Opportunities for Nursing Clinical Leadership and Management in New Zealand: Understanding the Past to Inform the Future

ABSTRACT
This study explores the consequences of the late 1980’s health reforms in New Zealand and their impact on nursing clinical leadership. At that time senior nurses were removed from governance and leadership roles. Consequently, clinicians have felt unable to influence and partner in health care decision making, delivery and design. An action research approach was taken to enable our participants to identify unique characteristics of clinical leadership prior to the 1980’s reforms. We advocate for investment and support for clinical leadership and management through a partnership model. We look to the past to inform the future, so that we can grow new clinical leaders in the face of a looming international crisis - exponential health care demands.
INTRODUCTION

In mid 2009, New Zealand’s Health Minister Tony Ryall released a Report (Ministerial Review Group, 2009) with a series of recommendations to improve the quality and performance of the New Zealand public health system (Ryall, 2009). “The report recognises to improve services we need more input from frontline staff, and there are recommendations to strengthen clinical leadership and clinical networks.” The key theme of the review was to create a series of recommendations around ensuring that New Zealanders continue to be well served by a world class health service. Nine principles were recommended, clinical leadership and management were presented as key.

Realisation of this vision requires understanding of our historic health sector, robust planning and major change. However, it is complex and no defined map has been provided. Consequently the Ministry of Health has advised District Health Boards’ that they need to develop and operationalise clinical leadership models. Nursing clinicians have felt unable to influence health care delivery decisions. However they are expected to be accountable and responsible for health outcomes.

This research focuses on the consequences of the 1980’s health reforms on nursing leadership in New Zealand. It explores the past to help inform and grow clinical leadership for the future. Our research is important because the health sector is expecting a crisis with unsustainable financial concerns due to:

- an aging population with high health needs and subsequent
- workforce requirements to meet future demands and
- lost capacity to take up clinical leadership roles resulting from the 1980s reforms.

LITERATURE REVIEW

Next we explore the literature to: outline New Zealand’s 1980’s health care reforms and their impact on nursing leadership; discuss the impact of the aging population on the availability of health care professionals; finally we examine patient safety and care and the impact of clinical leadership.
The 1980’s Health Reforms of Nursing

New Zealand’s 1980’s health reforms brought a major turning point and changed the way in which nurses were organised and managed. Since 1983 the New Zealand public health service has undergone four significant restructures. With each change, new sets of organisations and bureaucracy have been developed to fund, manage and deliver health care services. In the 1980’s Area Health Boards administered and governed health care. In the mid 90’s Health Funding Authorities and Crown Health Enterprisers were established with separate purchaser and provider responsibilities. They used contracts and competition in an attempt to drive efficiency and accountability. The 1991 Green and White Paper “ushered in an era of market orientated reforms...” (Hyslop, Dowland & Hickling, 1993:9). Public health services were ‘unbundled. A separate public health purchasing agency, the Public Health Commission, was established under the Health and Disability Services Act, 1993.

Generally clinicians acknowledge that the reforms may have brought some benefits such as competitive pay rates to (supposedly) reduced the migration of health professionals. But, overall they failed to produce anticipated performance improvements. Documented inferior health outcomes include understaffing of an emergency department and deaths from cross-infection as a result of over-crowding in wards (Health and Disability Commissioner 1998; Quaintance, 2000). Overall, commercialisation within the public health system, and the introduction of a business approach within hospitals, has not built effective health systems (Van Eyk, Baum & Blandford, 2001).

