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Frontline nurse leadership: an international perspective

Case Studies from Australia, New Zealand and the United States

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Introduction and purpose of this paper

The Francis Inquiry stressed the importance of strong nurse leadership from ward to board in order to drive up standards of excellence, support an open organisational culture and deliver high quality and safe patient care. Recommendation 195 of this report championed the principle that the ward leader should be a supervisory role, stating:

"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."

Following on from Francis, successive reviews have also flagged the need for empowered nurse leaders. The most recent of these, the Shape of Caring review, which was undertaken by Health Education England (HEE) and the Nursing & Midwifery Council (NMC) has recommended that nurses and health care assistants at all levels be required to "adapt, support and lead research and innovation to deliver high-quality care."

Strengthening nurse leadership at all levels is an international nursing priority with many nursing organisations developing leadership roles and representation at national or board level. The RCN supports the Francis recommendation and believes that all ward management positions in the UK should be supernumerary with an explicit job focus on supervisory capabilities.

Although none of the international case studies looked at in this paper officially recognise the Francis interpretation of 'supervisory/supernumerary', this does not mean that there are no ward leadership positions operating in a supernumerary context. In truth, many have been doing so for a long time and a lot of the essential elements of a ward manager's role, as we would recognise them, are present across international care settings. What is striking is that although supernumerary might not be as acutely defined in these countries as in the UK, the challenges which international ward leaders face are often the same irrespectively.

As a result, it is likely that the job roles and responsibilities of international ward leaders are likely to vary significantly during the practical day-to-day demands of a ward setting.

This paper looks at how some other English-speaking countries have developed their ward leadership structures with the findings grouped around three key themes. These are:

- clarity of role and responsibilities
- effectiveness of succession planning, and
- managing realistic workloads.

At the end of this paper readers can find a '**Lessons for the UK**' section which summarises the findings in this paper to help inform the UK policy debate about how to make ward nursing more effective and responsive to the challenges of restricted funding and rapidly changing patient needs.

The RCN and nurse leadership

Effective leadership on the ward is essential to ensure safety, better health outcomes and greater patient satisfaction. However, in spite of this, an RCN Frontline First report published in March 2014 found that the pressure to identify efficiency savings has led to a 5.98 per cent decrease in the number of nurses in the principal leadership Agenda for Change bands (7 and 8) over the period April 2010-September 2013 in England.

The report also found that certain English regions, particularly those with less robust health indicators, such as adult mortality rates, fared worst off. Yorkshire and the Humber for example registered an 11.62 per cent decrease and the East Midlands a 7.22 per cent decrease. This compares unfavourably to regions with stronger health statistics such as London, which saw a 2.64 per cent decrease.ⁱⁱⁱ

The role of the ward sister/charge nurse in the UK is ideally situated in the hospital system to supervise clinical care, oversee quality and safety standards, co-ordinate patient care activities at ward level, and promote nursing leadership and mentoring. Within the National Health Service (NHS), the job specification for ward sisters varies across health providers – with some having budgetary and staffing duties while others have much more clinically focused roles. The Francis Inquiry recommendations recognised the importance of supporting ward sisters in a supervisory capacity so that they have time to mentor staff, be visible to patients and families, and promote safe practice by overseeing a sustainable distribution of junior nurse workloads.

However, a 2013 UK-wide RCN survey among ward sisters found that only 50 per cent of respondents had budget-holder responsibility for staffing needs, whilst 35 per cent did not have responsibility for signing off staffing rotas. Furthermore, 65 per cent did not have supervisory status and a large majority (70 per cent) did not have enough time to carry out their roles as they would like to.^{iv} Other key responsibilities such as mentoring staff and students, appraisals and professional development have suffered as a result of budget cuts and resource constraints. In the business case for ward sisters, the RCN outlined how cost-effective the change to supervisory practice for ward sisters/team leaders can be, through improvements to areas including:

- patients' experiences, outcomes and safety
- the health and well-being of staff

- increased productivity and enabling innovation, and
- a work place culture that sustains the local population's confidence in health care provision.^v

The Royal College of Nursing (RCN) also published a report in 2009 called, 'Breaking down barriers, driving up standards'^{vi} where it strongly recommended that ward sisters be supernumerary, highlighting the link between effective ward leadership and a reduction in medication errors, higher staff retention and lower sickness rates, and greater patient satisfaction.

The Francis Inquiry highlighted the prevalence of care failures in wards that lacked strong nurse leadership and a 'caring culture'. There was a specific recommendation (number 195) that stressed the significance of strengthening the role of ward sisters in a supervisory capacity to oversee and co-ordinate patient care and staffing needs like education, mentoring, training and development at ward level.^{vii} Robert Francis QC himself stated, "The ward manager's role as leader of a unit caring for patients is universally recognised as absolutely critical...Not all nurses want to undertake, or are capable of undertaking, this challenging but rewarding role, and it is not always easy to identify suitable candidates."^{viii}

The RCN's ground-breaking clinical leadership programme (CLP) has been recognised across the UK as an effective development programme for frontline ward leaders giving them the necessary tools and skills to effectively transition into this role. The core aims of the initiative identified five themes that appeared to be common in the most effective leaders: **self-awareness, team work, patient focus, networking and political awareness.** The Department of Health in England commissioned the programme as part of the *Making a Difference Strategy for Nursing* in 2001. Variations of the CLP have also been commissioned by the Welsh Assembly and the programme was commissioned by the Scottish Government for every Board in NHS Scotland. After a review of its content in 2013/14, the CLP will resume in October 2015.

