change from the experiences reported by many ward sisters (RCN, 2009) of finding themselves in leadership positions without the opportunity for targeted leadership development beforehand.

Conclusion

The ward sister role is and will remain central to consistently high-quality care and an outstanding experience for patients. It has been recognised that while nurses deliver a great deal of excellent care every day, too often care falls below the standard expected. A lack of clinical leadership is often a factor in these failures and there is an increasing call to strengthen the ward sister role.

This creates the risk of overemphasising the individual qualities of ward sisters and romanticising the ward leadership of the past. To truly ensure excellent ward leadership requires a more holistic approach to tackling the issues. This involves looking critically at healthcare organisations and taking a whole-systems approach to change. Such an approach will ensure all elements of the organisation are designed to make it easy to do the right thing and to lead others in doing the right thing. It means making changes at all levels of the organisation including addressing individual capacity and performance as well as systems, structures, culture and strategy (Burke, 2011).

In the words of Pembrey (1980): “The ward sister is a complex and senior nursing role... of vital importance to the proper nursing of patients: it is a role that the profession should not neglect.”

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“Education gives nurses the power to influence others” Wendy Ness p24
Why management skills are a priority for nurses

In this article...

› Why all nurses need management skills
› The difference between management and leadership
› Why the NHS needs a management framework

Author Joanna Kerridge is practice educator, Sue Ryder Nettlebed Hospice, and associate lecturer, University of West London.

Abstract Kerridge J (2013) Why management skills are a priority for nurses. Nursing Times; 109: 9, 16-17. Newly qualified nurses and new nurse managers are often expected to hit the ground running with no management training. Management skills are as important as leadership skills in addressing some of the failings identified in the Francis report. A management framework is required to provide a consistent approach to management development for all staff in healthcare, irrespective of discipline, role, function or seniority.

For many years there has been an emphasis on developing nurses as leaders, culminating in the launch of the Leadership Framework and the NHS Leadership Academy in 2012.

The NHS Institute for Innovation and Improvement (NHSI) acknowledges that an unprecedented level of responsibility is being devolved to frontline staff, and identifies the Leadership Framework as a significant resource to ensure that the whole workforce has the leadership knowledge, skills and behaviours needed to improve health and care (Sheikh, 2012). At the launch of the Leadership Framework in 2011, the health secretary said: “Effective and successful leadership from all staff is crucial to the delivery of high-quality healthcare to counter the challenges we face” (NHSI, 2011).

Leadership has been identified as the panacea for ills facing the NHS, but what is the role of management? Day-to-day management of services, resources and staff is the bread and butter of healthcare workers, but this is rarely acknowledged, even by staff. Management skills are valued less than leadership and clinical skills, yet the NHS would come to a halt without them.

The King’s Fund report The Future of Leadership and Management in the NHS (2011) supports this view, suggesting that excellence is needed in both management and leadership, and that “politicians in particular need to recognise that leadership in the NHS can only be as effective as the environment in which it is allowed to operate”.

The report’s authors stress that the NHS will only be able to meet the significant challenges ahead if the contribution of managers is recognised and valued; they say this includes all clinically qualified staff, at every level, who are involved in management. The report warns that viewing such managers as bureaucrats, concerned only with administrative form-filling, is insulting and can lower staff morale and inhibit the engagement of clinicians with management roles. Good management is as vital to care as the hands that deliver it, and the King’s Fund (2011) is clear that high-quality health services do not happen without skilled management.

Management and leadership links

While there is undoubtedly a distinction between management and leadership, Covey (2004) suggests they are closely linked, explaining that effective management and leadership both require putting first things first. Leadership decides what

5 key points

1. High-quality health services require skilled management
2. There is a correlation between high-quality management and leadership and a range of outcomes, such as higher-quality patient care and reduced patient complaints
3. Leaders rise out of the need to improve a situation. Managers take over the day-to-day functions required to sustain the improvement
4. A management framework could provide a consistent approach to management development for all health professionals
5. Management skills should be considered a priority for staff development

Viewing managers as bureaucrats lowers staff morale
the “first things” are, but it is management that puts them first, day by day, moment by moment. Management is the discipline that carries things out (Covey, 2004).