Little research exits in New Zealand regarding the impact these major changes have had on specific professional groups such as nursing. The hospital restructures and redesign initiatives have changed the ways in which registered nurses are organised and deployed. Research conducted by Decker, Wheeler and Parsons (2001) in the United States found nurses held low trust in hospital administration and management, after reforms similar to those in New Zealand. They found nurses believed that change had been primarily focused on financial efficiency at the expense of patient safety.
Duffield, Kearin, Johnston and Leonard, (2007) explored the impacts of restructuring upon nursing management. They found that such changes often depleted the capacity of key management positions to provide adequate and safe care. Clinical nursing leadership has been reduced at multiple levels. Nurses’ voice regarding patient care has diminished due to re-engineering of structures that decreased the number of traditional nursing departments. Tucker and Edmondson (2002) found that nursing staff believe there has been a decline in chief nursing executives with delegated power and authority equal to that of other top hospital managers. This decline limits their abilities to address problems and reduces direct management support for ‘shop floor’ nursing staff. Nurse managers are now responsible for larger and more diverse ranges of staff and services. As a consequence they are unable to supervise and mentor junior staff. Duffield and Franks (2001) found that this has resulted in junior staff and new graduates feeling isolated, dissatisfied and unsafe.

In Canada (Greenglass & Burke, 2001), drastic financial cuts to public health in the late 1990’s saw widespread closures of wards and hospitals. Nurses working in downsized hospitals suffered from stress due to decreased job satisfaction and professional effectiveness; which in turn had negative impacts upon recruitment, retention, absenteeism and patient outcomes. According to the American Institute of Medicine (2004), internationally, the breadth and span of nursing management has flattened. Consequently, nurse executives have lost responsibility and accountability for the strategic direction of nursing care. Nurses are unable to manage operational decisions and issues and thus weakening the link between nurses and hospital administration.

**Ageing Population**

New Zealand’s population is ageing. According to the 2006 Census of Population and Dwellings the number of people aged 65 and over has doubled since 1970 and is expected to exceed 1.3 million by 2051 (Statistics New Zealand, 2006). Overall, the number of people aged over 85 years has trebled since the 1970’s. It is estimated that by 2051 there will be approximately 320,000 people aged 85 years and over (Dunstan and Thomson, 2006). An increasing demand for care, associated with our aging population, will incur increasing demands for nurses.
It is forecast that the world’s labour force will decline, due to our ageing population. The Potential Support Ratio is an indicator of the dependency burden (or number of people over 65 years) that will require care as a ratio against the actual numbers of care workers. “Globally between 1950 and 2000, the Potential Support Ratio fell from 12 to 9 people in the working ages per person 65 years or older. By 2050 the Potential Support Ratio is projected to fall to four working-age persons for each person 65 years or older” (United Nations. 2002). New Zealand’s Department of Labour (Workforce 2020, 2009) estimates over 48,000 paid care-givers will be required by 2036. But if the status quo is maintained there will be approximately 21,000 carers available.

New Zealand’s nursing workforce represents approximately half of the regulated health workforce. In 2008 over 40,000 nurses held a practicing certificate and were working in nursing on a paid or voluntary basis (Nursing Council of New Zealand, 2008). The total nursing numbers has increased in major urban cities with some downturn in smaller and rural communities. The workforce is predominantly female (93%), approximately half of the workforce work part-time, mostly in emergency, acute settings or long term care environments. The average age of active nurses in New Zealand in 2008 was 46.7 years (Clinical Training Agency, Ministry of Health, 2009).

Longley, Shaw and Dolan (2007) prepared a report advising the United Kingdom Nursing and Midwifery Council of alternative scenarios for 2015. They expect the role of the registered nurse to change quite dramatically to meet changing health needs. They predict nurses will be key workers in the care of chronic disease, will need to have flexibility skills to enable them to move between roles/specialties, have strong leadership skills to co-ordinate and commission care, work across traditional professional boundaries, work with families and lay carers, and work more independently. Overall they will need to have greater accountability. How this is achieved is the question that requires further analysis to help inform how the sector can respond to increasing health demand.
Patient Safety and Quality of Care and its Relationship with Leadership

There is strong evidence to support patient safety and high quality of care is dependent on effective nursing care. Findings from a number of studies provide evidence that nurse staffing levels and adverse outcomes experienced by patients are directly related. Aiken, Clarke and Sloane (2002) conducted a cross national study examining the effects of nurse staffing and organisational support on quality of patient care. They found poor quality care was three times as likely in hospitals with low staffing and support levels for nurses. Consequently they reported an association between low staffing levels and dissatisfaction and burn out in five of the six surveyed sites.

