

**STRENGTHENING DECISION-MAKING
WITHIN SHARED GOVERNANCE: AN ACTION
RESEARCH STUDY**

II Volumes

Volume II of II

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**CONTAINS
PULLOUTS**

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ABBREVIATIONS

CPS	Clinical Professional Services
HRC	Human Resources Council
MHC	Mental Health Council
PSMT	Psychiatric Services Management Team
SG	Shared Governance

STRENGTHENING DECISION-MAKING WITHIN SHARED GOVERNANCE: AN ACTION RESEARCH STUDY

This thesis presents an action research study concerned with strengthening decision-making within a councillor model of shared governance in a UK hospital trust. Shared governance seeks to flatten traditional hierarchies by empowering clinical staff to make decisions affecting policy and practice.

Chapter 1 sets the scene for this exploratory case study through identification of the national and local health care context. The model of shared governance chosen for investigation is presented. An overview of the thesis is given.

Chapter 2 presents a literature review of shared governance framed by undertaking of a concept analysis. Existing evidence concerning shared governance and decision-making is examined.

Chapter 3 considers methodology issues and justifies the selection of a qualitative approach that embraces action research as a means of promoting integration of findings into decision-making practice.

Chapter 4 sets out the methods used to collect data in response to the research questions. Issues around access to the research setting are discussed. Sampling decisions are made explicit and a description of the data collection process is given. Extensive use has been made of participant-observation as well as interview techniques.

Chapter 5 presents a detailed narrative of the approach to analysis centring on the use of basic and advanced data displays to aid qualitative data analysis.

Chapter 6 details the study findings and culminates in the presentation of a conceptual model of shared governance decision-making.

Chapter 7 provides a substantive reflective narrative concerning my research practices and experiences throughout the action research journey, and the impact of these on my personal development.

Chapter 8 discusses the study findings in light of a summative review of the literature and evidence around shared governance and decision-making. Implications for practice and policy are identified along with areas for future research.

APPENDICES

Appendix 1 - Whole Systems Governance Strategy

Whole Systems Governance Strategy – RHT (abridged)

INTRODUCTION

The purpose of this strategy is to describe a way forward to achieve the Trust's intention to link up our Shared, Clinical and Corporate Governance programmes within a whole- systems Governance framework.

Rochdale Healthcare NHS Trust 's aim has always been for all staff to work together to achieve the best outcomes of care for patients. We want patients to be satisfied that this is the most appropriate care for them and that it is carried out through clinical processes that are known or believed to be clinically effective. We also want patients to be assured that robust control systems are in place across the Trust to uphold good Corporate Governance standards of accountability, probity, openness, and upholding public service values.

In order to develop this Whole Systems approach to Governance, we will emphasise the importance of the above systems in maintaining our drive for continuous improvement of clinical quality - the most important outcome of Clinical Governance, and we will achieve this through effective teamwork, clinical leadership and the development of an inclusive organisational culture, which are key Shared Governance objectives.

All staff will be aware that this is a time of major change for the Trust. We have recently opened the new hospital development on the Infirmary site, and we have provided a full range of healthcare services, in hospital, in specialist mental health services and in the community, including services for people with learning disabilities – all within the Trust for many years. Over the coming year, however, the configuration and management of these services will change as the new Primary Care Trusts, the new Mental Health Trust and the new Acute Trust emerge. This will require us to plan the transitions with the minimum of disruption to patient care and to ensure that our commitment to good whole – systems governance principles and practice do not waiver.

The whole systems model proposed is intended to carry the organisation through this transitional period and will be reviewed on an ongoing basis to ensure the best strategic and operational fit.

Shared Governance

The model of Shared Governance introduced in Rochdale was multi- professional and across an integrated healthcare facility. Shared Governance has now been in place for three years, has successfully delivered much of the professional practice agenda for nurses & therapists, and has provided a focus for leadership development within an evolving leadership culture. Clinical Governance was introduced into the NHS during this development phase, so it made sense for the Trust to take a parallel approach to the introduction of two similar systems over time and then move into a whole systems governance model which would address both the clinical quality and the professional development agendas.

Evidence from the recent and ongoing evaluation of the Shared Governance programme has indicated that the Shared Governance key purpose and Council structure needs to be reconsidered.

The Policy Council has provided leadership and direction to the practice – based councils, and provides the prime link to the Trust Management Team, Executive and Board. The Policy Council's key aim has been to develop and deliver the strategic direction for professional practice in the organisation, and the evidence from the evaluation is that it has achieved this primary objective.

The Practice Development Council has dealt enthusiastically and effectively with a broad range of clinical and professional practice issues which have had a significant impact on the quality of patient care e.g. oxygen humidification, medication policy, nutritional issues.

The Research and Development Council's work has underpinned the new practices that have been introduced, and this Council has enabled nurses and therapists to effectively contribute to the broader corporate R & D agenda.

The Human Resources Council's work has been particularly challenging but has helped to meet several national objectives and has led to the Trust being identified as a site for good practice in terms of involving staff in decision-making. The introduction of HR expertise to the Council's membership during Year 2 of the Council's work was viewed to be of particular benefit.

The way forward for the Shared Governance programme during 2001 is: -

- ◆ to maintain the Policy Council in its current form
- ◆ to actively engage medical staff in the Shared Governance programme at Directorate level, and to bring the management and professional processes together by introducing Directorate – based Councils.
- ◆ to reconfigure the Practice – based Councils from three to two, with revised briefs of Practice Development, and Research, Education and Development

Magnet

The Trust is currently working towards accreditation of its services through the Magnet Hospital Recognition Programme. The Magnet programme is based upon the principles of effective clinical leadership development and the achievement of high quality patient outcomes. These principles of the accreditation process are being supported through the Shared Governance framework.

Several of the Magnet standards directly link with the organisation's clinical and corporate governance objectives and therefore will facilitate the achievement of our whole systems approach.

Currently the Trust is fourteen months into the pilot programme and is preparing a submission for accreditation in early 2002.

Corporate Governance

is the system by which the Trust is directed and controlled in order to achieve its objectives and meet the mandatory standards of accountability, probity and openness, and upholding public service values.

It has to date been taken forward via the Controls Assurance programme and the process around its 18 standards. This has involved a baseline self-assessment exercise for each of the standards and the subsequent completion of action plans designed to achieve progress against each of the targets.

Monitoring of this progress has been undertaken by the Corporate Governance Committee. The Requirements to achieve compliance against certain milestones are monitored and reported to the Trust Board on a regular basis, so that the Controls Assurance statement can be signed off by the Chief Executive

It was recognised from an early stage, however, that whilst Controls Assurance must maintain a high priority, it was only one element of the overall governance agenda and its relationship with the other governance elements needed to be clarified and developed.

It is planned therefore that responsibility for compliance with control assurance standards should fall within the responsibility of Directorates, as with other performance/governance issues, and therefore should fall within the Whole-Systems Governance infrastructure, provided that all elements of performance management are included. It is proposed, therefore, that the current Corporate Governance Sub Committee and Clinical Governance sub-Committee will merge into one Governance Sub-Committee, the role and function of which is described later.