The King’s Fund report (2011) concurs, defining leadership as the art of motivating people toward a common goal or vision, and management as getting the job done. It identifies a correlation between high-quality management and leadership and outcomes such as higher-quality care, better productivity, higher clinical governance scores and fewer patient complaints.

Although the two are closely linked, they are not the same. If we have only leaders, we will have no followers; if there is a vision, we need people to organise and plan how to reach it. Leaders rise out of the need to improve a situation or attain a goal but, once this has been done, managers take over the day-to-day functions required to sustain improvements. In an ideal world, leaders would be good managers, and managers would be effective leaders, but this is not an ideal world.

Who leads and who manages?

Simply giving someone the title of leader or manager does not make them proficient in that role, and the titles themselves may be misleading. A nursing team leader is effectively a manager, with little of the power or authority that goes with a leadership role, whereas a ward manager is expected to be a leader, motivating and being a role model to their staff through organisational change. Given the importance of good management in creating a healthy work environment, it is crucial that the differences and challenges of these roles are acknowledged to create more realistic expectations of those who hold them (Baker et al., 2012).

Giving titles may also be unhelpful as may divert responsibility for management and leadership functions away from the rest of the team. The Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust (Francis, 2010) repeatedly identifies a lack of leadership as significantly contributing to the poor care rife in some of the wards, but primarily aims criticism at those leading from the top. Turnbull James (2011) primer, recommends a move towards a less formal and more collaborative model, where leadership is exercised across shifts 24 hours a day. This model could be extended to management practices, as Baker et al. (2012) point out that every member of a healthcare team has some management and reporting functions as part of their job.

Turnbull James (2011) highlights the danger in ignoring this individual responsibility, suggesting good practice can be destroyed by one person who does not see they can exercise leadership, or who leaves something undone or unsaid because someone else is supposed to be in charge.

The Mid Staffordshire inquiry (Francis, 2010) seems to support this view; it is critical of a hospital culture in which staff separated themselves from management, and identifies a high degree of confusion among staff at all levels as to who was responsible for nursing care. It appeared that no one took charge and neither did individuals take responsibility for managing their own practice. This led to a general acceptance of poor care and behaviour, with systems designed to improve performance, such as audit, appraisal and professional development, given a low priority.

Preparing nurses for management

Although performance management falls within the remit of managers, Baker et al. (2012) found a lack of training in this. They also said that new nurse managers, promoted from direct care roles, are often not given formal training for their new role but expected to hit the ground running. The same could be said of newly registered nurses and newly appointed nursing staff. Clinical aspects are usually addressed but management needs are rarely identified or seen as a priority (Baker et al., 2012).

It is assumed people will gain these skills on the job – but they need good role models. It could be argued that, if learning on the job was effective, we would have a more competent and confident workforce.

A framework for developing managers

So, where is the framework for developing effective managers? There is an argument for considering this for all staff, as all roles require organisational skills such as communication, planning, prioritisation and documentation. For designated nurse managers, staff allocation and human resource issues seem to occupy a large portion of their time (Baker et al., 2012). This includes administration such as organising the off-duty rota and skill mix, as well as staff recruitment and induction. Performance management linked to appraisal and dealing with poor performance is a key responsibility, alongside clinical supervision and staff development. However, these often take a back seat to clinical demands, as they are generally seen as lower priority when a service is short staffed.

Clinical governance is often seen as management responsibilities, but this is to misunderstand the term. All staff are required to ensure patients receive high-quality care. They do this through professional and contractual obligations to:

- Adhere to organisational policies and best practice;
- Attend statutory, mandatory and professional training;
- Participate in risk assessment and risk management, ensuring compliance with regulatory standards;
- Identify and report where these are not happening.

This list confirms the complexity and variety of management responsibilities and skills needed in different roles.

