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REGIONAL OFFICE FOR EUROPE

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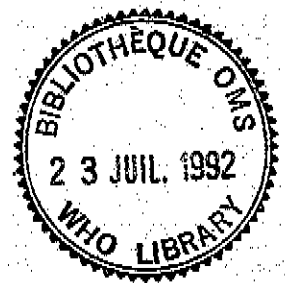
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## *SELECT NURSING LEADERS*

Report on a Consultation

Copenhagen, Denmark  
24 - 25 April 1992



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EUR/HFA TARGET 27

This activity was organized by the WHO Regional Office for Europe to promote work aimed at achieving the following target in the health for all strategy.<sup>a</sup>

## **TARGET 27**

### **HEALTH SERVICE RESOURCES AND MANAGEMENT**

*By the year 2000, health service systems in all Member States should be managed cost-effectively, with resources being distributed according to need.*

#### **Keywords**

**NURSE ADMINISTRATORS  
NURSING – trends  
HEALTH FOR ALL  
EUROPE**

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<sup>a</sup> *Updating of the European HFA targets. Copenhagen, WHO Regional Office Europe, 1991 (document EUR/RC41/Inf.Doc./1 Rev.1).*

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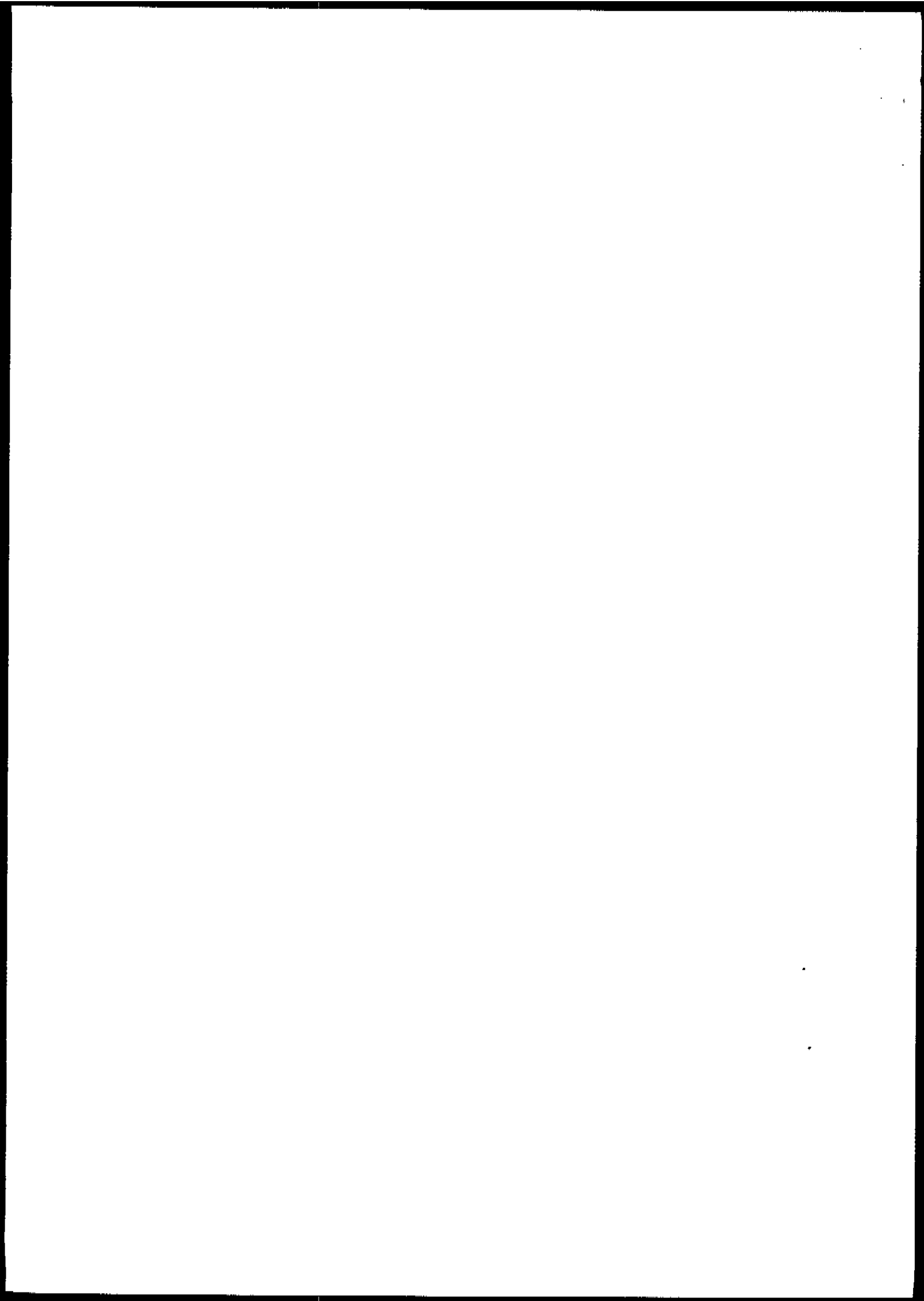
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A WHO Consultation of Select Nurse Leaders was held at the WHO Regional Office for Europe from 24-25 April 1992 with participants from Belgium, Czechoslovakia, Denmark, Hungary, Netherlands, Lithuania, Romania, the Russian Federation and the United Kingdom. Ms Jane Salvage, Regional Adviser for Nursing, Midwifery and Social Work opened the meeting and welcomed the group on behalf of the Regional Director of the WHO Regional Office for Europe, Dr Jo-Erik Asvall.