Many other organisations and indeed, countries, have followed the CLP example and set up their own ward leadership programmes.^{ix} In Australia in 2014 for example, the Australian College of Nursing (ACN) announced a new major strategic direction for advancing leadership by providing nurses - at all stages of their career - learning experiences and opportunities to prepare and enable them to lead change and contribute to a range of policy issues. According to the ACN, this will be done by setting up new state-based leadership forums, nursing leadership courses, online networks and communities of interest.

The UK nations in focus

Responsibility for health spending and operational reform is devolved (to varying extents) across the four constituent nations of the United Kingdom. As a consequence, the 'UK-picture' contains significant internal variations and differences, the most significant of which are identified below. This section is not intended to provide a comprehensive picture of the state of

nursing leadership in each of the four nations, but rather to highlight the principal (and sometimes unique) challenges which these countries face.

England

Ward nurse leaders in England have faced significant upheavals since the government announced that the UK-wide NHS would need to identify some £20 billion of savings by 2014/15. Whereas health funding enjoys varying degrees of devolved autonomy in Scotland, Wales and Northern Ireland, England is directly beholden to the centralised authority of the Department of Health.

Reductions in the numbers of ward sisters and charge nurses has been a key challenge, details of which can be found in the RCN's Frontline First report, 'Not Just A Number' published in 2014.^x **A key finding for English hospital wards in this report is that numbers of senior leaders (bands 7 and 8) in acute, elderly and general settings have declined by 1.15 per cent for the period April 2010-September 2013,** in spite of continuously rising demand for ward services.

Some English hospitals however have managed to improve this situation. Macclesfield District General Hospital in Cheshire for example has put all of its band 7 ward nurses into full supervisory positions, enabling these individuals to spend more time overseeing their wards.^{xi} Since this change, the number of patients across the East Cheshire NHS Trust who received assessments has improved markedly. Falls assessments rose from 75 per cent to 94 per cent, nutrition assessments rose from 62 per cent to 95 per cent and pain assessments improved from 74 per cent to 91 per cent.^{xii}

In addition, despite severe financial difficulties, the NHS is looking at various ways in which it can train more ward leaders, while simultaneously strengthening career routes for future generations. A 2010 NHS Leadership Academy initiative is aiming to deploy an additional £45 million of funding by 2015 in training for general nurse leaders, and whilst ward leaders are included in this category, it is not clear what portion of funding will be committed to this area. In terms of career structuring the academy has stated that it hopes that the qualifications which this funding is aimed at will become a staple requirement for future aspiring leaders across the NHS.

This indicates that although the NHS is looking to formalise a career path for leadership, it is not singling out ward settings for particular focus.^{xiii} Finally, whilst the RCN has welcomed this particular initiative, it has noted that it will take time to reverse the adverse effects of previously steep reductions in leadership funding. It should also be noted that whilst the £45 million funding is guaranteed until 2015, there are currently no commitments to extend this programme beyond that date.

Scotland

In Scotland, ward leaders/sisters are referred to by a variety of terms with one of the most common being “Senior Charge Nurse” (SCN). **In 2002 a report by Audit Scotland found that the SCN role had become increasingly fragmented, with poorly specified responsibilities and a growing workload undermining the effectiveness of the role.**^{xiv} This resulted in the roll out of a national NHS Scotland programme to support SCNs entitled “Leading Better Care (LBC).”

The programme went on to incorporate elements of ‘Releasing Time to Care.’ A progress report in 2010 stated that, “the role (SCN) was veering significantly away from a focus on providing clinical coordination and managing patient care towards a more management and administrative orientation, which was recognised as representing a denial of the true potential of the role.”^{xv}

The LBC initiative, involves, “asking nurses to look anew at the way they work, identify how they can be more productive and effective, then make changes to their environments and working methods to improve quality and increase the amount of time they spend providing direct patient care.”^{xvi} In addition, the initiative identified that defining the key responsibilities of SCN’s, setting core competencies and outlining specific job descriptions would also help to improve effectiveness.

However, LBC is not a mandatory programme. Participating wards are provided with an education package and participating SCNs work their way through a set of guides or modules, each of which aims to improve a particular ward process. As outlined in the report, “The guides develop ward teams’ skills and understanding of how part of their work consists of processes that can be improved, ultimately resulting in a more effective and efficient clinical environment and increasing the amount of time staff have to spend with patients.”^{xvii}

The RCN has welcomed this and similar programmes launched by NHS Scotland, but has also highlighted that a crisis in recruitment and an impending wave of retiring SCNs presents significant problems for ward leadership in the medium-to-long term. It should also be noted that the Leading Better Care report focuses on standardising and clarifying the responsibilities of the SCN role. It pays no direct attention to incentivising future recruitment of ward leaders, or defining the career structure for senior grades.

Wales

In 2008, the Welsh Government initiated a flagship leadership programme called ‘Free to Lead, Free to Care.’^{xviii} The particulars of this initiative are incorporated under various terms across different hospitals, but its defining feature is a drive to train ward leaders (bands 6, 7 & 8) so that the Welsh health system has a sustainable supply of future leaders.