A management framework that mirrors the Leadership Framework (NHS Leadership Academy, 2013) could be invaluable in enabling all staff to attain the management behaviour required to deliver good care. Some of it could be adapted from the Leadership Framework, specifically the section on managing services. However, work is needed to draw up a management framework equivalent to the one for leaders.

Conclusion

Management skills should be considered a priority if we are to avoid a repeat of the standards of care and behaviour that led to the Mid Staffordshire inquiry. Unfortunately, this is unlikely unless management skills are seen as valuable and needed by everyone, rather than add-ons for those who desert clinical care for an easy life behind a desk. A good start would be for the government and NHS to start promoting them with enthusiasm, giving them the same priority and profile as their leadership cousin.

References


Fishbone analysis can be used to identify and solve problems, and assist staff to make changes to benefit both patients and staff.

In this article...

- What is fishbone analysis?
- How this tool can be applied to clinical settings
- Case study of fishbone analysis being used in practice

**Keywords:** Fishbone analysis/Root cause analysis/Change management

**5 key points**

1. Visual diagrams can be helpful in analysing and illustrating clinical problems.
2. Root cause analysis is increasingly used in healthcare settings by a variety of staff.
3. Using a group facilitator helps prevent problem-solving groups from going off on tangents and being unable to develop an action plan.
4. Exploring issues in detail can reveal possible solutions that might not have been previously considered.
5. Using an open question approach to analysis is helpful in determining the relationship between root causes.

**In the 1950s,** Japanese Professor Kaurou Ishikawa was the first person to describe the cause of a problem using a visual diagram, commonly known as the fishbone analysis diagram, named for its resemblance to a fish backbone and ribs. It has since become a key diagnostic tool for analysing and illustrating problems within root cause analysis (Galley, 2012) and is a useful diagnostic tool in service improvement projects.

Fishbone analysis begins with a problem and the fishbone provides a template to separate and categorise the causes. Usually there are six categories, but the number can be changed depending on the problem (Fig 1). This method allows problems to be analysed and, if it is used with colleagues, it gives everybody an insight into the problem so solutions can be developed collaboratively (NHS Institute for Innovation and Improvement, 2008).

Organisations in which staff are encouraged to evaluate practice, risk and mistakes when they occur tend to have a culture where root cause analysis or fishbone analysis is used. This helps to truly understand the cause of a problem and to clarify issues (Esmail, 2011).

**Root cause analysis**

Root cause analysis is increasingly being used in health and social service to improve safety and quality and minimise adverse events (Pearson, 2005) as it provides retrospective reviews of incidents or events.
A cause and effect chart (Hughes et al, 2009), such as fishbone analysis, provides a tool to identify all the possible causes of a problem not just the obvious ones. It seeks to locate the “root” of the problem from a systemic perspective rather than through personal blame.

Root cause analysis aims to answer the following questions:

» What happened?
» How did it happen?
» Why did it happen?
» What solutions can be developed and fed back to staff (NHS Scotland, 2007)?

When using a fishbone diagram method of root cause analysis, the following steps should be taken:

» The group should be made up of all staff available from the service or clinical pathway;
» They should start with a mind-mapping exercise to evoke ideas and issues (causes) that are related to or affect the problem (effect);
» Each main category should then be explored in detail to identify the causes of issues;
» A facilitator should act as a note taker and keep the group on track, preventing members from being side-tracked by tangents, which detracts from the event at hand and could prevent them from developing a strong action plan (Moravec and Emmons, 2011).

This process elicits root causes rather than just symptoms and results in a detailed visual diagram of all the possible causes of a particular problem. Exploring issues in detail often demonstrates possible solutions that might not have been previously considered.

There are a number of factors to consider when organising and facilitating a session that uses the fishbone diagram to identify issues relating to a clinical pathway or process review (Box 1) (NHS III, 2008).

Although participating in a root cause analysis exercise may seem daunting, the critical thinking skills gained through the experience can help staff in their roles in health (Tschannen and Aebersold, 2010). Lambton and Mahlmeister (2010) involved student nurses in root cause analysis exercises to develop their awareness of the responsibility and professional duty to participate in making a patient environment safer.