Clinical Governance

is the framework through which the Trust and its staff are accountable for the quality of patient care. It is comprised of the systems and processes for monitoring and improving services and should also include

- ◆ a patient centred approach which treats patients with courtesy, involves them in decisions and keeps them informed
- ◆ an accountability for quality which ensures that clinical care is up to date and effective and that staff are up to date in their practice
- ◆ high standards and safety
- ◆ a programme of continuous improvement in services and care

We have learned a lot since the introduction of Clinical Governance into the NHS and the Trust, and thus are now much clearer as to how we can ensure corporate accountability for the quality of care we provide, by explaining

- ◆ our whole – systems Governance goals and strategy, and the infrastructure we need to have in place which clearly identifies key responsibilities and accountabilities for our Whole-systems governance programme
- ◆ the systems we need to have in place to measure and improve the quality and safety of patient care

It is important to remember that the Clinical Governance agenda is mandatory and that despite the changes ahead and the considerable competing priorities we all face, our responsibilities must be met. Our Clinical Governance programme will also be subject to review by the Commission for Health Improvement. The first CHI reports are now available on the CHI website and it is our view that action needs to be taken to deliver the objectives of good clinical governance and be well prepared for a monitoring visit. This document proposes a structure to achieve these aims.

AIMS OBJECTIVES AND PRINCIPLES

Our Whole-Systems Governance aims, objectives and principles are:

- ◆ to ensure that the Trust consistently follows the principles of good corporate governance
- ◆ to aim to provide high quality care that meets defined clinical standards, and that where a problem is identified, prompt action is taken to resolve it
- ◆ to recognise that everyone in the Trust has a contribution to make in their responsibility to provide quality patient care and to help resolve any problems that arise. Staff will be actively encouraged to bring any problems to the Trust's attention in an open manner without fear of recrimination
- ◆ to have systems in place that assures the quality and safety of the clinical care we provide, to have our clinical staff participate in those systems and to act when any one of those systems suggests that we need to improve what we do. We will make sure that our systems operate within a just culture and do not blame staff when a problem occurs but encourages them to learn from the experience of analysis and acting on the problem
- ◆ to link these systems and the provision of patient care together and make sure that the Management Team and Trust Board are kept informed about any findings and take prompt corporate action to make improvements when needed
- ◆ to be explicit about the responsibilities and accountabilities of named staff for leading the implementation of these quality and patient safety systems

We acknowledged in our recent Clinical Governance Annual report that full implementation of all of the programmes included within Clinical Governance is a long term process that will take several years. Key priorities in the first year, however, have been to

- ◆ review the systems that are in operation and determine how these need to be improved
- ◆ identify individuals to take lead responsibility and accountability on behalf of the Trust for strengthening our existing quality and safety systems and to revise job descriptions accordingly
- ◆ introduce the concepts of clinical governance to staff through a range of education and training activities
- ◆ carry out a baseline assessment of our services
- ◆ develop Clinical Governance action/development plans

The Trust has delivered its first year objectives on time and has made significant progress, particularly in the area of staff awareness and training.

The need for more accurate, clinically relevant and timely information has been highlighted during year 1 of the programme and a major priority for the future will be the need to develop integrated clinical information systems that are accessible to staff in clinical areas. The new Patient Administration System, to be implemented in 2002, is expected to be a key driver for progress to be made in this area and will facilitate the sharing of information within and outside of the Trust.

Effective communication between staff, with other organisations and most importantly with patients is an essential outcome of a robust governance programme and the need to make improvements in this area has also been highlighted.

Systems

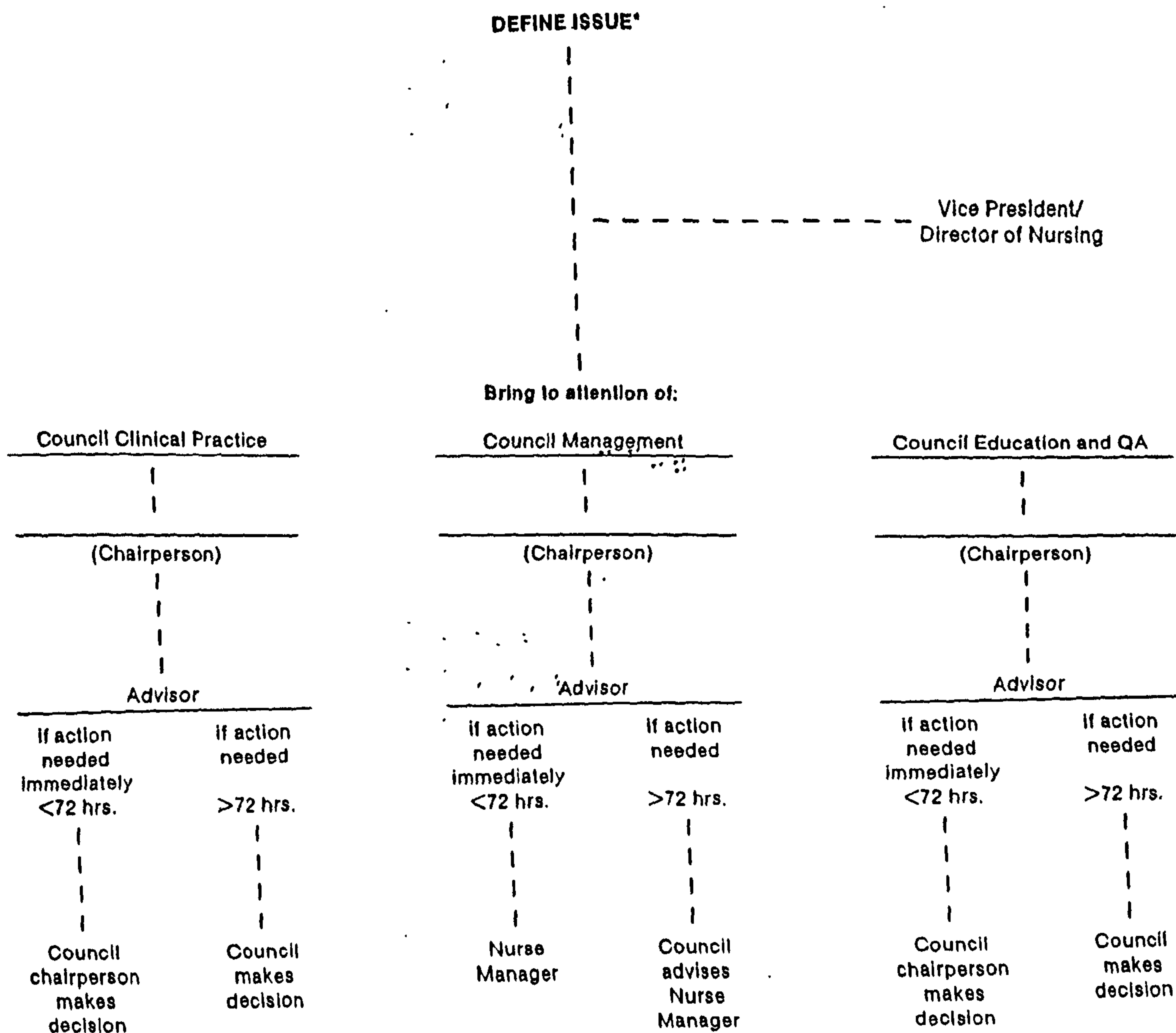
The functions, processes, and systems that will be needed to fulfil our Governance responsibilities have been defined and are listed in the following table: -