A critical part of delivering this aim has been making ward leadership training modules a required component of CPD in acute care settings. According to the Welsh Assembly, “...all existing and newly-appointed staff will undertake core modules of this training as part of their continuing

professional development, offering experience of other environments to learn new styles and skills, and better understanding of the impact of leadership on patient care.^{ix}

Wales has also pioneered a quality improvement toolkit which provides guidance for ward leaders on how to improve performance in specific areas of their workplace, such as staff contentment for example. **This has been cited as helping leaders to deliver incremental progress, often seen as more attainable as opposed to wholesale improvement which is often beyond a ward leader's resource and time capability.**

Input from the RCN's Wales Office indicates that the day-to-day job role of ward leaders can vary quite significantly. Depending on their place of work, some have indicated that they have extensive responsibility for budgeting, staff appointment, training, etc. and that they are given sufficient time to deliver these responsibilities. However, others have indicated that much of their time is spent helping to plug shortages in staff rotas.

Northern Ireland

Historically, ineffective staff deployment systems have added to the workloads of ward sisters and charge nurses who have to navigate complicated bureaucracy in order to secure shift cover for any short term absence. These pressures became more acute in Northern Ireland after 2007 when 18 trusts were amalgamated to five. This change led to a significant reduction or redistribution of senior nurse leaders and, consequently, nursing staff noted a reduction in leader visibility.^x

In June 2009, the then Health Minister, Michael McGimpsey announced £2 million in support to ward sisters and charge nurses in order to free up 20 per cent of their time to focus on quality, safety and the patient experience. These funds have been delivered and the RCN's Northern Ireland office has noted a general improvement in ward performance.

International case studies

1) Australia (Queensland)

For purposes of clarity, this paper will review the experiences of ward leaders in two of Australia's states: Queensland and New South Wales. This approach has been adopted because healthcare in Australia is decentralised across its constituent territories and consequently, there is no standardised role description.

Nurse Unit Managers (NUMs) in Queensland manage a ward within a hospital, aged care facility or community hospital. For all intents-and-purposes this is a supervisory position, without being termed as such.

The principal purpose of NUM's is to undertake supervisory responsibilities, including: overseeing nursing practice, monitoring quality and professional standards, and developing/mentoring staff. However, day-to-day operations can see NUMs pulled out of their supervisory capacity to help manage staff shortages and/or high patient volumes.

NUMs require a bachelor degree or higher education qualification and at least five years working experience as a registered nurse in order to transition into this role. In theory, NUMs in the Australian context enjoy extensive responsibility over areas including:^{xxi}

- monitoring the performance of nursing staff on the ward and providing visible leadership
- developing and implementing policies that promote safe and high quality patient care
- administering staffing rotas, including recruitment, HR management, maintaining the budget and other fiscal responsibilities
- promoting working relationships with community services and other health and education entities
- focussing on evidence to deliver effective nursing care, accounting for cost, resources and other variables, and
- promoting organisational priorities.

However, in 2007 the office of the Chief Nursing Officer in Queensland reviewed the NUM role to test its effectiveness and impact in keeping up with health sector reforms and growing patient acuity. Key issues that emerged from the review were:^{xxii}

- a lack of clarity on lines of responsibility - particularly due to inconsistent training and transition into practice
- significant mismatch between levels of responsibility and remuneration. The NUM role was classified at grade 7 which was cited as being too low and not adequately compensating NUMs for the accountability and workload associated with the role
- an increasing administrative workload which made it difficult to maintain a stronger clinical presence for both staff and patients on the ward
- an excessive focus on administrative tasks which diminished the clinical focus
- insufficient IT systems
- disparity between upper management styles which diminished the influence of ward leaders over decisions at the top level, and
- limited coaching and mentoring opportunities

Clarity of role and responsibilities

Research by Gaskin in 2012 which also assessed the challenges facing NUMs found similar issues to the Queensland review relating to role clarity, limited NUM interaction with staff on the ward, and NUMs voicing difficulties with the managerial aspect of their role.^{xxiii} Furthermore, research by Paliadelis found that NUMs often felt ill-advised and overwhelmed with the scope of the role and this was partly due to limited support during the transition phase.^{xxiv}

A link was also identified between NUMs, their relationships with staff, and the subsequent impact on quality and safety at the workplace.^{xxv} To improve clarity of the role, the Queensland review reaffirmed that the NUM's core function was to support clinical leadership and mentoring of staff by adapting models of clinical care to improve coordination with appropriate doctors, nurses and allied health professionals.

Effectiveness of succession planning

As part of its review of the NUM role, **a decision was made by the Queensland government to link the Nursing and Midwifery Classification System for NUMs with clear career progression pathways** by developing a comprehensive orientation and training programme to assist NUMs in the role and to access coaching and formal mentoring for a period of six months.^{xxvi} The health board also agreed to develop a state-wide mentoring framework to promote role consistency - especially for NUMs working in remote and rural locations. The review also

recommended that unofficial development opportunities, including shadowing and mentoring undertaken by aspiring ward leaders be recognised by employers.

Another key recommendation was to use employer appraisals to identify RNs working at Grade 5 and 6 who were interested in shadowing and/or undertaking formal training to become an NUM. In tandem to this, a review of the NUM role Grade 7 classification was also undertaken.^{xxvii} This resulted in a commitment to the creation of clearer career pathways for each of the Grade 7 streams: clinical, management, education and research.