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number of clinic rooms had not previously
been considered in conjunction with the clinic list, which meant there was no cor-
relation between the number of patients on the clinic list (demand) and the avail-
able clinic rooms (capacity). The group also identified that checking patient notes was done during the afternoon before the clinic started, which did not leave enough time to chase any missing notes.

By using root cause analysis methodology, they were able to highlight a number of solutions to their problem (Kerridge, 2012). These included:

- Scoping the requirement for a patient notes tracking system and considering moving the outpatient clinic to a clinic with more space. The facilitator assisted the group in drafting an action plan for next steps that offered structure to resolving the problem and a small project was initiated to deliver improvements. The action plan included:
  - Looking in to the feasibility of increasing the number of clinic rooms based on activity;
  - Drawing up a spaghetti diagram, a diagram representing the path followed, to clearly understand department flow inefficiencies;
  - Discussing arrival times with patient transport;
  - Processing a map of how patient files are pulled and prepared for clinic.

Conclusion

Fishbone analysis provides a template to separate and categorise possible causes of a problem by allowing teams to focus on the content of the problem, rather than the history. It is useful in root cause analysis, which is increasingly being used in health services to improve safety and care quality.

A successful way of using fishbone analysis is to encourage a group of staff who are involved with a service or clinical pathway to work together to identify all possible causes of a problem. These causes are then categorised in groups, such as environment, method, people and equipment. On completing this exercise, the solutions will likely be identified and an action plan for next steps can be drawn up.

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CHANGE MANAGEMENT TOOLS

1. Using fishbone analysis to investigate clinical problems – 16 April
2. Managing clinical improvement projects – 23 April
3. Use of process mapping in service improvement – 30 April
Managing clinical improvement projects

In this article...

- Principles of project management in clinical settings
- How to write a project plan
- Case study of project management used in a clinical setting

Projects are not undertaken only by those in management, administration or construction; many clinicians and nurses are excellent project managers because of their skills in managing patient care. However, the terminology used can often make project management daunting for those not in a business arena, as it is often confusing. Jargon is commonly used and, although it is useful to understand this terminology, it is not always necessary to use it (NHS Institute, 2007).

Project structure
The key to a successful project is having a clearly defined structure identifying roles and responsibilities. Although the size of the project will influence the number of people involved and therefore the structure, any project should have the following key roles:

- **Project lead**: responsible for the overall delivery of the project plan, and
- **Project manager**: responsible for the day-to-day management of the project.

Good communication should keep all staff involved and up to date with progress.
often the person who updates the project board (if appropriate). This person is the main point of contact, particularly for issues requiring escalation;

- **Project manager:** responsible for producing, updating and maintaining the project plan, and may also need to deputise for the project lead if they are unavailable.

In small-scale projects, the project manager and project lead roles may be combined, but the responsibilities and roles remain the same.

### Project plan
A project plan is vital to deliver a successful project. It lists all activities that need to be completed to achieve the project’s goal, with each task given a start and end date to ensure they are completed within the project timescale. Tasks are assigned to particular people or teams to take lead responsibility.

The plan can be set out using the template below.

### Project set up and structure
This section should list all the tasks associated with setting up the project and deciding on its structure. These may include the following:
- Arranging monthly project meetings;
- Agreeing project structure;
- Identifying key leads within specialties;
- Producing high-level, detailed project plans;
- Defining project priorities;
- Creating and maintaining a risk log;
- Defining the project scope (what the project’s remit is);
- Producing clear written objectives and measures.

### Diagnosis
This section should detail all the tasks that help to identify any issues that may arise. These may include:
- Identifying and agreeing priority areas for review;
- Processing map services, patient pathways or business processes;
- Reviewing current patient pathways;
- Reviewing current workforce structure;
- Understanding current ways of working.

### Consultation and redesign
This concerns actions around redesigning a process or patient pathway, or activities associated with making the change. These may include:
- Organising workshops to feed back process mapping findings;
- Proposing new ways of working, patient pathways or business processes for pilot testing;
- Meeting departments and support services that may be required to give an input into the redesign;
- Drafting new operational procedures or amending existing documentation for sign-off.