GOVERNANCE FUNCTION	SYSTEM / OTHER REQUIREMENTS
Whole Systems Approach to Governance	<ul style="list-style-type: none"> ◆ Systems and processes to be developed to link Clinical Audit, R & D, Clinical Effectiveness, Education & Training, QA, Risk Management, Controls Assurance, Health & Safety, Complaints & Litigation, IM & T and Shared Governance Councils to enable more effective team working, and to inform the Governance infrastructure (see later)
Clinical Audit	<ul style="list-style-type: none"> ◆ Trust- wide Clinical Audit programme to be in place ◆ Clinical Audit Committee will report into new Governance Steering Group ◆ System needed for monitoring that audit outcomes are implemented at service level
R & D and Clinical Effectiveness	<ul style="list-style-type: none"> ◆ R & D Strategy and Action Plan needs to be implemented at Directorate level ◆ Research Governance systems to be developed ◆ Shared Governance Practice Development Council in place ◆ Magnet accreditation programme in development phase ◆ Programme of access to databases and Internet at service/ ward level in place ◆ System needed to monitor use and application of EBP into everyday clinical practice ◆ Care pathway development needs acceleration ◆ Need system for dissemination of NICE guidance and for monitoring its use at service level ◆ Need system for monitoring outcomes of NSF implementation at service level
Risk Management and Controls Assurance	<ul style="list-style-type: none"> ◆ Terms of reference and membership of Risk Management Committee to be revised, to incorporate all aspects of the risk agenda, including performance management of Controls Assurance ◆ Maintain CNST Level 1 accreditation and work towards Level 2 ◆ Risk register to be developed in line with NHS guidance ◆ Introduce systems to comply with new national mandatory reporting scheme of all adverse events and near misses ◆ Risk Co-ordinator post required(clinical & non-clinical risk) ◆ Clinical Risk Management Training programme to be established ◆ Improved clinical Incident/near miss reporting systems to be reviewed and developed ◆ System/policy for managing & learning from serious clinical incidents required ◆ System to link incident, complaints and claims information to be developed ◆ System to link clinical effectiveness, audit and infection control programmes to promote clinical risk reduction to be developed

Clinical Quality and Safety	<ul style="list-style-type: none"> ◆ Drugs & Therapeutics Committee to monitor Medicines Management arrangements & to report outcomes to Governance Steering Group ◆ Infection Control Committee to report outcomes to Governance Steering Group ◆ Transfusion Committee to report outcomes to Governance Steering Group ◆ Cleanliness in Hospitals/Patient Environment Group to report outcomes to Governance Steering Group ◆ Health and Safety Committee to report outcomes to Governance Steering Group ◆ Controls Assurance programme to be incorporated into Clinical Governance programme as part of converging strategy ◆ New PCG/T & Trust joint Clinical Quality Forum outcomes to be reported to Governance Steering Group
Complaints	<ul style="list-style-type: none"> ◆ Complaints Monitoring Group to report outcomes to Governance Steering Group ◆ All Directorates to review complaints as part of Directorate Governance/Quality programme
Performance Review & Management	<ul style="list-style-type: none"> ◆ Appraisal systems for all clinical staff to be implemented in 2001 ◆ Review of system re poor performance management needed
Education and professional development	<ul style="list-style-type: none"> ◆ Education & Training Strategy Group to report outcomes to Governance Steering Group ◆ Education Committee to report outcomes to Governance Steering Group ◆ System to monitor impact of Whole systems Governance Training programme on staff performance to be developed ◆ Training in Quality Improvement methodologies within clinical services to be set up for front line staff ◆ Training in use of EBP to be set up ◆ Clinical supervision systems to be extended Trust – wide ◆ Personal Development Plans to be in place for all clinical staff
Information flow / I M & T	<ul style="list-style-type: none"> ◆ Caldicott Steering Group to report outcomes to Governance Steering Group ◆ I M & T Steering Group to report outcomes to Governance Steering Group ◆ Need system to monitor use and impact of new clinical databases on clinical outcomes ◆ Need system to monitor use and impact of Clinical and other Indicators on clinical outcomes ◆ Trust web site to be fully operational in 2001. Need system to monitor its use and application ◆ Improved Directorate/ service level performance monitoring system to be developed to include activity, finance and clinical elements to inform HIMP, SaFF, and CHI review processes
User Involvement	<ul style="list-style-type: none"> ◆ System for managing Patient Satisfaction/ Feedback programme to be reviewed ◆ PALS service to be set up (based on outcome of pilot projects) ◆ Improved user involvement systems to be set up

Appendix 2 - Decision Tree

DECISION TREE FOR SHARED GOVERNANCE



***If the issue is pertaining to:**

The Council for Clinical Practice

- Clinical standards of nursing practice such as concerns about patient care,
- Issues around role and responsibilities of the Registered Nurse,
- policies regarding nursing practice and resultant nursing care,
- peer review — evaluations,
- Clinical Ladder Program,
- Nursing Standards

The Council for Education and Quality Assurance

- Nursing Inservices/Continuing Education
- Preceptors
- Orientation
- Maintaining care plans, policies, procedures, care conferences
- Revision of nursing procedures

- JCAH Review preparation/meeting standards of
- Incident Reports

The Council for Nursing Management

- Hiring/Interviewing
- Staff Conflicts
- Time requests/scheduling
- Policy-making
- Nurse Licensure

Nurse Manager

- Allocation of fiscal resources which include budgetary, operational, capital, and contingent financial resources essential to the practice of nursing in the Pain/Rehab Program
- Time Cards
- Policy-Making <72 hours
- Back up for all of the above council activities.

Appendix 3 - Access to Site & Data Agreement

AGREEMENT TO SITE & DATA ACCESS **FOR PhD STUDY – by Tracey Williamson**

The following agreement pertains to the proposed research study, Evaluation of the Implementation of Shared Governance in an Integrated NHS Trust. The purpose of this agreement is to meet the following:

- To clarify the researcher's position regarding access to the Rochdale Healthcare NHS Trust site.
- To clarify the researcher's position regarding access to data that may be stored within the Trust, including the ownership issues surrounding data developed by the researcher.
- To reassure the Trust as to the researcher's intentions during the period of the study and that appropriate ethical approval will be met.
- To ensure mechanisms are in place for two-way communication to permit the smooth running of the proposed study.
- To ensure that processes are in place by which the study findings can be fed back to guide the implementation of Shared Governance.