Key challenges to effective succession planning remain however. The combination of long travelling distances and isolated locations has restricted accessibility to key training and development opportunities – a majority of which occur in Australia’s eastern cities. The creation in 2008 of a network of discussion groups by health providers which enables existing NUMs to share best practice and identify barriers and enablers to the role have gone some way towards alleviating this pressure however.

Although the 2008 Queensland review recommended that NUMs working in isolated areas should be able to videoconference into these group meetings, and be provided with funding to visit regional facilities at least twice a year, challenges regarding insufficient internet coverage and questions as to whether twice yearly visits are sufficiently regular have been raised.

Managing realistic workloads

The 2008 Queensland review recommended that any tasks that do not require NUM expertise should be delegated to an administrative officer as part of wider efforts to rebalance NUM workloads. However, the extent to which this recommendation has been taken up by individual employers in Australia is not clear as the definition of ‘tasks’ is not specific, nor is there a defined scope of expertise for NUMs.

Practical improvements to the daily working of NUMS have been identified and widely implemented. Ready access to IT support for example was a key recommendation, enabling NUMs to respond promptly to key decisions on clinical care and budget responsibilities. However, it is not clear whether the provision of additional IT infrastructure has been consistently partnered with sufficient training in how to use relevant software.

This same challenge has also been cited for NUMs based in rural locations. In the aftermath of the review, many of these were given handheld blackberry phones or similar devices to help ensure regular contact and support. A number of NUMS in remote locations however have cited a lack of readily available IT support when technical problems occur and poor training (especially for older NUMs) in operating advanced mobile communications technology.

Finally, a commitment was made by the Queensland Government to re-evaluate the NUM role via the ‘Job Evaluation System’ (JEMS). This framework is widely utilised across

healthcare settings in Queensland to assess and establish the relative work value of roles, which in turn informs what the grade classification and remuneration levels for each role should be (this is comparable to the UK's Agenda for Change initiative). The result of this process was that the NUM position was up-banded to reflect their heavier workloads.

2) Australia (New South Wales)

As with Queensland, the New South Wales (NSW) NUM position is intended to focus on supervisory responsibilities, without having a formal definition as supervisory/supernumerary. NUM's supervisory oversights include: overseeing nursing practice, monitoring quality and professional standards and developing/mentoring staff.

However, day-to-day operations often saw NUMs pulled out of their supervisory capacity to help manage staff shortages and/or high patient volumes. The creation of the Clinical Support Officer (CSO) position in 2010 (see section 'Findings on managing realistic workloads' on p. 14) has been cited with helping to free NUM time to focus more on their supervisory responsibilities – but this is not universally observed throughout the state.

Reform to the structure of ward leadership became a top political priority in New South Wales in 2008, when a series of patient deaths attributed to poor nursing care over a period of time attracted sustained media attention. In 2008, the Garling Report, undertaken at the request of the New South Wales Government concluded that the acute sector and wider healthcare services in the state were “on the brink”, with 22 per cent of the entire state nursing profession eligible for retirement in 2011.

The report also noted that many of the nurses in public hospitals were junior nurses with insufficient senior staff available to supervise them.^{xxviii}

In 2010, the NSW Health Department conceded that many of these deaths were unnecessary, tragic and avoidable, and that a new system of monitoring to detect deteriorating patients was needed statewide. The report also set out 139 individual recommendations to help prevent similar instances from occurring in the future.

One of the most important of these was that, **“The rigid demarcation between what a doctor's job is, and what a nurse's job is, needs to be consigned to history. Once the concept of teamwork is accepted as the norm in treating a patient, it is easier to see why a qualified nurse practitioner should be able to do many jobs once reserved for doctors.”**^{xxix} Following the report, the New South Wales Nursing and Midwifery Office developed the 'Take the Lead' (TTL) project to help strengthen and support the Nursing/Midwifery Unit Manager (NUM) role, and to assist in delivering safe, effective and patient-centred care.

Clarity of role and responsibilities

Following the Garling Report, in 2010 the NSW Ministry of Health published a conceptual framework on the role of the NUM to highlight the broad scope of responsibility, improve clarity and encourage consistency across the state.^{xxx} Qualitative results from an interim and mid-TTL project evaluation showed a boost in NUMs' self-confidence and self-esteem.

Findings also highlighted that these changes did not necessarily require financial investment as some of the NUMs were able to use the skills they had acquired during the programme to implement minor reforms that would later have a significant impact on patient health outcomes on the ward.^{xxxi, xxxii}

Effectiveness of succession planning

In 2008, a structured training programme for NUMs was introduced as part of the TTL project, with a target to have approximately 1500 NUMs completing all five modules. As of June 2010, nearly 1609 NUMs had completed one or more of the professional development modules.^{xxxiii} The TTL project was implemented based on evidence that linked training programmes with strong nurse leadership, which in turn had a positive impact on health outcomes and staff satisfaction.^{xxxiv}

The TTL programme^{xxxv} focuses on five key areas:

- **facilitating critical communication** - addressing key challenges and building effective work and team environments through good communication
- **lean thinking and leadership** - introducing the lean thinking concept and its application to the health care setting which looks at practical ways to improve clinical practice, the work environment and culture on the ward
- **financial management of the nursing/midwifery unit** - training NUMs to develop or sharpen their accounting and/or budget resourcing and management skills
- **rostering for patient care** - effective 24 hour rosters with staff that account for good skill mix based on patient acuity, and
- **leadership: making it happen** - self-reflection on leadership behaviours and offering support to help NUMs develop staff, address appraisal issues and focus more on succession planning.