### Implementation and evaluation
The final section details actions associated with implementing the new process, pathway or way of working, and evaluating its success. These may include the following:
- Developing training manuals;
- Drafting a training programme;
- Developing an implementation programme;

#### Table 1. Case Study – At-the-Bedside Handover

<table>
<thead>
<tr>
<th>Activity</th>
<th>Deadline</th>
<th>Lead</th>
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<td><strong>Project structure and set-up</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree project team membership</td>
<td>3 April</td>
<td>Matron</td>
</tr>
<tr>
<td>Produce and agree project plan</td>
<td>10 April</td>
<td>Ward manager</td>
</tr>
<tr>
<td>Define project priorities</td>
<td>10 April</td>
<td>Matron</td>
</tr>
<tr>
<td>Set up project team meetings</td>
<td>4 April</td>
<td>Matron</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process map the current way of handing over in the morning, afternoon and evening (including the timing of each handover)</td>
<td>15 April</td>
<td>Band 6s</td>
</tr>
<tr>
<td>Develop a patient questionnaire to understand how patients feel about the current way of handing over and the proposed at the bedside handover</td>
<td>20 April</td>
<td>Ward manager</td>
</tr>
<tr>
<td>Complete patient questionnaires</td>
<td>26 April</td>
<td>Band 6s</td>
</tr>
<tr>
<td>Liaise with information governance re patient confidentiality</td>
<td>26 April</td>
<td>Band 6s</td>
</tr>
<tr>
<td><strong>Consultation and redesign</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree and organise a workshop to discuss process mapping and other findings with ward staff and other stakeholders (those with an interest in the project)</td>
<td>10 May</td>
<td>Ward manager</td>
</tr>
<tr>
<td>Design new process for at-the-bedside handover</td>
<td>20 May</td>
<td>Matron and ward manager</td>
</tr>
<tr>
<td>Present new process at project team for sign-off</td>
<td>25 May</td>
<td>Matron</td>
</tr>
<tr>
<td>Present new process to executive team for sign-off</td>
<td>28 May</td>
<td>Matron</td>
</tr>
<tr>
<td>Scope training requirements for at the bedside handover</td>
<td>1 June</td>
<td>Ward manager</td>
</tr>
<tr>
<td><strong>Implementation and evaluation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop training programme to ensure all staff are briefed in new process and go-live date</td>
<td>10 June</td>
<td>Professional development nurse</td>
</tr>
<tr>
<td>Develop evaluation tool to assess success of at-the-bedside handover</td>
<td>10 June</td>
<td>Professional development nurse</td>
</tr>
<tr>
<td>Develop communication plan for specialty team including medical team</td>
<td>10 June</td>
<td>Professional development nurse</td>
</tr>
<tr>
<td>Sign off training programme and communication plan at project team meeting</td>
<td>15 June</td>
<td>Matron</td>
</tr>
<tr>
<td>Commence implementation of the new process and evaluate</td>
<td>20 June</td>
<td>Ward manager</td>
</tr>
<tr>
<td>Write up and communicate project findings across the trust</td>
<td>1 July</td>
<td>Matron and ward manager</td>
</tr>
</tbody>
</table>
Developing an evaluation tool;
Agreeing feedback method.

Using this template in practice
The fictional case study in Table 1 examines how “at-the-bedside” patient handover was implemented on an acute surgical ward. This example illustrates a project plan for a ward with a two-month implementation plan. The ward matron is the project lead and the ward manager has been designated as project manager.

Understanding the risks
Most projects will have some associated risk. It is important to assess and understand each risk and indicate how to limit its effect. Table 2 shows an example risk log with mitigation plan for the case study.

Communication
Good communication is essential to help make everyone involved in the project feel included and valued. This can be achieved through various methods including meetings or briefings, with the project manager regularly updating the project plan and distributing this to key project members.