Ms Salvage explained that this meeting was a follow-up to the "Nursing Leaders in Action: Second Meeting of Chief Nurses, WHO Collaborating Centres and Nursing Organisations of Europe" held at Debrecen, Hungary, from 15-17 October 1991. Its main purpose was to facilitate the formation of a nurse leaders' network and identify the support they require.

## 1. Introduction

In 1989 the World Health Assembly passed a resolution on 'Strengthening nursing and midwifery in support of strategies for Health For All' (WHA42.27). Among other recommendations, this resolution urged Member States to "encourage and support the appointment of nursing/midwifery personnel in senior leadership and management positions and to facilitate participation in planning and implementing the country's health activities".

This recognition of the vital role of nurse leadership in health development was endorsed by the government Chief Nurses of the European region in Debrecen in October 1991. They also recommended that, in order to provide support to WHO nursing activities and in turn ensure better assistance to Member States, nursing leaders should be closely involved in the planning and implementation of WHO nursing programmes.

Nursing leadership needs to be strengthened in a number of ways, for a number of reasons. At present, despite the numerical predominance of nurses as care providers and their acknowledged importance in health care delivery, the profession's representatives are often omitted from top decision-making or policy-making fora. Leadership positions in nursing are still frequently occupied by physicians, both in central and eastern Europe and in other countries. Even when senior nursing posts exist and are occupied by nurses, the leaders' effectiveness is limited by lack of resources, lack of support staff and lack of professional development opportunities. This has implications for nursing practice, management and education throughout the entire health system: a vacuum at the top means nurses in the field either have little vision and direction, or find their ideas and capabilities blocked because no one endorses them at a more senior level.

The development of nursing leadership has therefore been incorporated as a priority in the Nursing, Midwifery and Social Work Unit's (NMS) key project, the Nursing in Action Project (Output 1). This consultation was the first step to achieving the goal of strengthening the nursing contribution to Health for All through supporting and developing nurse leaders.

The participants also stated what they would like the consultation to achieve:

- (1) development of international goals;
- (2) development of support networks/mentoring/exchange visits;
- (3) formulation of national strategy/planning techniques;
- (4) sharing of ideas and innovations for change.