In terms of effectiveness, a 2011 review of the TTL project by the University of New South Wales concluded that leadership and succession planning remained a challenging issue. However, the leadership module was found to have encouraged the creation of a succession plan

in several ward settings so that staff were better able to fill the role of the NUM when he/she was away and to integrate this experience as part of employer recognised learning.

One ward leader commented: “When I first started in this job there was nobody who wanted to relieve the NUM...now I have two people who have expressed interest to relieve the NUM ---- so that succinct planning is starting to happen, and people are starting to recognise this.”^{xxxvi}

Managing realistic workloads

A review of the NUM role following Garling’s findings highlighted some key concerns related to excessive workloads which presented a potential risk to the delivery of safe patient health outcomes. The results showed 64 per cent of NUM time was absorbed in fulfilling administrative duties, allowing only 14 per cent to be focussed on patient safety, quality and risk management and only 6 per cent on clinical leadership.

The report also identified that high levels of paperwork and communication, for example regular report updates to senior management, writing proposals to obtain funds for services or equipment, and audit reports also took NUMs away from their clinical and staffing responsibilities.^{xxxvii}

Heavy workloads had been a historic concern that stemmed from the removal of middle managers during the hospital restructuring in NSW in the 1990s. This resulted in administrative tasks being absorbed by the NUMs.^{xxxviii} Nursing shortages, increasing demand for services and escalating costs have also contributed to the increasingly complex challenges which NUMs face in effectively managing their changing environments.

The Garling report acknowledged this challenge and as a result of this, the Clinical Support Officer (CSO) role was created.

The CSO position was not intended to replace existing administrative staff but to complement their roles. CSOs work across multiple wards and services and report directly to the NUM. Main tasks include: general administrative duties, data entry and reporting (key performance indicator reports, audits, writing reports, etc.), documents and record management, addressing workplace issues such as rostering, recruitment, payroll and leave, resource management, ordering stock and equipment, and other duties such as organising patient transport.

In 2009, targets were set up to fund approximately 500 CSO full-time equivalent roles. A survey of NUMs reported that the CSO role has had a significant impact on NUM workloads, reducing the time they had previously spent doing administrative tasks and allowing time to co-ordinate patient care.^{xxxix}

3) New Zealand

In 1993, fiscal pressures and hospital re-structuring strategies had significant repercussions on nursing workforce numbers in New Zealand. Nursing full-time equivalent (FTE) numbers decreased by nearly 36 per cent while skill mix favouring unregulated nursing staff increased by 18 per cent. Nurse managers were replaced with non-nurse business managers, nursing departments lost control of their budgets and senior nurses were substituted with new graduates.

These changes had substantial ramifications on patient services and quality of care, leading to an increase in adverse clinical outcomes and health costs rising by nearly 40 per cent.^{xi} The health reforms also dismantled nurse leadership structures in hospitals.

The role of the **Charge Nurse Manager (CNM)** has evolved in New Zealand since the 1990s, with nurses now requiring advanced leadership skills and competence in business administration, human resource management and finance to run a unit. Currently the scope of the role is wide-ranging which has diluted some of the efforts to improve role clarity.

While the job descriptions of CNM's will focus heavily on supervisory skills, the practical day-to-day workings of the role will likely see these individuals working in non-supervisory capacities as well.

CNMs are largely administrative, focussing on management of budgets, rosters, bed flow, patients and families, and mentoring and developing staff. They are also responsible for managing compliance, professional practice and regulation issues, organisational policies, procedures and quality assurance systems.^{xii} In some facilities, the CNM is supported by a Clinical Nurse Manager who is responsible for the clinical priorities on the ward, including patient care, staffing levels, skill mix and rosters. **This job sharing has helped to reduce the immense work load on the CNM but funding for clinical nursing managers is not holistic across New Zealand.**

Clarity of role and responsibilities

In 2010, the New Zealand Nurses Organisation (NZNO), a professional organisation and trade union, surveyed CNMs from the country's various district health boards (DHB's) – equivalent to NHS Trusts – to understand the different aspects of this role. **Role ambiguity and excessive workloads were commonly expressed concerns.^{xiii}** Inadequate preparation for the role was a key priority that came out of the findings, especially since many nurses had the clinical expertise but were not trained in human resources, strategic management and setting up budgets.

In those DHBs, where formal training was provided by HR managers and senior staff, CNMs reported higher levels of satisfaction and confidence to fulfil their role.^{xiiii} Limited resources

and increasing financial pressures have also had a knock-on effect on the CNM's ability to prioritise and balance between clinical and managerial responsibilities. General responsibilities outlined in the job description did not meet the expectations of senior management. Concerns voiced by charge nurse managers were aptly summarised in a 2010 NZNO survey:

“The managerial load is high and takes me away from the clinical area. It is not possible to improve the quality of patient care when away from the floor” – New Zealand charge nurse manager.