Keeping up-to-date

- **Implementation process - *time scales, elected council members.***

The researcher will be supplied with information regarding the Shared Governance implementation time-scales and council membership.

- **Meetings - *dates/times/venue of Practice Councils, Policy Council, Trust Board, Management Team and Directorate Meetings.***

The researcher will be supplied with dates/times/venues of meetings that may be relevant for her to attend when conducting fieldwork

- **Newsletters & miscellaneous documents - *Shared Governance newsletter, NHS Executive reports etc.***

The researcher will, where possible, be added to all relevant mailing lists and be forwarded appropriate items that are not generally circulated.

- **Conferences/presentations - *researcher's involvement, attendance and presentation opportunities.***

The researcher will actively seek, and requests to be informed about, any relevant conferences & presentations that she may be eligible to attend and/or present at.

Access

- **Documents - *Shared Governance related, other relevant papers/minutes.***

The researcher will be supplied with, or referred to, any additional sources of information that may be of relevance to the research study.

- **Letter of Authorisation - *permission to access data, presence of researcher and ownership of the research.***

A letter of authorisation specifying the researchers access to data will be provided. This will include guidance relating to ownership of the research and copyright issues. Data will be jointly owned by the researcher and the Trust. Permission to reproduce the data will be sought by the researcher prior to its publication or presentation.
(Letter of Authorisation received - dated 11/11/98)

- **'Participant/observer' role at meetings - *permission to observe, participate and maintain personal records of meetings.***

It is agreed for the researcher to act as 'participant/observer' and maintain field-notes.

Ethical Agreement

- **What is private/public? - *in view of researcher role, information imparted by personnel***

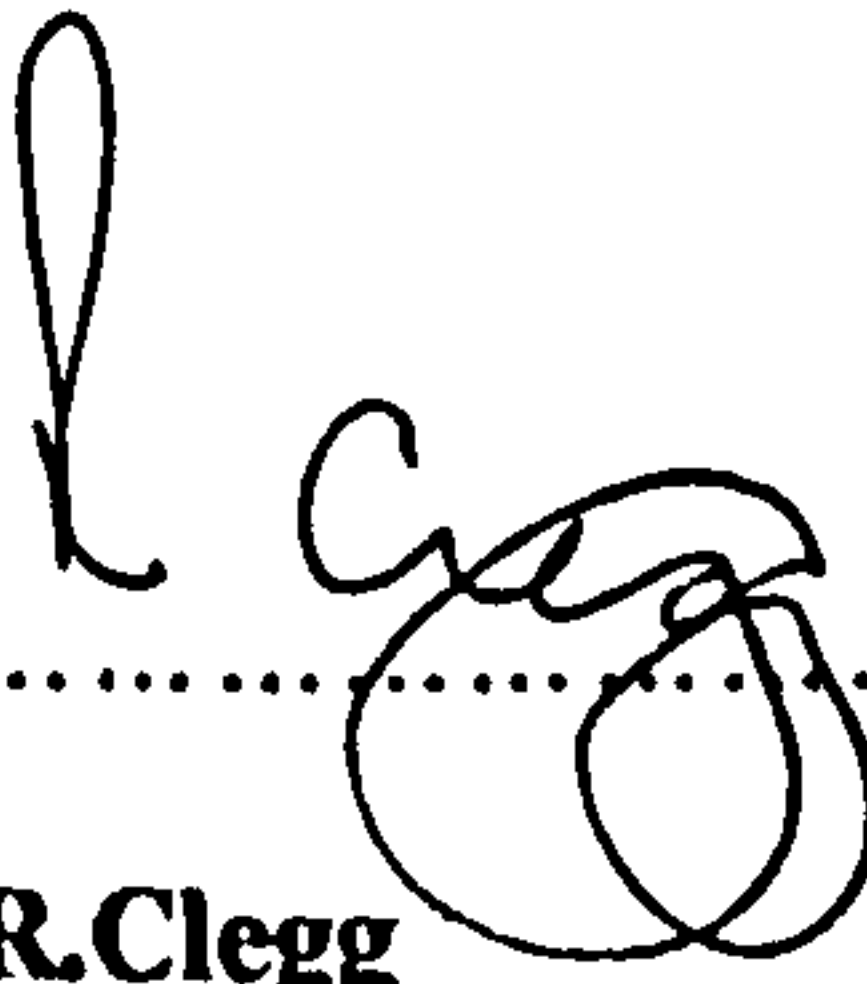
There is presently no specific guidance on what is private or public. In the event of consumer representation, the member/s of the Public, and the Trust; will be safeguarded by obtaining the necessary ethical approval and informed consent.

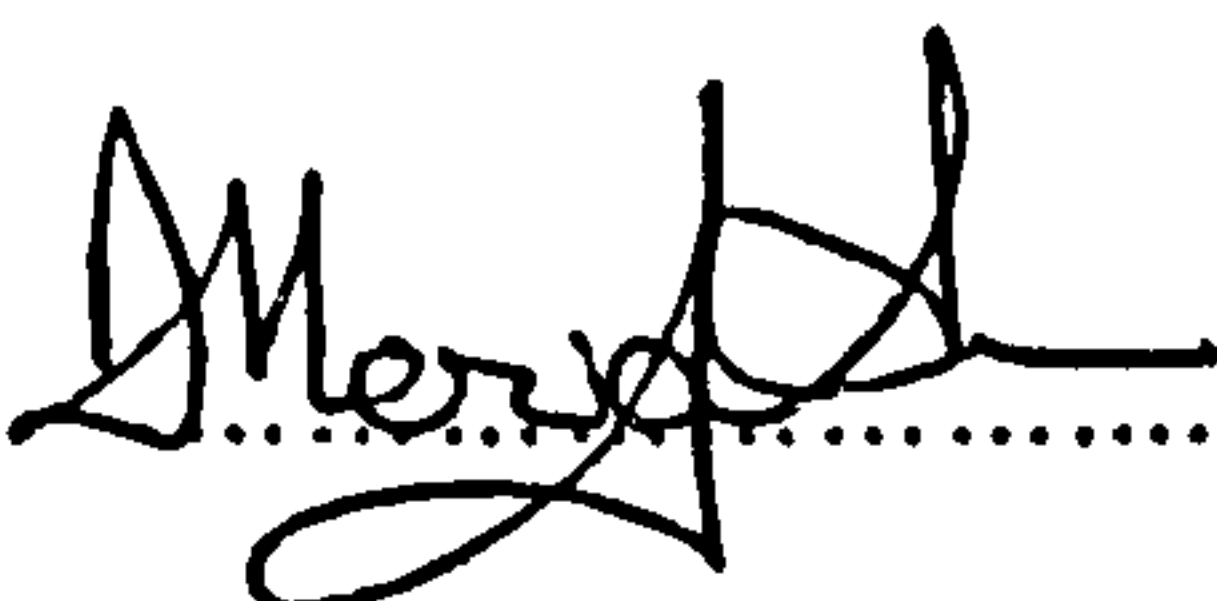
- **Process/venue for feedback of findings - *Policy Council, Advisory Group, written reports***