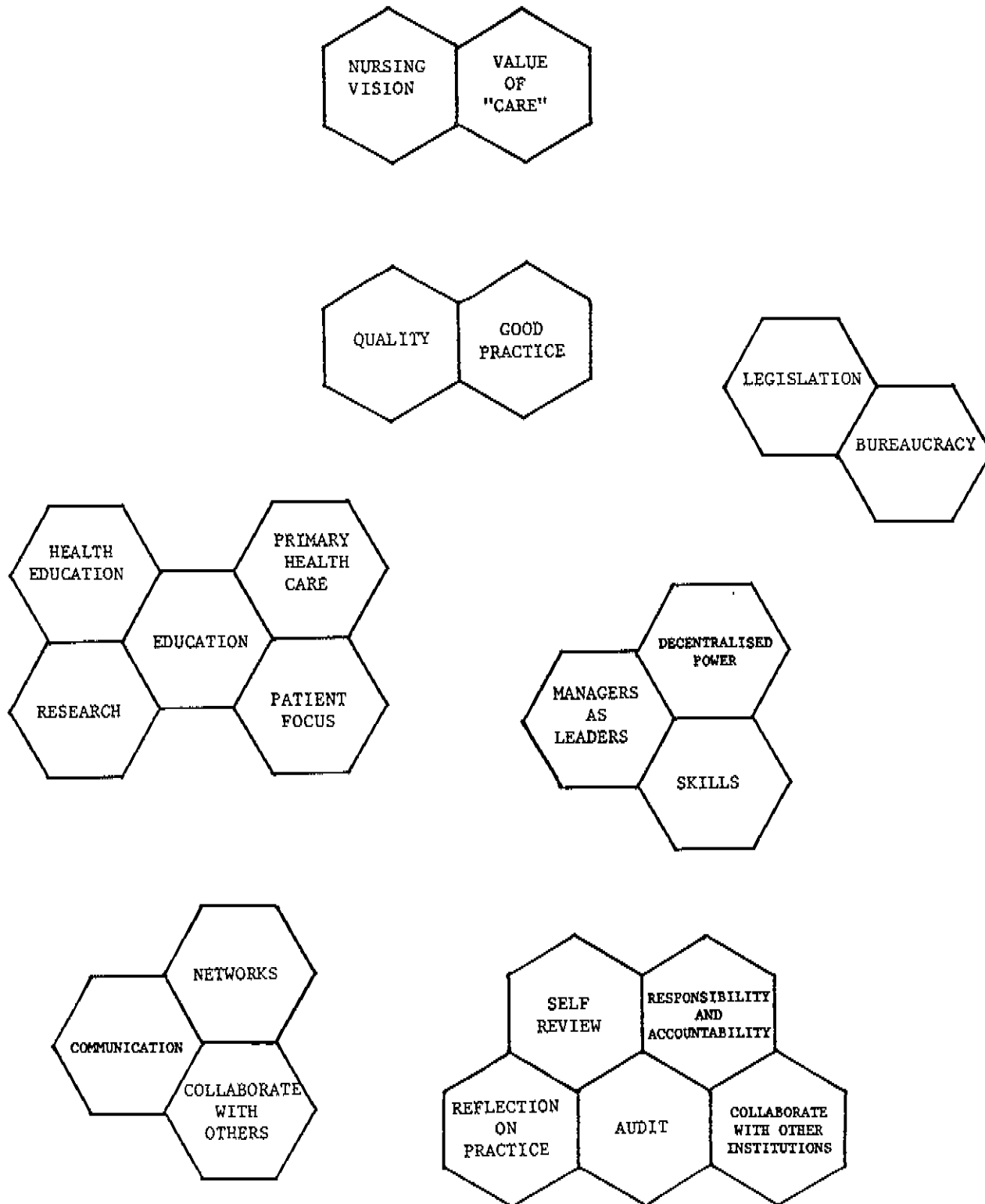
2. Country reports: some common themes

Each participant gave a brief report on the current issues in nursing in her or his country. After each presentation the group discussed the key issues that were emerging. There was seen to be a great deal of overlap of current priority areas between countries, and these were summarised as follows:

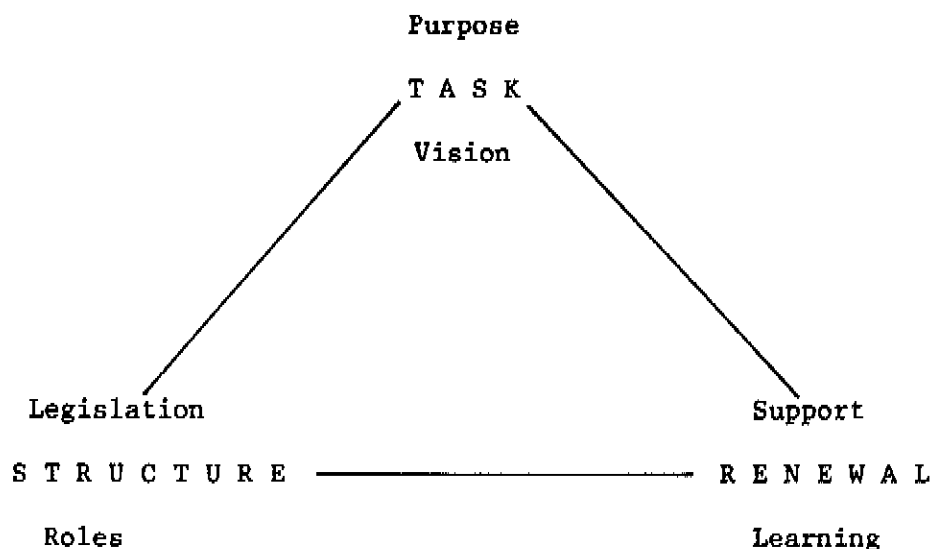
- (i) many countries were focusing on the regulations surrounding nursing practice; there was large-scale reform of legislation, with some countries developing new legislation and others attempting to summarise existing laws. Other trends were the development of programmes to support the implementation of new laws; the reduction of bureaucracy; the development and/or refining of the nurse registration system and the desire to conform to EC directives;
- (ii) all countries were concerned with the issue of quality, the setting of standards of nursing practice, the development of good clinical practice and the scope of clinical practice;
- (iii) countries were reviewing their provision of nurse education: its infrastructure, its educational content, the shift of focus to health education, primary health care and health as the population's responsibility, the development of nursing knowledge and the move from a medical model of care to an holistic model, nursing research and continuing education;
- (iv) evaluation was considered a priority with the introduction of such mechanisms as self-review, accountability and reflection on good practice, internal and team audits;
- (v) the countries also stressed the importance of nurse management, the need to ensure managers have leadership skills, and the ability to set priorities, engage into team-working and carry out decentralisation of control and power;
- (vi) the value of good communication was highlighted by many countries. Other items mentioned in this connection were the role of the nursing associations, the development of national and international networks, and reciprocal supporting links with institutions, other countries, and other leaders.
- (vii) all countries valued their vision for nursing which included such issues as the preservation of key values, the future role of the nurse, patients' rights and the value of nursing care.

The following diagram details these themes and represents the participants' groupings of the key priorities.

PRIORITIES FOR NURSE LEADERS



The following model was then proposed as a means of categorising the types of priorities the nurse leaders had identified in their current work programmes.



This model summarises the interdependency between the task or objective set by the organisation or, in this case, the nurse leader; the structure or framework within which individuals, or teams, work to achieve that task, i.e. rules, regulations and procedures; and those renewal functions, such as training and support, which enable the individual or team to perform within the framework and to achieve the task.

It is important that all three areas are considered when planning activities for change and that a balance between the three activities is maintained. It is futile to devise and then pursue an objective if there are no structures or suitably trained people to achieve it. Likewise, people find it difficult to reach a specific goal if they are unaware of what the target actually is.

The participants categorised their priorities into these three areas. All the leaders had a vision of how nursing should be and their other priority areas could be categorised as either relating to ensuring the appropriate frameworks were in place, or ensuring that the renewal processes were available to achieve these visions. For example, the vision might be the future role of the nurse; the structures within which this role might be developed may be a legislative framework; and the present staff might require education (renewal) to take on this role.

The participants agreed that the model would aid their comprehension of their current priorities and how they were interdependent.

### 3. Country Nursing Profiles

The NMS Unit, believing that a successful strategy is built on assessment of accurate information, had decided to create a data base on each country in the European region, starting with central and eastern Europe. This data would be useful in at least three ways:

- providing the Regional Adviser with the basis for a detailed analysis of each country, highlighting intercountry similarities and differences;
- supporting nurse leaders who report inadequate information sources within their own countries and need help with data collection;
- briefing for consultants who may work in the European region, and for other international project work.

The NMS Unit wanted to collect pertinent but also minimum data sets and thus proposed a minimum data list (Annex 2). Some country profiles were constructed and sent as background papers to the consultation's participants. The participants were then asked about this list's value as a data collection tool (how useful was such a tool to them, and was the list comprehensive or not detailed enough).

The list was positively received. It would, when completed, provide each country with a comprehensive base on which to plan and would be a powerful information source when negotiating for resources. The data would also provide background when writing reports. It was considered appropriate for the country profiles to be circulated to all nurse leaders present at the meeting as a source of information, innovations and problem-solving techniques and for comparing progress. It was suggested that the Regional Office might usefully summarise nursing trends, perhaps bi-annually, as a means of evaluating progress in the European region. Local negotiation would be necessary to determine how often the profiles could be updated to be used in these reviews of trends.