“While most days I am enthusiastic about my role I feel this has become less and less due to the increased workload and higher patient acuity, financial pressures, increased patient expectations, aging workforce, multi-skilling” – New Zealand charge nurse manager.^{xliv}

Effectiveness of succession planning

Despite the pivotal role of the CNMs in co-ordinating patient care and maintaining quality standards, the NZNO is worried that nurse manager roles continue to be targeted by cuts, with experienced staff being replaced by junior colleagues in an attempt to deliver short-term savings. This has been cited as contributing towards low morale and a high turnover rate of staff which increases training costs, further incentivising financial reductions in order to keep budgets in check.

In the case of primary care nurses in New Zealand, a 2009 survey found that 82 per cent of respondents favoured training for a leadership role.^{xlv} In addition, the survey responses indicated that postgraduate courses were available locally to 59 per cent of respondents, that over half (59 per cent) received encouragement from their places of employment to attend courses and 56 per cent reported having their attendance supported through paid leave. Despite these positive figures however, the same report found that only 30 per cent of respondents felt satisfied with the current level of career progression on offer to them.

Managing realistic workloads

To help address widespread concern over heavy workloads for ward leaders, a number of DHBs piloted a programme called Care Capacity Demand Management (CCDM) in 2006. CCDM is a programme designed to support care providers in achieving better patient safety by consistently matching the demand placed on care services by patients with the resources required to meet this (staff, knowledge, equipment, facility, etc.).^{xlvi}

A component of this programme is ‘TrendCare’, a computer software system which records data on the number of current and projected nursing hours required to make accurate projections on safe staffing levels and optimal skill mix on a day-to-day basis.^{xlvii}

Although NZNO and other organisations have cited positive results from the use of CCDM in ward settings,^{xlviii} **media reports in 2013 which claimed that numerous DHBs were rationing care in order to meet CCDM requirements without increasing staff levels, have raised concerns that financial tightening of the health budget has exhausted internal efficiency measures and that active, long-term recruitment of more ward leaders and nurses is urgently required.**^{xlix}

United States

This section focuses on the training and career development systems for ward nurses as utilised by two of the largest and most high-profile healthcare providers in the United States – Kaiser Permanente and the Veterans Health Administration (VHA). These were selected because both organisations operate across the United States and so can evidence a genuinely ‘national’ approach to nurse training, rather than a narrower state-approach.

In the United States, senior ward leaders are referred to by a variety of titles, but one of the most common is the Clinical Nurse Leader, or Clinical Nurse Manager (CNL). This role was developed through the collaborative efforts of a number of professional associations, including the American Association of Colleges of Nursing (AACN). The stated purpose of the role is to focus on clinical leadership issues, rather than administrative functions. It should be noted however that CNL’s will have very different responsibilities and scopes of practice depending on where they work.

4) Kaiser Permanente – An introduction

Founded in 1945, Kaiser Permanente is an integrated managed care consortium based in Oakland, California. In terms of structure, Kaiser is made up of three distinct organisational entities, comprising the Kaiser Foundation Health Plan and its regional subsidiaries; Kaiser Foundation Hospitals and the regional Permanente Medical Groups. Kaiser operates in nine US states, as well as the District of Columbia, and is the largest managed care organisation in the United States with 8.9 million health plan members, 167,300 employees, 14,600 doctors, 37 medical centres, and 611 medical offices.¹

Clarity of role and responsibilities

The CNL role in the context of Kaiser can be responsible for overseeing entire ward systems. The company’s internal training systems and the general American emphasis on academic specialisation as the principal route for career progression can lead to ward management responsibilities conflicting with more lucrative research and laboratory-based roles however. This has been cited as contributing towards a culture of absentee leadership and restricting available pathways for future CNLs.

Effectiveness of succession planning

Information on Kaiser's specific succession planning policies is restricted due to competition concerns. However, **Kaiser does operate a Nursing Leadership Institute (NLI) which primarily serves the educational needs of frontline CNLs and Nurse Practitioners (NPs)**. There is also a heavy focus on ensuring that aspiring CNLs are given the opportunity to participate on keynote training opportunities. Unfortunately, information on how this is negotiated between the nurse and their employer is not readily available.

To clarify, NPs are registered nurses (RNs) with an advanced educational skills-set who sit just under the CNL position. The NLI programme is designed to address concerns about the growing gap between the increasing responsibilities and the skills of nurse managers at the frontline of patient care. In 2003, the programme was expanded to all eight Kaiser locations with nearly 300 all-day seminars involving 8,912 participating managers (as of May 2007).ⁱⁱ In 2006, the NLI reportedly held 67 all-day seminars in all eight regions with 2,186 participants from all levels of its nursing leadership.

In addition to the NLI, **Kaiser also supports a 'Manager's Corner' – an online portal which provides tools and insights developed by other ward leaders that can help both new and experienced CNLs in their roles.** These tools cover a wide range of specialist areas which nursing managers are expected to be involved with, including a ward's financial performance, staff morale and retention, cross-departmental collaboration, patient and physician satisfaction, technology implementation, regulatory compliance, patient care quality and staff development.ⁱⁱⁱ It is not clear however, to what extent these programmes specialise in ward settings.

Managing realistic workloads

The third component of CNL training at Kaiser is the National Nursing Leadership Council (NNLC) which brings together senior nursing leaders from across the organisation (including, but not limited to ward managers). The purpose of this organisation is to ensure that nurses have sufficient resources to undertake necessary development and that issues surrounding workplace safety for example are also addressed through collaboration with internal labour groups.