Conclusion
Project management can seem daunting because the process is not always clearly described and much of the literature on the subject is discussed within business and construction arenas, rather than health settings. However, the key principles described in this article set out the processes of managing projects’ structure and definition, which are key features of successful projects. By applying these, progress can be easily monitored and issues highlighted at an early stage, giving time to develop a resolution.

Reference

Table 2. Example Risk Log

<table>
<thead>
<tr>
<th>Risks associated with implementing at the bedside handover</th>
<th>Mitigation plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly confidential patient information will need to be discussed away from the patient’s bedside, potentially disjointing handover</td>
<td>Develop an operational procedure to hand over all confidential patient information away from the bedside, followed by at-the-bedside handover for all other clinical information</td>
</tr>
<tr>
<td>Patients may feel uncomfortable having their progress discussed at the bedside in earshot of other patients.</td>
<td>Understand patient perceptions of at-the-beside handover through the questionnaire. Ensure handover is undertaken discreetly and efficiently</td>
</tr>
<tr>
<td>Staff may be constantly interrupted during handover, prolonging the handover process</td>
<td>Ensure patients understand the process of at-the-bedside handover when they arrive on the ward to minimise interruptions and identify a floating staff member who can assist patients during this time</td>
</tr>
</tbody>
</table>

CHANGE MANAGEMENT TOOLS
1. Using fishbone analysis to investigate clinical problems – 16 April
2. Managing clinical improvement projects – 23 April
3. Use of process mapping in service improvement – 30 April

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Use of process mapping in service improvement

In this article...

- Why it is important to review processes
- How care pathways and processes can be mapped
- How this information can improve patient experience

Author Joanna Phillips is service improvement manager; Lorraine Simmonds is head of service improvement; both at University Hospitals Birmingham Foundation Trust.


This article, the last of our three-part series on change management tools, analyses how process mapping can be used to show how processes are currently carried out and identify any changes that may improve the patient experience. The tool takes into account patient opinions so staff are able to see the pathway from patients’ perspectives. It offers advice on how to write up the results and how they can be analysed to identify where changes can be made.

Service improvement seeks to continuously adapt and improve processes and pathways to benefit patients, carers and healthcare providers, and to support clinical excellence (NHS Institute for Innovation and Improvement, 2008).

Recently, national initiatives have emphasised the importance of frontline staff in service improvement; ensuring that these staff can influence and manage change is essential for delivering new models of care (Kerridge, 2012). Clinical pathways and service processes have evolved over time, often through a local response to workforce, service or clinical modifications rather than through conscious decisions to improve them. This can often result in complex patient pathways that lack logic; when asked why something happens, the answer can frequently be “because that’s how it’s always been done” rather than “because this is the best way”.

The aim of pathway and process reviews is to give a clear and full understanding of the existing state so problems can be identified and changes made to improve the patient experience and care pathway. One way of doing this is through process mapping, which aims to clarify the clinical pathway by providing a visual presentation of each step of the process (Hong, 2010).

Process mapping

A process is a series of connected steps or actions that achieve an outcome (III, 2008). Process mapping can be used to document the steps of any process or pathway, whether at a high or more detailed level. Fig 1 illustrates a high-level process map of a patient arriving at the emergency department and being admitted to a ward.

Taylor and Randall (2007) describe process mapping as a simple but powerful tool to unpick the many layers to both service processes and patient pathways, which involve a number of staff in different roles and departments. It is a valuable method of identifying issues, developing solutions and enabling interdisciplinary teamwork (Taylor and Randall, 2007).

Many clinical pathways are complex in nature, which makes it difficult to clearly

Maps can reveal where issues arise

Keywords: Patient experience/Care pathway/Process mapping/Visual representation
identify the issues or problems that affect their efficiency and the patient experience. As Kerridge (2012) noted, it is often difficult to pinpoint exactly what is wrong and use this information to develop a solution to put it right.

Using a process map makes the pathway more transparent as each step is described, making it easier to highlight the problems and propose solutions. Having a map also prevents assumptions being made about the problems, which can result in solutions that do not address the actual issues.