The list was also perceived as a method for structuring the current somewhat haphazard methods of data collection within some countries. It could be distributed locally within a country for local managers to use for data collection and planning.

The group made the following general recommendations:

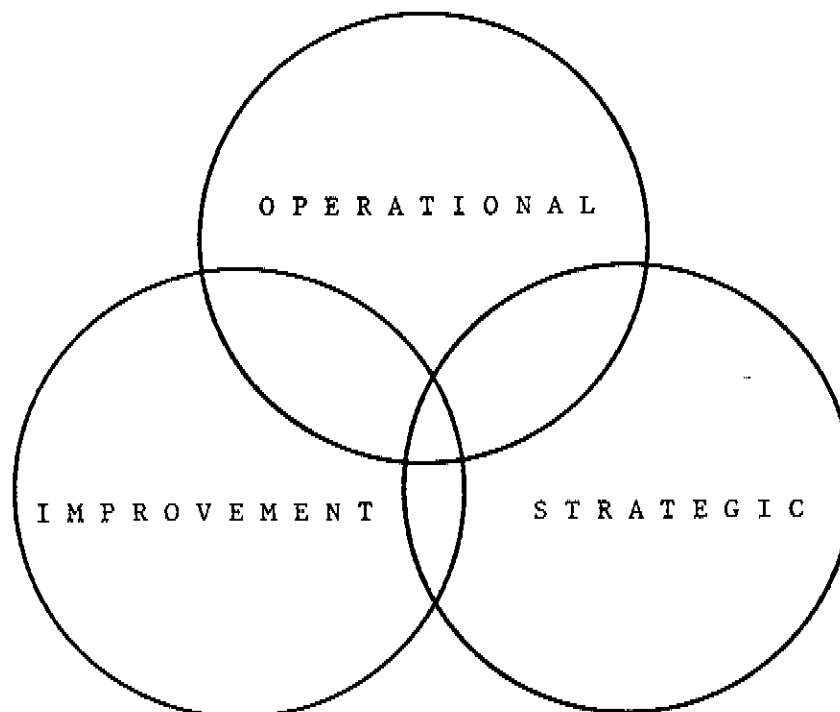
- (1) all the terms used in the minimum data list should be described in a glossary of terms;
- (2) the terms used should be reviewed to ensure they are relevant to all countries, and not culture specific;
- (3) the broad subject headings are useful but it would be more appropriate to have suggestions for inclusion in each area, rather than the specific subheadings currently detailed;

- (4) a broad subject heading encompassing all other staff involved in performing nursing duties is necessary;
- (5) the data needs to be computerised and presented in tables, lists, etc. to comprehension and updating (this is not possible in all countries and WHO might need to offer support);
- (6) it should be made clear that the tool is flexible and can be used and amended as required within a specific country.

More specific recommendations were made about the actual subheadings used. These were noted by the NMS Unit and the revised minimum data list is included as Annex 2.

#### 4. Introduction to strategy

The following model was introduced to describe the working areas of the ideal organisations. All three types of work that occur within an organisation, namely planning, improving the plan and implementing the plan, should be inter-related and inter-dependent.



However, in the majority of organisations and societies these three areas of work are arranged hierachically, with strategy at the top and the operational level at the bottom, and limited communication between the three levels. This traditional way of arranging the work may lead to difficulties:

SEPARATION OF

THINKING	—————	ACTION
DATA	—————	PERCEPTIONS
POLICY	—————	OPERATION
PLANNING	—————	IMPLEMENTATION
EXPERTS	—————	WORKERS

THIS IS  
VERY TIME--CONSUMING  
AND LEADS TO  
OPPRESSED, DEPOWERED VICTIMS  
INFLEXIBILITY  
INABILITY TO HANDLE CHANGE  
LOSS OF ACTION, INFORMATION, ENERGY AND CREATIVITY

Thus experts elaborate, make policy and plan and have the workers carry out the plans - even though their perceptions and operational experience may indicate that the plans are inappropriate.

There needs to be some cross-fertilization of the experience and knowledge of both groups, to ensure that strategy reflects the environment within which the strategy is to be implemented.