Despite the presence of these systems however, a 2012 Institute of Medicine (IOM) report has concluded that overall health outcomes for patients have improved little since a landmark 1999 report flagged significant internal weaknesses across the US healthcare system.ⁱⁱⁱⁱ Among the key recommendations were that health practitioners, especially in acute settings, needed to foster a culture of 'continuous learning'. The report stated: "Governing boards of health care delivery organizations should support and actively participate in fostering a culture of continuous improvement, request continuous feedback on the progress being made toward the adoption of such a culture, and align leadership incentive structures accordingly."

It seems reasonable to assume that a significant part of any such reform will be freeing up more

time on the part of existing nurse leaders to not only train and mentor aspiring ward leaders, but also to increase their visibility within ward settings to cultivate a more positive culture of leadership. Although the report did not single Kaiser out for specific criticism, the challenges described by the IOM are likely applicable to its operations given the scale of its presence.

5) Veterans Health Administration (VHA) – An introduction

The VHA is part of the United States Department of Veterans Affairs and is responsible for implementing a holistic medical assistance programme for veterans. For the year 2014/15, the VHA had a budget of US\$163.9 billion (£98.6 billion) - close to the entire NHS budget. In addition, this funding is safeguarded for a veteran population of 21.9 million (as of 2012).^{liv}

Leadership training across the VHA equates to less than 1 per cent of total spend. Approximately half of this funding, US\$59 billion (£35.5 billion), is allocated to the delivery of the VHA's various medical programmes and of this, approximately US\$949 million (£571.9 million) will be spent on various development and leadership programmes in 2015.^{lv}

As the VHA is a public body, it is required to present its accounts for scrutiny by the US Senate. This does not apply to Kaiser, which as a private company, is not obliged to disclose this information – making it difficult to assess whether the figures for leadership funding at the VHA represents a comparatively high or low amount. However, a 2009 report by the Commonwealth Fund indicates that Kaiser has spent at least US\$4 billion (£1.8 billion) on developing and training for its HealthConnect paperless patient record system.^{lvi} This indicates that Kaiser's leadership budget is likely to be larger than the VHA's.

Clarity of the role and responsibilities

According to the VHA, the role of the CNL is to “deliver clinical leadership in all health care settings and to respond to individuals and families within a micro-system of care”.^{lvii} Specific areas of responsibility include:

- cost/financial outcomes such as length of stay, patient flow, readmission rate and registered nurse (RN) turnover
- patient satisfaction, staff satisfaction and retention
- quality/internal process outcomes such as medication management, patient safety, and prevention of nosocomial infections, and
- practice Model Transformation such as evidence-based and collaborative, interdisciplinary practice.

In 2011, the VHA committed itself to ensuring that a CNL should be present at all points of care throughout its medical system by 2016. This has been enabled by year-on-year growth in its annual budget throughout the 1990s and 2000s.^{lviii} An internal review in 2011/12 reaffirmed that the organisation would seek to tackle key obstacles to increased CNL participation at ward-level settings by promoting mentoring opportunities for NPs looking to advance their career for example and by readying the organisational environment for a more independent CNL structure.^{lix}

Evidence suggests that many CNLs have a variable work schedule, inconsistent job responsibilities and ad-hoc opportunities for further promotion. **It is possible that this lack of role clarity is in part related to an ongoing dispute with the VHA's doctors, many of whom have criticised proposed moves to allow NPs and other suitably trained nurses to care for patients without any supervision by a physician.**^{lx} The American Society of Anesthesiologists (ASA) has said that by allowing nurse anaesthetists to work unsupervised, the VHA risks decreasing the quality of care patients would receive.

The American Association of Nurse Anesthetists have countered this assertion by arguing that physicians are seeking to preserve their privileged status, citing studies that showed no difference in patient outcomes when comparing anaesthesia administered by physicians and nurse anaesthetists.^{lxi}

Effectiveness of succession planning

As the largest publically funded health provider in the US, the VHA has considerable resources to focus on securing future leadership talent. However, as with the Kaiser case-study, the organisation is affected by significant local and state variations in the number of sufficiently qualified nursing leaders and connected socio-economic divides. In order to bolster its recruitment and retention of ward leaders, the VHA has championed a series of nurse-led initiatives in the state of Indiana which were found to have improved patient outcomes, including improving overall patient satisfaction by 20 per cent and a reduction in pressure ulcers by 60 per cent.^{lxii}

In addition, the initiatives (which were developed by the American Association of Critical Care Nurses (AACN)), are projected to have saved healthcare organisations in Indiana more than US\$5.2 million (£3.1 million) in 2013/2014.^{lxiii}

Managing realistic workloads

It is hoped that a clearer standard of practice (introduced by the VHA in 2013) will help address significant disparities in the levels of responsibility within and between NP and CNL grades. As an example, one VHA job advertisement for an NP position in 2012 required that the successful candidate manage the renal transplant programme at a hospital in Alabama with an annual salary of up to US\$110,000 (£66,000). This job specification would likely require advanced

managerial skills equivalent to a CNL. By comparison, another NP role advertised at the same time involved working in a bipolar and depression research programme in California with no stated management responsibilities and an annual salary of up to US\$139,000 (£83,000).^{lxiv}

Like the UK, the picture for US nurse leaders and their workloads remains uncertain due to inconsistent government-led change. The 2010 Patient Protection and Affordable Health Care Act, often referred to as “Obamacare”, has increased the budget for the Health Resources & Services Administration (the body responsible for nursing recruitment) from \$171 million to \$263 million. However, most of this additional funding is aimed at training more nursing staff to help stem the growing deficit of trained personnel which has become even more pressing with millions more Americans achieving insurance cover, rather than expanding nurse leadership programmes.