McCloskey and Diers’ (2005) research identified that New Zealand’s hospital re-engineering primarily adversely affected patient safety (11 Nurse-sensitive patient outcomes). They also found that the late 1980’s re-engineering efforts were associated with reducing numbers of nurses and collapsing nursing management structures, as follows: “After health care reengineering began in 1993, medical and surgical nursing full time equivalents and nursing hours in New Zealand’s public hospitals decreased by 36%” (McCloskey & Diers, 2005, p.114). They also identified a statistical relationship between adverse patient outcomes and a decrease in the number of nurses and nursing hours per patient. This study contributes to the growing body of evidence that nurses are a vital component in the delivery of care, patient safety and quality improvement. Further, Needleman, Buerhaus, Mattke, Stewart and Zelevinsky (2002) found reduced patient/ nurse time is directly associated with higher rates of infection, gastrointestinal bleeding, pneumonia, cardiac arrest, adverse outcomes or death.

The United Kingdom National Health Service has implemented a strategy called “the modern matron” with positive results including clinical leadership to improve standards of care, strengthening of clinical governance to improving skill mix and staff retention (Scott et al., 2005; Department of Health, 2004). “The modern matrons worked from the ‘bottom up’ often remaining firmly rooted in the clinical domain and setting their own targets for improvement based on their knowledge. Such Matrons have been described as powerful agents of change” (Savage & Scott, 2004:425). Similar clinical leadership success has been achieved in Kaiser Permanente Colorado and the US Department
of Veteran affairs. They both introduced clinical leadership strategies with accountablities. They have became world leaders in clinical quality, and patient and staff satisfaction (Mountford & Webb, 2009). The ‘modern matron role offers opportunities to improve front line leaders work in inter and multi-disciplinary teams, enhancing the patient and whanaau experience with excellence of care.

Buerhaus, Needleman, Mattke and Stewart (2002) argue nurses and management need to work together in service redesign. Their research showed that stronger nurse and management relationships positively impact upon any hospital’s ability to provide quality care. Overall, there is clear evidence that healthcare cannot be managed and led by professional managers alone. The inclusion of leadership clinicians, across the breadth of organisations, it is vital to achieve the best health outcomes for patients and their communities (Mountford & Webb 2009). Further, Dorgan, Bloo, Homke, Sadun and van Reenen (2010) found in a study of 1300 hospitals across the United States and Europe, well managed hospitals with clinically qualified leaders produced higher standards of care in the majority of instances. The relationship between patient safety and clinical leadership is pivotal. Leadership in health systems, both directly and indirectly affects patient safety and organisational effectiveness.

Kleinman (2003) surveyed Nurse Managers in the United States to identify their preparedness for major changes influencing the health industry. Kleinman identified the competencies required for healthcare leadership are a new hybrid of two traditional roles - management and clinical expertise. The research identified: firstly, business and nursing administration must be built into nursing graduate degrees as a foundation for professional development; secondly, current nurse managers who have been promoted due to their clinical expertise must be developed to bridge any educational gap and to provide balance between management, leadership and practice aspects of the role.

**METHOD**

We invited subject experts and to collaborate in determining answers to our qualitative questions through action research. Generally qualitative research is implemented to discover how people experience and interact with their social worlds. Action research is used in nursing research to
generate nursing theory from practice (Deloughery, 1995). It enables researchers to participate and take an active role in the research process (Bryman & Bell, 2011). Overall, action research defined by Argyris, Putnam and Smith (1985) as: Research focused on real problems to find solutions; an iterative process of problem identification, planning, action and evaluation; about change and doing things differently; both a contribution to academia and to practice.