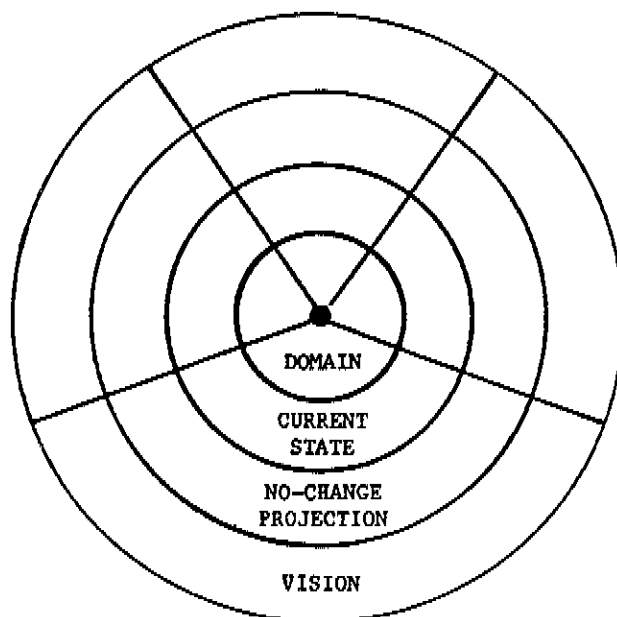
MOVE FROM

Managing change by blue-print

TO

Engaging with our changing environment in an interactive, empowering way such that we learn and trust ourselves and move towards our own developing vision.

One technique for use in strategic planning is the Domainal Map. This map provides the strategist with a means of reviewing the entire area of work, including the operational, as well as the forces influencing activity within the whole area.



The area to be investigated is placed in the centre of the diagram, which in this case would be the role of the nurse leader. The first ring represents the "domains" or areas with which the central item interacts or is involved (such as education reviews, other nurse managers and so on). There can be as many of these domains as one wishes.

The second ring represents the current state; the relationship between the centre and each domain. This ring can be very impressionistic and relationships might even be represented pictorially.

The third ring is only used if the centre is complacent or wishes to predict the result of inaction - "the no-change projection". Here the relationship between the centre and the domain is predicted if the centre were to remain static and the environment to change.

The fourth ring represents the centre's vision; what would the centre wish the relationship between it and each domain to be if there were no restraints.

The resulting map can be used to identify priority areas, that is, where there is the greatest tension, or gap, between the domain (current state) and the vision. In these priority areas the centre may wish to identify which forces are helping it move towards this vision and which are hindering. Both of these forces may be at any level: environmental, organisational, departmental, team, interpersonal and intrapersonal. It should be remembered that merely pushing harder on the helping factors will not result in change; the hindering factors also need to be tackled and removed or reduced.

The participants found the model useful for reviewing their own situation, and spent some time applying it to their own circumstances and developing plans for action.

It was suggested that by finding visions that were shared with others, there would be more energy to move the present state forward. The participants also felt the identification of obstacles and facilitating factors was very useful, because in certain domains something might be perceived as an obstacle and in others as a helping force. The development of appropriate structures to capitalise on or to avoid these forces then needs to be addressed.

Finally, the overview which the map provides was considered a useful diagrammatic representation of current workload which also included reference to the visions that energised the leaders and motivated them to continue.

#### 5. The way forward

The participants discussed the next meeting for nurse leaders. All agreed upon the success of the present meeting, the support they had received and the new concepts to which they had been introduced. It was now deemed necessary to expand the group, inviting all nurse leaders throughout Europe, but also to cascade these ideas of leadership support networks and tools for data collection, planning and so on in individual Member States.

#### 6. Conclusions and recommendations

The group concluded that the meeting had been a success; a supportive environment had been created and the participants had gained new strategies for their work. All the participants had developed close links with each other and were determined to use this relationship for continued support.

The group agreed the recommendations made regarding the country profiles in Section 3, and in addition also recommended that:

- (1) WHO should continue to facilitate this group of nurse leaders to offer both peer support and personal/professional development;
- (3) WHO should expand the group to include leaders from all Member States, and attempt to re-create the same supportive environment and offer the same development opportunities;
- (3) WHO should aim to hold the next meeting in October 1992, using the present participants as a core group to assist in planning and facilitating the larger group. The core group wished to meet the day before to plan its input and continue its networking activities.