Process mapping is a valuable and useful way for teams to reflect on the way they work, diagnose and understand problems and identify areas where they can improve. Creating a visual representation of the steps involved in a clinical pathway enables everyone involved to see the overall picture.

A key to successful process mapping is seeking clarification for the reasons behind a step or decision made during the clinical pathway. A useful technique for obtaining more detailed responses when talking to those involved is using the “5Ws and 1H”, which refers to open questions starting with why, what, when, who, where or how. It can also be beneficial to map a process that is unfamiliar as it averts the temptation to make assumptions about the pathway or process. By working out how things are done currently, the team can reflect and decide what the ideal clinical pathway should be.

A successful process mapping exercise should reveal:
- Unnecessary steps, handovers, delays;
- Any waste – duplication of effort;
- Things that do not add value to the patient journey;
- Bottlenecks and constraints;
- Unhelpful variation;
- Potential to create safer care;
- Understanding of the patient experience;
- Where further analysis is required (NHS III, 2008).

It is important to communicate with a service, department or staff group before starting any process-mapping exercise, particularly if a service improvement team, or someone who is not part of the team running the service in question, leads the exercise. It is essential for teams to feel involved with the improvement process because it will be up to them to deliver any changes the process shows are necessary.

Involving staff can be done in the form of a briefing session, task and finish group or informal discussion with staff, all of which are good opportunities to seek the team’s views on current practice and any issues they are already aware of. The aim is to inform staff, seek engagement in the process and mutual acknowledgement that the patient is the focus of any service or clinical pathway review. This is vital because process mapping and outcome feedback can cause anxiety and defensiveness and can be interpreted as judgement and criticism if not handled sensitively.

**Observational process mapping**

Observational process mapping involves observing the clinical pathway first hand so the observer can note patients’ experiences while mapping the pathway; “go and see for yourself” is a useful message.

When using observational process mapping it is important to capture the patient’s perspective without preconceived ideas (NHS III, 2008). The observer should try, where possible, not to intervene in the steps of the clinical pathway. For example, if a patient arrives in a department and is not greeted immediately by a receptionist or nurse, the role of the observer is not to initiate communication, but to wait with the patient to see what happens “in reality”. This, however, should be balanced with a duty of care to ensure the patient is not adversely affected by this passive approach.

**Conventional process mapping**

Conventional process mapping involves bringing together a range of people who represent different roles and functions associated with the clinical pathway. The group is involved in mapping the pathway using a table-top exercise where everyone has opportunity to discuss the steps taken through the pathway from their perspective. The overall outcome is the same as observational process mapping; a visual representation of the steps is produced but this is without the patient’s perspective unless a patient is involved in the mapping exercise.

**Writing up a process map**

While completing an observational process map, it is useful to take detailed notes including time-recorded steps, for example:
- 9.00am, patient arrives at reception;
- 9.05am, patient called into assessment room.

Each step of the clinical pathway should be annotated with detailed observational notes that relate to patient experience or general observations. These will assist the observer when writing up the pathway as well as giving additional information if the process is complex. For example:
- The receptionist was welcoming and smiled when the patient arrived;
- There was no reading material in the waiting area;
- The patient commented the waiting room seats were uncomfortable;
- The nurse made sure the patient understood all aspects of their care.

When mapping a clinical pathway using the conventional method, steps can be noted in Post-it notes or slips of paper so their order can be changed on a larger piece of paper to complete the pathway and additional notes can be added.

A process map should not be written up until after the observation to make sure the observer focuses on mapping the clinical pathway and is not distracted by capturing the process, resulting in the discussion being stifled and possible solutions being missed. Not writing up until after the event also gives an opportunity for reflection, which is a valuable in considering solutions to problems. However, write-up should not be left too long after the observation so that the events are still fresh in the observer’s memory.

**Basic flowchart symbols**

Numerous software programmes can be used for mapping processes, some of which are free. Although these are useful they are not essential; most process maps should reveal:
- Unhelpful variation;
- Bottlenecks and constraints;
- Unnecessary steps, handovers, delays;
- Any waste – duplication of effort;
- Things that do not add value to the patient journey;
- Potential to create safer care;
- Understanding of the patient experience;
- Where further analysis is required (NHS III, 2008).