We approached a branch of the New Zealand Nurses Organisation Old Girls Network and asked for participation from nurses that worked in the system prior to the reforms. They formed two groups of 7 and 6 people. The groups were from two large district health boards. Our investigation focused on the perspectives of 13 senior female registered nurses that had held senior nursing roles prior to the 1980’s reforms. In total they held 514 combined years of clinical wisdom and experience. The participants’ breadth of clinical experience ranged from Medical, Surgical, Critical Care, Community, Primary Health, Public Health, Operating Theatres, Outpatients, Infection Control, Transition from Hospital to Community, Hospital Operational Management and Emergency sub specialties. This provided a rich range of experiences and ensured that the results were not only relevant to a sub system/speciality within the profession and provided multiple perspectives (Table 1).

Participant led focus groups were conducted to explore their stories and wisdom through the following questions:

- How can we learn from the past to help inform and grow clinical leadership as a response to the anticipated looming crisis of health demand?
- How were nurses organised prior to the 1980’s health and labour reforms?
- Why did this work or not work?
- How would you use those strengths in a modern nursing clinical leadership model?

FINDINGS AND PARTICIPANT DISCUSSION
In response to the questions, the participants provided rich insights through colourful stories and experiences. They reported that prior to the 1980’s reforms the wards were run by one or two
registered nurses per shift, with a very well defined pecking order ranging from 1st to 5th Nurse. The first nurse was likely to be an Acting Staff Nurse close to sitting hospital final exams. The fifth nurse was likely to be a first year student, or new entrant to the profession, that was relegated to defined tasks of cleaning bed pans, the sluice room and maintaining fluid balance charts. The team of nurses looked after the whole ward. Accountability rested with the registered nurse and duty matron.

Roles and tasks were aligned to years of experience and modelled a hierarchical structure with a distinctive military flavour. They were nurses for life. Their rank was represented on their immaculate uniform epaulettes. Registered nurse wore a medal awarded for meeting the regulations of conduct and passing of a final exam. Strict discipline and an intuitive chain of command prevailed. They agreed that this structure wouldn’t work today but they agreed there were some components that would add value. That was around accountability, communication, visible leadership, respect for leaders and excellent patient care are the essence of nursing care.

They reported very little choice in selecting their clinical placements; however they strongly believed that everybody knew what their roles and responsibilities were. One participant stated “you wouldn’t dare go home before your job was finished”. Indeed all the participants talked of their nurse leaders with mixed emotions including fear, grateful respect, reverence and occasionally terror. The group described their nurse leaders, matrons, sister, and charge nurse as expert clinicians. “They ran the management of the patient, if the doctor asked about the state of a patients wound, she knew exactly how it was.”

The ward sister managed the patient care and co-ordinated all of their needs. She deployed staff, ordered stock, organised and taught her subordinates, managed the families and wrote all of the clinical records after hearing all patient statuses via the chain of command. Her delegation skills were expert. She knew the abilities of all her team and their scope of practice boundaries. They described how hard the matron/sister worked and the heavy burden of responsibility that went with the job. “Very few of them were married, they were dedicated to the cause” as one participant described. They
believed prior to the 1980s reforms patients got excellent care and their daily living activities were met. They believe this has now eroded due to reduced staffing levels and new nursing models that assigned patients to nurses rather than a team approach.

The group recalled vivid memories of their experiences of the disestablishment of the nurse leader roles during the reforms of the late 80’s. Their reflections were of loss and sadness with statements such as “nurses lost a lot of voice within the organisation due to that restructuring” and “removing the charge nurses was a disaster, decisions weren’t made and there were a lot in delays in patient care and some bad outcomes occurred”. The emphasis was a business model. They felt inexperienced and without the skills to manage budgets, accounts and formal management practices. They felt they had been taught to nurse and then their whole world was suddenly in turmoil. Their new managers expected them to operate on a business footing. The reforms were implemented very quickly. One previous charge nurse described how she found out about the disestablishment of her role. “I found out in a general meeting of about 18 staff that my position had gone. I was listening in the meeting and then I thought, um they are talking about my position, it’s gone”. The impact went on for many years with the disestablishment of the nursing infrastructure. “The Nurses felt shell shocked; we lost a lot of clinical and organisational knowledge and expertise. Nurses didn’t know who to go to and ask for expert knowledge”.