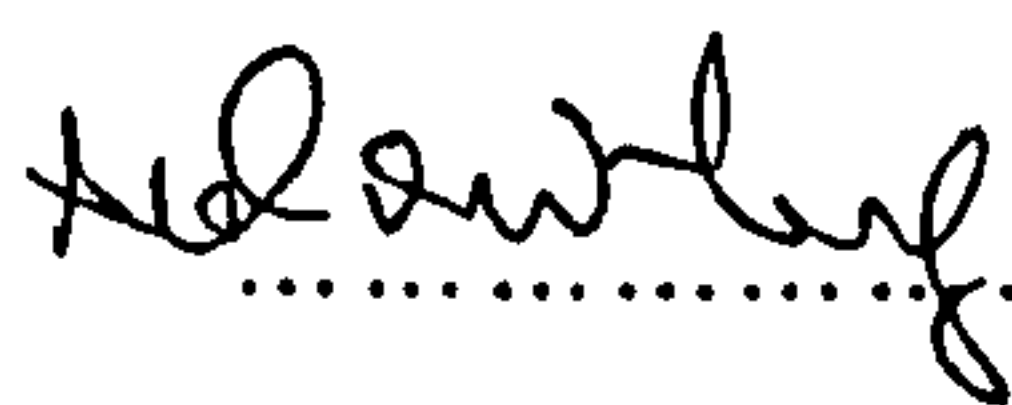
Information pertaining to the study will be fed back via the Policy Council. The researcher will also facilitate an Advisory Group to comment and advise upon the study findings.


- **Ethical approval - *of fully developed proposal***

Local Research Ethics Committee approval will be sought once the refined research proposal has been submitted to the North West Regional NHS Executive at the end of December 1998.


..... date.....17.12.98
R.Clegg
Chief Executive


..... date.....17/12/98
Mrs D.Houghton
Executive Director of Nursing/
Clinical Director (Community)


..... date.....18.1.99
A.F.Long
Professor/Director
Health Care Practice R&D Unit


..... date.....18/1/99
Tracey Williamson
Research Fellow

Appendix 4 - Study Approval



Bury & Rochdale

HEALTH AUTHORITY

Our Ref: IB/CM
Your Ref:
Address for reply: SILVER STREET
Telephone: 0161 762 3097
FAX: 0161 762 3157

21 Silver Street
Bury BL9 0EN
Telephone 0161 762 3100
Facsimile 0161 764 5042

Telegraph House
Baillie Street
Rochdale OL16 1LJ
Telephone 01706 869911
Facsimile 01706 359011

29th January 1999

Tracey Williamson,
Clinical Nurse Practitioner,
Birch Hill Hospital

Dear Tracey,

BRLREC 26 - An Evaluation of the Implementation of Shared Governance in an Integrated NHS Trust.

The above protocol was considered at the meeting of the Bury & Rochdale Local Research Ethics Committee held on Tuesday, 19th January 1999.

Assurances were provided by yourself during the BRLREC meeting, regarding the opportunity being given to participants in interviews/meetings to review and agree the contents of the participant observer summary records of these events, prior to them being fed back to the policy council and advisory group meetings.

On the basis of these assurances approval was granted to the study.

The committee would like to draw your attention to the fact that it is the responsibility of the person conducting any Trial to ensure that all professional staff and management of NHS Trusts involved are notified that it is taking place.

I look forward to receiving a copy of a report when the study is completed.

Yours sincerely

Collette Mullins

Ian Buchanan ^{VP}
Chairman
Bury & Rochdale Local Research Ethics Committee



Bury & Rochdale

HEALTH AUTHORITY

Our Ref: IB/CM
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Rochdale OL16 1LJ
Telephone 01706 869911
Facsimile 01706 359011

29th April 1999

Tracey Williamson,
Clinical Nurse Practitioner,
Birch Hill Hospital

Dear Tracey,

BRLREC 26 - An Evaluation of the Implementation of Shared Governance in an Integrated NHS Trust.

Thank you for your correspondence (dated 5th March 1999, which you sent to us by fax on the 22nd April), confirming the assurances given by you at the meeting of the Bury and Rochdale LREC on the 19th January 1999.

This has been noted by the Chairman

Yours sincerely

Collette Mullins
Administrator, Bury & Rochdale Local Research Ethics Committee.

It would be appreciated, if when corresponding with the Bury & Rochdale Local Research Ethics Committee, you provide 20 copies of any documents, for distribution to the Committee members. Can you please also refer to Study Ref. No. (ie., BRLREC ?) in all communications. Thank you.

Appendix 5 - Individual Interview Letter

Trust Logo

Tracey Williamson
Research Fellow
Pennine Offices
Birch Hill Hospital

Tel: ext 4699

Dear

As you are aware, I am in the middle of a three-year research study of shared governance as part of a Regional Research Training Fellowship. *If you agree, I would like to interview you to find out your views concerning decision making in relation to shared governance.* The findings will form part of the evaluation of shared governance and will be used to make changes to the way it is implemented in our Trust.

The interview will last approximately 30-45 minutes and will take the form of an informal discussion. You are free to change your mind about taking part, for any reason, whenever you wish.

With your permission I would like to tape-record our discussion for use only by myself and Research Associate, Sarah Petts. Once typed up, I will invite you to read through and verify the record of our discussion. Your name will not be mentioned on the tape-recording, transcript or in the written findings. I will ensure findings are suitably anonymised so that your post etc, cannot identify you. Where this is difficult, I will consult you first. The tape will be destroyed at the end of the study.

Should you have any questions after the interview, please contact me on the above phone number so that I can help with any issues that you may have.

I will communicate emerging findings widely throughout the study.

Yours sincerely

(Tracey Williamson)

Appendix 6 - Network Diagram Verification Form

~ Shared Governance Research Study ~

Network Diagram Verification Form

Council issue:

Looking at each diagram and associated narrative answer the following:

1. Generally speaking how accurate do you think this diagram is at illustrating the Council's decision making with regard to this issue? *(please explain)*
2. Is there anything 'missing' (such as events, actions or influences) that you think affected the Council's decision making in some way? *(Highlight on the diagram and explain your reasoning here)*
3. Is there anything 'extra' shown (such as events, actions or influences) that you think should NOT be there? *(Highlight on the diagram and explain your reasoning here)*
4. Are there any elements within the diagram that you feel were particularly important or influential on Council decision making? *(Highlight on the diagram and explain your reasoning here)*
5. Are there any elements within the diagram that you feel were particularly insignificant or unimportant? *(Highlight on the diagram and explain your reasoning here)*
6. Do you think any of the 'directions of influence' (➡ ➠) are inaccurate? *(Highlight on the diagram and explain your reasoning here)*
7. Do you think any of the 'types of influence' (positive + or negative -) are inaccurate? *(Highlight on the diagram and explain your reasoning here)*
8. Please add any other comments or suggestions you wish to make.