A spaghetti diagram is a helpful tool to establish the optimum layout of a department or ward based on the distances travelled by patients or staff.

These diagrams often expose inefficient layouts and can identify large, unnecessary distances that patients need to travel between stages in the pathway (NHS III, 2008). The simplest way to create a spaghetti diagram is to draw a simple map of a layout, then lines indicating flows. The diagram can be used to redesign a process by showing how the flow can be improved or reduced.
can be written up using Microsoft Word or Excel. There are some standard basic flowchart symbols used to identify specific activities in the map (Fig 3).

**Fig 2. Case Study: Process Mapping an Outpatient Appointment Attendance**

This example of observational process mapping describes a patient pathway for attending an outpatient appointment. The example is simple but illustrates the importance of time-recorded steps with additional commentary relevant to patient experience. These are important to ensure the process map and commentary detail is clear.

<table>
<thead>
<tr>
<th>Process Map</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00am</td>
<td>Patient arrives and parks the car</td>
</tr>
<tr>
<td></td>
<td>It took 30 mins for patient to find a space</td>
</tr>
<tr>
<td>10:10am</td>
<td>Patient walks to outpatient department</td>
</tr>
<tr>
<td>10:25am</td>
<td>Patient arrives at outpatient reception and registers</td>
</tr>
<tr>
<td></td>
<td>Patient is 15 mins late due to difficulties in parking, which makes them anxious. The receptionist tells them to sit in waiting area without making eye contact</td>
</tr>
<tr>
<td>10:30am</td>
<td>Patient sits in waiting area</td>
</tr>
<tr>
<td>10:45am</td>
<td>Nurse asks patient if they have had a blood test in the last two weeks</td>
</tr>
<tr>
<td></td>
<td>Patient has a blood test as they haven’t had one in the last two weeks</td>
</tr>
<tr>
<td>11:50am</td>
<td>Patient called by the nurse to see the consultant</td>
</tr>
<tr>
<td></td>
<td>The waiting area is busy and it is difficult to hear the nurse calling patients</td>
</tr>
</tbody>
</table>

**Fig 3. Basic Flowchart Symbols**

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Representation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rectangle</td>
<td>an activity or task</td>
</tr>
<tr>
<td>Diamond</td>
<td>a decision</td>
</tr>
<tr>
<td>Delays</td>
<td></td>
</tr>
<tr>
<td>Arrow</td>
<td>transport/movement</td>
</tr>
<tr>
<td>Oval</td>
<td>starts/finishes a process</td>
</tr>
</tbody>
</table>

**References**


**Change Management Tools**

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**Analysing the pathway/process**

On completing the observational or conventional process-mapping exercise and write-up, the problems and possible solutions often become self-evident. However, the following questions may be useful to assist with analysis (NHS Institute, 2008):

- How many steps does the patient have to complete and are they all necessary?
- How many times is the patient passed from one person to another?
- How long does each step take and what is the time between steps?
- How long does the whole pathway take?
- What are the delays – do they occur regularly?
- Where are there problems for patients and staff?

**Conclusion**

Process mapping is a vital tool used in service improvement to clearly understand each step of a clinical pathway or process.

Patient pathways often result from the evolution of complex pathways that may not always be as efficient as they could be and do not offer the best care in terms of patient experience.

Mapping a process is useful as it offers, often for the first time, an objective, visual representation of the patient journey highlighting the problems; this activity often generates solutions. There are two methods of process mapping: observational, involving first-hand experience of the patient’s journey by following the patient; and conventional process mapping, that is, a table-top exercise involving all stakeholders who map out each step.

Process mapping can be used not only to map existing practice, but also to evaluate the impact of the change project. A spaghetti diagram can be used to demonstrate distances travelled in a department and establish the most efficient layout.

When writing up a process map, it is useful to use the standard flowchart symbols to clearly indicate activities and decisions through the process (Fig 3); annotated notes can be used to provide patient observations or additional information, particularly if the process map is complex. NT