The medium to long-term indication is that nurse leaders could find themselves with larger teams to manage. Whilst this would be a positive step for ensuring better overall staffing levels, if this growth is not matched with a comparable increase in nursing leaders then there is a risk that patient care outcomes could suffer.

Key Lessons for the UK

Many of the international examples looked at in this paper encompass supervisory/supernumerary responsibilities – without being officially identified as supernumerary. However, as with the UK, many of these international job roles see significant involvement in practical day-to-day demands of a ward setting which risks diluting the supernumerary component. The experience of the UK, where the supervisory element is often more clearly defined following Francis, shows that specifying a ward leadership role as ‘supervisory’ is insufficient to prevent this component from being diluted on a day-to-day basis. Consequently, this strongly indicates that the best assurance of protecting supernumerary status is by investing in adequate workforce numbers and skills-mix, in order to prevent managers from being pulled into patient caseloads.

Effective ward leadership is dependent on having the right investments in place, including (but not limited to) a sustainable nursing capacity, accessible career routes to leadership roles and support structures for those who choose to pursue leadership responsibilities. There is also strong evidence to suggest that effective nursing leadership benefits from an autonomous working culture, which empowers leaders to identify and challenge poor practice and where they are given the authority to act and discharge their duties.

Some of the key observations identified below have direct relevance to the UK case study, but this is not holistic. The UK, along with many of the other countries analysed in this paper also share a set of common challenges and so identifying best practice on the alleviation of these is not always possible.

Addressing role ambiguity

- **Frontline ward leaders often set the tone and culture of the workplace environment, which influence nurse recruitment, retention, workplace culture and satisfaction.** The New Zealand case study shows the severe impacts which cuts to this part of the workforce can have in compromising the entire process of care delivery. The RCN’s Frontline First report, ‘Not Just a Number’ has identified significant staffing reductions at the senior management level – including wards. This indicates a significant risk that the New Zealand experience could be replicated in the UK.
- **Advancements in the health care sector have changed expectations of frontline managers who are now required to be leaders as well clinical experts—changing the breadth and scope of an already demanding role.** The example of the United States reflects these changing expectations and requirements. However, ensuring that a sustainable balance is struck between ward engagement and clinical innovation is a key long-term challenge. The approach by the Queensland Government in Australia of reaffirming the principal responsibility

of NUMs as supporting the development of clinical leadership and mentoring of staff has helped to shape successive employer work policies around this core function.

- **The creation of a clear, conceptual framework (as in New South Wales – Australia) which combines overarching responsibilities, with allowing individual NUMS to adjust their focus as and when they need to, has been cited as improving the confidence of ward leaders and of delivering significant financial savings.** Although the absence of a formal recognition of supernumerary status for ward managers in the UK is disappointing, the emulation by individual NHS employers of the NSW approach could help ward leaders to prevent a repeat of the Mid-Staffordshire scandal.

Succession planning

- **A structured and well-financed approach to succession planning, such as the TTL project in New South Wales can improve ward performance, bolster patient outcomes and see long-term costs fall.**
- **Ensuring that existing ward leaders have sufficient input in how recruitment systems are designed is important.** Recognising unofficial mentoring and shadowing activities can mean that nuanced leadership skills which generic training modules may not pick up on, are passed on.
- **Equitable access to training and mentoring remains a key challenge.** Ensuring that rural locations are connected to best practice in urban areas and vice versa not only increases the flexibility of ward leaders in their movement between locations but also expands the pool of potential future leaders as dissemination of knowledge expands.
- **Internationally, there is strong evidence that role ambiguity can discourage junior nurses from taking up leadership roles. As a result, career pathways and training opportunities need to be actively championed.** A 2009 survey of primary nurses in New Zealand for example found that 82 per cent of respondents were keen to advance their careers by training for a leadership role. Despite these positive figures however, the same report found that only 30 per cent of respondents felt satisfied with the current level of career progression on offer to them.

Managing workloads

- **Frontline ward managers across the case studies looked at in this paper are overburdened with unnecessary administrative tasks that take them away from clinical supervision and staff mentoring.** This mismatch between formal qualifications for frontline ward managers and the knowledge and skills required on the job, has led to low morale and also deterred future potential nurses from a leadership-oriented career path.

- **Investing in support officer functions** (such as the Clinical Support Officer role in New South Wales, Australia) to focus exclusively on administrative tasks and the logistics of team management has been found to improve the visibility and practical involvement of ward leaders in patient settings.
- **Designing internal safe staffing systems (such as the CCDM programme in New Zealand) can highlight ways in which staffing levels can be made more flexible, enabling some license in managing shortfalls in numbers.** However, this can lead to abuse of the system with care rationing observed in New Zealand hospitals in order to meet the requirements of the CCDM system, without investing in nursing numbers.
- **Heavy and complex workloads are likely to remain a challenge for ward leaders as demand for services continues to grow, public finances in the developed world remain restricted and patient care needs continue to change.**

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