Appendix 7 - Council Comparison

Council Comparison – Human Resources and Mental Health

Tracey Williamson – April 2000

The purpose of this paper is to begin the presentation of data pertaining to two contrasting councils that have been identified as case studies within the doctorate. The key contrasts that have prompted these councils selection are summarised in the table below. Firstly, each council is described in turn. Following this similarities and differences are discussed and evidence provided from the fieldwork to support this discussion. Lastly, consideration is given to the role of the Research Fellow as action researcher within these council contexts.

COUNCIL COMPARISON		
Characteristic:	Human Resources	Mental Health
Remit	Address corporate HR issues	Address local practice issues
Focus of council	Trust-wide	Directorate-wide
Commencement date	January 1999	February 1999
No of members	9	11
Membership	Multi-disciplinary	Multi-disciplinary
Professions represented	Nurses, CPS, Health Visitors, Midwives	As previous but also a Nursing Assistant, Psychiatric Consultant and Administration
Venue	Board room	Varied informal settings
Meeting time	2 hours 15 minutes	3 hours
Facilitator	Yes	No
Work approved by	Policy Council	Psychiatric Services Management Team
Style	Formal	Artistic
Topics addressed	<ul style="list-style-type: none">• Millennium issues• Recruitment & retention• Support Worker role• Communication• Personal Development Plans• Canteen hours• Shift patterns	<ul style="list-style-type: none">• Communication• Violence & aggression• Case notes• Bank Nurse Training• Practice Development Unit accreditation• Skills database• Patient contact• Staff motivation

In brief, the rationale for the selection of these two councils is that fieldwork to date has provided evidence of their utility in gaining an understanding about what is going on in the council setting. The general characteristics of these two councils are most

polar and so provide opportunity for meaningful comparison. They are also the councils that the Research Fellow is to spend most time in.

~ Human Resources Council ~

Background

The Human Resources Council (HRC) was incepted in January 1999 as part of the Rochdale NHS shared governance model. This comprises three councils whose remit, structure and processes were designed by the Shared Governance Working Party and includes a Practice Development Council and a Research Education Council.

Structure

The HRC consists of 9 members:

- ❖ A facilitator
- ❖ Department Manager – Critical care (Vice Chair)
- ❖ Ward Manager – Medicine
- ❖ Ward Manager – Mental Health
- ❖ Staff Nurse - Day Surgery (Chair)
- ❖ Junior Sister – Paediatrics
- ❖ Ward Manager – Paediatrics
- ❖ Physiotherapist
- ❖ Occupational Therapist
- ❖ Staff Nurse – Learning Disabilities
- ❖ 3 vacant seats – Community, Mental Health, Medicine

Council members were selected through a process of voting. The areas of representation, number of seats per council and remit of each council had previously been determined by the Working Party. Wide publicity by the Working Party encouraged Trust Staff to write manifestos, for the Council they wished to be a representative on. These were then circulated and ‘qualified’ staff in the Trust placed the candidates in order of priority. This democratic process led to the identification of staff to hold the first council seats. As the HRC proved difficult to recruit for, some council members were elected whose own first choice was another council and

some Community seats remained vacant (Community, Medicine & Mental Health). Once identified, each council member attended a 'Leading an Empowered Organisation' (LEO) course which was their only formal preparation to assist them on becoming a council member.

Focus & Remit:

The remit of the HRC is to address Human Resource issues that have a Trust-wide implication.

The Policy Council was a newly created structure whose purpose is to provide direction, leadership and support to the Trust-wide councils, and as such, set the HRC agenda in the first instance. At a Workshop in January 1999, the Nurse Executive informed council members that they are to discuss important organisational business and make a contribution.

A philosophy was developed by the HRC members at their first meeting in January 1999:

"The Human Resource Council is founded on the principles of shared governance and aims to help develop Rochdale Healthcare Trust as an empowered organisation".

The aims of the HRC were also brainstormed. Many of these topics were the idea of the facilitators who suggested it was not an exhaustive list, and would evolve:

- Collaboration-statutory agencies eg Health & Safety
- Personnel issues ie local working patterns
- Recruitment & retention
- Staff Development issues ie night-staff, changing roles,
- Representing the views of the workforce
- Health of the workforce
- Management systems ie communication
- Staff support eg Clinical supervision, creche
- Representing and informing colleagues

- Global issues

Process:

The HRC has monthly meetings pre-set for the year and usually meets in the Board Room for two and a quarter hours on a Monday afternoon. The Chair is their second as the first Chair went on Maternity Leave in October 1999 and the Vice Chair became the new Chair. A council member has agreed to be new Vice Chair temporarily until a volunteer is found, as they do not wish to be a full-term Vice Chair. This council has had the same facilitator throughout who has attended 77% of the meetings having missed three consecutive ones in summer 1999. The role of the facilitator is to support the council and provide supportive information whilst gradually empowering them. Since January 2000, all Chairs have received additional support and information by attending a monthly Chair's meeting with the facilitators and the Nurse Executive. This meeting focuses on gaining an insight into each other's agenda and being briefed as to what the Policy Council will be addressing. The initiation of these meetings was in response to research findings pertaining to a lack of integration amongst the councils.

All councils had an OARRR's model for managing meetings introduced to them in March 1999 by their facilitator as a framework to organise their meetings. At the start of each meeting a council member agrees to be Process Facilitator whose role it is to ensure that times are set for each item and stuck too, and that no ground rules are broken. Ground rules are not on visible display, but are a typed document drawn up by the HRC at its inception. A copy of these is kept in the Chair's information file. Using an OARRR's framework means that the Chair is free to co-ordinate the meeting and the Process Facilitator ensures the meeting runs smoothly and feeds back at the end as to how well this was done. There is usually a reluctance to be Process Facilitator and the role is usually performed in an incomplete manner. For example, outcomes for each item ie decision, feedback, actions needed, are often not pre-set, hence there is no check by the Process Facilitator that these have been met. Times are not properly set and on several occasions the model hasn't been used at all. The use of this model has been one of the foci subjected to the action research cycle.

Topics that have been addressed to date include:

- Millennium Issues
- Recruitment & Retention
- Support Worker role
- Communication
- Personal Development Plans
- Canteen Hours
- Shift Patterns

HRC meetings have been observed to be inadequately organised and effective at managing their agendas. This lack of progress has been attributed to several factors including a junior, inexperienced Chair. This is a view supported by the Chair herself, the facilitator and Research Assistant. This lack of being organised is evident by last minute agendas and minutes being circulated, missing items on the agenda, a forgotten meeting that had to be cancelled, not ensuring guests are attending, poor control over the running of the meetings, heavy reliance on the facilitator, not briefing guests, forgetting to bring papers to the meeting, not clarifying 'suggestions' and deferring until more information is available, not cascading information from the Policy Council and not clarifying directives from the Policy Council. A second key factor in lack of progress has been the repeated abstinence of a Personnel Department representative from the meetings despite numerous invites. The Chair has recently met with this department and a representative is expected from next month. To date, their absence has meant that the HRC has had insufficient information to make decisions. A key example of this is their work on the Support Worker role. This has been the main agenda item since February 1999 and the job description they have been trying to develop is only now near completion. Additionally, a model for managing meetings was introduced to the councils in March 1999 called OARRR's. The HRC has never used this model in full, yet there is evidence from across the councils that where it is used fully, the resultant meetings flow better and keep to time with clear outcomes achieved. The HRC struggles to make progress up to the present day and whilst council members are now used to working with each other, they do not seem to gel well as a team. Few HRC members knew each other at the outset due to the fact that they come from a wide range of directorates and departments. The actual remit of this council is most unclear as other groups exist that are addressing similar and overlapping issues. Few HRC members have much previous experience of working on human resource issues as is evident in the recently collated profiles on all council members. Two council members are on this

council because they were not elected to other councils that they would have preferred.