There was a sense of loss and grief within the groups due to the change that had been imposed upon the profession, its influences and diminished power the matron role (in comparison to that held pre reform). They believed a whole layer of nursing expertise was removed that caused a shift in power, decreased leadership presence and a painful process that damaged individuals. The group identified a fundamental difference between the current charge nurse and the matron/sister. That in order to be in charge pre re-forms you needed to be the clinical expert in that speciality, proven by lengthy years of service as well as being able to organise all the other aspects of the ward. Where today these two functions have split off and two distinct roles have emerged of clinical nurse specialist and nurse manager or charge nurse. There is not the expectation or clinical credibility associated with the nursing
management roles now. However, their leadership competencies span both roles. It is assumed that a good nurse manager is generic and can work in any clinical setting.

The groups were able to distil the information shared in the workshop. They formed some recommendations, identified transferable skills and lessons learned from reflection over time. They saw the value in a hybrid model of clinical leadership that reflects competencies of both clinical expertise and business acumen. They agreed senior nurses need to learn about business models and be leaders and managers of budgets, understanding the cost of care, reducing waste, and teaching for the profession and patients and family/whaanau.

They described the need for nurses to get more political, become astute and savvy, having a presence at the table of decision makers to influence and represent the voice of nursing. They also believed that the sector needed to be careful about who makes decisions affecting patient care. They were adamant that nurses need to be part of that process and that clinical leadership is essential in going forward to be able to participate in that process.

They believed that adaption and resilience are essential skills that nurse leaders need to acquire. They recommended such nimbleness, in order to avoid the sense of confusion that they experienced when they didn’t understand the bigger picture or predict the consequences of the reforms. They described a feeling of being “hit from left field” by the reforms and unprepared for the impacts. A lot of good people were lost through this poor process and careers were damaged. From this we must learn the value and importance of robust change management and good industrial processes.

They also recommended: a purposeful approach to identifying aspiring leaders, supported and mentoring them to achieve via a fast track approach; that leadership development and coaching be planned and led at executive level; that education and training of nurses must be regularly and critically reviewed to match the climate, and patient needs. They suggested nimbleness is essential to
support changing health needs and changing clinical environment in which care is provided - such as communities and patient own homes.

CONCLUSION

There is a plethora of evidence that demonstrates that the global health system is at a tipping point for a variety of reasons. In New Zealand, the health ‘reforms’ of the late 1980’s eroded nursing clinical structures and senior nurses’ skills. Further, our population is ageing; experts anticipate a significant nursing shortage. Consequentially, the status quo is not sustainable; we need a new approach to achieve effective nursing clinical leadership and management in New Zealand. A precise appropriate model has not been identified as yet. However, overall the literature and our research points to at least 4 key themes for optimal nursing leadership and management, as follows:

1. education and training for nurses beyond clinical expertise;
2. nursing decision making and authority within organisations and management structures;
3. work quality and patient safety should determine recruitment/retention and job organisation;
4. nursing structures that include span of control, adequate staffing levels, visible and accessible nurse managers and supportive work environments are key.

This study provides insight into nursing and nursing leadership in New Zealand prior to the late 1980’s health reforms. Our participants argued that the reforms disintegrated traditional nursing clinical leadership and management, the very skills that the Health Minister is recommending. We argue, along with our participants, that health providers need to enable nurses to more fully contribute to health care provision. Thus, enable clinical leadership to provide direction and mentoring for new nursing leadership. We recommend something akin to the ‘modern matron’ approach (Scott, et al., 2005; Department of Health 2004). This will help build a sustainable workforce that achieves organisational goals, meets professional requirements and provides quality patient care for our ageing populations.
TABLE 1

Breadth of Nursing and Management Roles Held by Participants

Table 1
REFERENCES


Opportunities for Nursing Clinical Leadership and Management in New Zealand: Understanding the Past to Inform the Future

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