Annex 1

PARTICIPANTS

TEMPORARY ADVISERS

- Mr Arunas L. Birutis  
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Personnel, Ministry of Health, Lithuania
- Mrs Gabriela-Luiza Bocec  
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TEMPORARY ADVISERS NOT PAID BY WHO

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Chief Nursing Officer, National Board of Health, Denmark
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Ms Jill Stanger  
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Annex 2

Minimum Data List

1. COUNTRY PROFILE

1.1 Capital city

To include resident population.

1.2 Geography

To include geographical position; area of country; climate and administrative divisions.

1.3 Demography

To include current population; predicted population in the year 2000; birth and death rates; fertility rate; age structure and urban population.

1.4 Economics

To include national debt; inflation rate; GNP per capita and main exports.

1.5 Politics

To include current political situation.

1.6 Language

To include first and second languages of population.

1.7 Ethnic and religious profile

To include breakdown of population by religious and ethnic background.

1.8 Education

To include source of funding; ages of compulsory school attendance; average number of years spent at school; description of the higher education system, number of students attending tertiary education establishments and adult literacy rate.

## 2. HEALTH PROFILE

### 2.1 Vital health statistics

To include life expectancy; infant and maternal mortality rates; main causes of death; lifestyle information such as smoking rates, alcohol intake and dietary fat; drug addiction rates; HIV status of population; numbers using some form of contraception; abortion rates and number of industrial accidents.

### 2.2 Health care facilities

To include control of the health system; public/private mix; number and type of primary health care facilities and number and type of in-patient facilities.

### 2.3 Health care activity

To include number of primary health care contacts per year; percentage of population receiving in-patient care; average length of hospital stay; bed occupancy levels and current health education programmes.

### 2.4 Human resources

To include number of doctors, dentists, nurses, other professional staff, support staff; problems of recruiting and retaining staff; current vacancy levels and problems of absenteeism.

### 2.5 Budget

To include percentage of GNP spent on health care and the proportion of this diverted towards primary health care.

### 2.6 Collaboration between WHO and country

To include all current activity.

### 3. NURSING PROFILE

#### 3.1 Regulatory framework

To include existing legislation regarding nursing practice, malpractice, working conditions, private practice and registration of nursing staff. To also include current registration systems, how they are operated, type of staff included on register, updating of register; details of who approves training establishments and supervises nurse training; terms and conditions of employment, including working hours, salary compared with national average, annual leave and maternity leave.

#### 3.2 Human resources

To include number of nurses; number of nurses by specialty; number of nurses in training; ratios of qualified to unqualified staff; gender ratio, recruitment and retention issues; staff turnover and geographical distribution of staff throughout the country.

#### 3.3 Role of the nurse

To include the role of the general nurse, the midwife, other staff groups, other staff involved with nursing duties; nurses' relationships with other health care staff; potential for extending the nurse's role and increasing his/her autonomy and relationships with other 'carers' e.g. family.

#### 3.4 Leadership

To include nurses at ministry, district and hospital level; nurses involvement in policy making; management structures at organisational level and education programmes offered to leaders.

#### 3.5 Education

To include general nurse, midwifery and other basic training programmes and for each include curriculum, orientation of programme (i.e. medical or nursing based), setting of education (i.e. school of nursing or higher education and so on), length of programme, entry requirements, educational materials and techniques, assessment procedures and qualifications awarded. To also include language used in schools; teachers qualifications and backgrounds; ratio of students to teachers; post basic and continuing education provision including for each curriculum: entry requirements, assessment procedures and qualifications awarded; the education infrastructure; funding for training and student remuneration.

### 3.6 Research

To include current research programmes in nursing practice, nurse administration and nurse education and also the funding available for research.

### 3.7 Clinical practice

To include collaborating centres; examples of good practice in nursing care or education; care of certain patient groups (e.g. the dying, AIDS and the elderly); career opportunities for clinical staff and measures of nursing workload.

### 3.8 Communication systems

To include nursing journals; national and local networks and government bulletins.

### 3.9 Professional organisations

To include nursing associations, other trade unions and for each detail membership and status.

### 3.10 Key personnel

To include key individuals at ministry level; educational establishments; clinical establishments; nursing associations; research institutes and other.