All initial agenda items were set for the HRC by the Policy Council. A small number of ‘suggestions’ have been received to date via suggestion forms that are available to anyone to complete within the Trust.

.....

~ Mental Health Council ~

Background

The Mental Health Council (MHC) was incepted unexpectedly in February 1999. This directorate-based council was the idea of the Senior Nurse Practice Development (SNPD) within the Directorate. Previously the Trust’s Nurse Executive had discouraged the development of this council, preferring to focus on establishing the Trust-wide councils first. However she was persuaded and the SNPD set up the council.

Structure

The MHC consists of 11 members:

- ❖ No facilitator
- ❖ Staff Nurse – Elderly Care
- ❖ Staff Nurse – Acute care (Vice Chair)
- ❖ Ward Manager – Elderly Care (Chair)
- ❖ Department Manager – Day Hospital
- ❖ Staff Nurse – Acute MH Care
- ❖ MH Nurse – Community
- ❖ Mental Health Nurse – Community
- ❖ Nursing Assistant – Acute MH Care
- ❖ Admin Representative – Outpatients
- ❖ Occupational Therapist
- ❖ Consultant Psychiatrist

The SNPD personally promoted the idea of a Mental Health Council and recruited volunteers. A number of MHC members had felt obliged to volunteer and so this process was not entirely democratic. The areas of representation, remit and number of seats on the council were determined by the SNPD following informal consultation with Directorate staff. Seats to represent all areas were filled. Once identified, each council member attended a ‘Leading an Empowered Organisation’(LEO) course which was

their only formal preparation to assist them on becoming a council member. This included the Nursing Assistant and Psychiatric Consultant.

Focus & Remit

The remit of the MHC is to address local Mental Health practice issues.

The relationship between the Psychiatric Services Management Team (PSMT) and the MHC is unclear. The PSMT was an existing structure prior to the shared governance initiative and the MHC has had to fit in with this. However there is evidence that the purpose of the PSMT is to work in partnership with the MHC and to approve their work. The MHC has identified its own agenda from the outset.

A mission statement was developed by an MHC member in conjunction with the SNPD:

“The Mental Health Council will achieve standards of excellence in patient care by the facilitation of evidence based practice and the support and encouragement of personal and professional development”.

The aim of the MHC was drafted for approval in March 1999, in a document developed by the SNPD who was at that time acting as a council member/facilitator:

“The Mental Health council is founded on the principles of shared governance. The Mental Health Council is seen as a resource to identify clinical issues and support the development of evidence based practice. The council will recognise and encourage standards of excellence in all areas of Mental Health practice”.

Topics to be focussed on were identified by the SNPD as:

- Enhance and develop practitioners skills
- Documentation
- Role development
- Practice guidance, protocols and standards
- Promoting user involvement
- Research evidence
- Audit
- Development of collaborative working
- Service developments

Process:

The MHC has monthly meetings that it has pre-set for the year and usually meets in varied informal settings. Meetings last for three hours and alternate from Thursday afternoons to Friday mornings for ease of attendance by all members. The Chair is their second as the first Chair went on sick leave and the Vice Chair took over as Chair. The original Chair is now the Vice Chair. This council originally had a facilitator who also functioned fully as a council member but who left in September 1999. Since then a new facilitator has not been appointed nor is there planned to be one. Since January 2000, all Chairs have received additional support and information by attending a monthly Chair's meeting with the facilitators and the Nurse Executive. This meeting focuses on gaining an insight into each other's agenda and being briefed as to what the Policy Council will be addressing. The initiation of these meetings was in response to research findings pertaining to a lack of integration amongst the councils.

A model called OARRRs was introduced to the council by their facilitator in March 1999 to provide a framework for them to organise their meetings around. At the start of each MHC meeting a council member agrees to be Process Facilitator whose role it is to ensure times set for each item are stuck too and that no ground rules are broken. In this way the Chair is free to co-ordinate the meeting and the Process Facilitator ensures the meeting runs smoothly and feeds back at the end as to how well this was done. There is usually only a little reluctance to be Process Facilitator and the role is usually performed fully. The Chair pre-writes a guide on flip chart paper and agrees leads, desired outcomes and times allowed for each item and adds up the time required. Adjustments to timings or items are made if the agenda is too large for the time available. The outcome for each item is written onto the flip chart and checked at the end of the meeting to see if agreed outcomes were achieved. The Process Facilitator ensures that ground rules are adhered to and these are readily available on a printed, colourful poster and displayed during the meeting.

Topics that have been addressed to date include:

- Communication
- Violence & Aggression
- Case Notes
- Bank Nurse Training

- Practice Development Unit accreditation
- Skills Database
- Patient Contact
- Staff Motivation

MHC meetings have been observed to be efficient and effective at managing their agendas. This high degree of organisation has been attributed to a confident Chair who has good interpersonal and organisational skills. Even the first Chair, although junior showed much of these skills and was supported by the facilitator and other council members in her role. Council members gel well as a team which is in part due to them knowing each other beforehand. This organisation is evident by timely agendas, papers being circulated for reading before hand, full use of the OARRRs model, little reliance on the facilitator and coping fine without a facilitator, remembering to bring all relevant papers to the meeting, sub-group work and preparation prior to meetings. A second key factor that has been observed and expressed by council members as aiding them has been their focus on local issues relevant to them all. All council members knew each other to some degree prior to the council's inception. The remit of this council is clear as it is focused on local issues and members know what other local groups are addressing issues relevant to them. Difficulty can and has arisen when the MHC has addressed an issue that has trust wide implications, such as bank nurse training, but these have been satisfactorily resolved by improving inter-council communication.

All initial agenda items were set for the MHC by their facilitator. A large number of 'suggestions' have been received to date via suggestion forms that are available to anyone to complete within the Mental Health Directorate.

Appendix 8 - Interview Rationale

CHARACTERISTICS – as at April 2000								
<i>Council member (pseudonyms):</i>	Council	Gender	Discipline	Seniority	Chair?	Prior meetings experience	Knowledge of subject area	Tenure to-date
<i>Nicky Walkden</i>	RE	M	Nurse – acute MH	Ward Manager	Yes – was 6/12	Lots & very wide variety	Patient satisfaction survey, setting up MH journal club	15/12
<i>Jam Glossop</i>	HR	F	Nurse - community LDS	Home Leader	No	Fair number and variety locally	Staff appraisals & devising job descriptions, clinical supervision, interviewing and selection	15/12
<i>Lucy Whitefield</i>	HR	F	Nurse – acute Surgery	D grade Staff Nurse	Yes – is 5/12	Own department meetings only	Non	15/12
<i>Ria Huddersfield</i>	HR	F	OT	Junior grade	No	Departmental only	Non	12/12
<i>Isaac Bolton</i>	PD	M	Nurse – acute Medicine	F grade Charge Nurse	No	Some G grade meetings only	Documentation group and local practice development at ward level	15/12
<i>Alice Clayton</i>	PD	F	District Nurse - Community	G grade Sister	No	Rep on course committee and support group	District nurse documentation group	3/12
<i>Zeta Manchester</i>	MH	F	Nurse – long term MH	G grade Ward Manager	No	Lots of attendance & wide variety	Lots of local practice development and in wider Unit. Work based projects	15/12
<i>Gwen Worsley</i>	MH	F	Nurse – acute MH	D grade Staff Nurse	Yes – is 13/12	Attendance at wide variety but little input	None	15/12

Interview Rationale - Council member selection for individual interview on decision-making

Appendix 9 - Time Frame for Decision-Making Data Collection

2000-2001 Calendar Months	J	F	M	A	M	J	J	A	S	O	N	D
Participant Observations												
Individual Interviews												
Focus Groups												
Data Coding												
Data Display Development												
Decision Making Workshop												
Conceptual Model Development												
Writing Up (commenced)												
Final Literature Review * Autumn 2003												

☆ = Last ever meeting of Human Resource Council

Timeframe for Decision-Making Data Collection

Appendix 10 - Sample Field Notes

Human Resources council meeting – 9th October 2000

Present – A - facilitator, B - chair, C, D, E, F, G, x Trust staff

B last minute checking with A where up to on some items eg Orientation Pack.

Did apologies and minutes and said that x couldn't come as an invitee.

SW role

B recapped SW, that the sub group met and have another meeting on the 18th.

Are using stuff from NMGH. May change SW document in light of portfolio headings.

A – didn't someone ring about it? Want to be involved?

B – yes it was x and she came to sub group meeting. (Shows SG bulletin sheet read)

C – not set any times! (NO pro-forma as forgot it but using old one). Went through – no desired outcomes set.

All struggled to agree a time needed for SW role as don't know what they are to be doing with it.

B – recap and writing a job summary.

D – is there a NMGH one?

B – NO! (D wanting to copy ideas from it)

B – have here an NVQ form from Mental Health

A – hasn't that been previously circulated? (YES, B not organised)

Had coffee and then B reading out her copy! Six points would have been better on flip chart or own copies. Difficult to take in.

B Looking at NMGH ones - A prompted x to copy them and give out. A – won't that do as a summary?

A – needs to be a statement not a list.

D – reword into one?

A - list could be headings.

D suggesting sentences – couldn't we just take as homework? (Is hard to generate ideas at meeting like this). No answer so carried on with wording.

A – seem to be struggling, perhaps do job description and then the summary. One option, just a suggestion.

B pinned up level 2 and 3 comparison done last time.

D – can we not just upgrade level 2 ones? (D only contributor. ?only one with these skills)

B scribing (?better to have a scribe and concentrate?)

A – would be good to build on level 2.

More silence.

E - ?take away like D said. Can bring ideas rather than trying to start from scratch. (Backs up 9-00 feedback that try to generate ideas at meetings instead of bringing them.)

D – or 3-4 of us could meet up.

A – or send comments to B

B - ?take a section each and bring next time?

A – better to have them before the meeting so can pull them together. Set a date. A section or whole document? – WHOLE agreed (yes-better).

50 B – we’re meeting as a sub group so bring next time.
51 A reiterating again to collect prior to next meeting so November 3rd agreed.
52 (Need to watch how many do the work as usually only one and this is first
53 time they have set a clear deadline for Council Member work I think).
54
55 **Orientation Pack**
56 B – still waiting for bits from other councils (unbelievable as was requested
57 in June). This could have been completed last month if the other councils were
58 responsive).
59 A – can you update me as missed last few meetings. Have all looked at the draft
60 pack.
61 B – No, will send a copy out once have other councils bit.
62 A – so to others for comments prior to finalising it? (advice posed as a question)
63 B – anything else needed in it?
64 F – might when seen the draft first
65 A agreed
66 B asking x to send it out when ready
67
68 **Recruitment Pack**
69 D – where up to on this?
70 B – F to do bits (not accurate and checked with x). Need bus time tables etc
71 (Why this is not an orientation pack)
72 B asking for mind map A has to go in while.
73 B – where get bus timetable from?
74 G – I can ring up bus stations – YES
75 A – Royal Infirmary has some info
76 B – said last time that we’d ask Directorate Managers to nominate people to
77 write a piece about own areas. Still want to do this? Will ask at PC.
78 A nodded. (DIDN’T ASK AT PC)
79 B – can you remember anything else to put in? (Not referring to any notes)
80 F – is this only an overseas pack?
81 A – no is a general one to supplement the existing one. Limited due to new
82 development.
83 A explained how new nurses had come to the council to inform this item
84 previously.
85 B – we mentioned entertainment info too. If there’s anything else, send it to me
86 and I will bring it to the next meeting.
87 F – will look around HR dept. (Good source of info)
88
89
90
91
92 **Communication**
93 B – this problem came up in Tracey’s feedback and our own discussion
94 D – to advertise stuff?
95 B – partly
96 D – could ask Training to send out things. Would be nice to have someone from
97 training here. Said we’d use the Trustee last time

98
99 Chatty finish at 3 40pm.

100
101 **THOUGHTS**

102
103 Whilst using pro-forma, Process Facilitator not setting desirable outcomes. Was
104 very useful that she recapped actual outcomes and action plans at the end so all
105 knew what they were supposed to be doing.

106
107 In terms of responsibility, need to see if actions are carried out as has not often
108 previously been the case eg HR to look around department, all to read NVQ
109 papers and bring written comments, G bus times, F long days info, B to ask at PC
110 for advice on H&S in job specs, D pre circulating staff induction and PDP
111 document and we are doing same with survey report. Accountability is an issue if
112 they do not do the work.

113
114 B not overly organised and not thought on to remind CMs to bring previously
115 circulated MH papers or to bring further copies to help at the meeting. Therefore
116 lack resources/info to do work at the meeting.

117
118 A still providing useful advice and info that helps meeting progress/decisions
119 about what action.

120
121 D asking to do it as homework so recognising that lack of time and climate at
122 meeting to do work and maybe taking it away in small groups may be better.
123 Also D only one with good skills to do with job specs and NVQs. Isn't really the
124 language of the other CMs?

125
126 A having to be strongly encouraging to make B see that it is best to send ideas to
127 her PRIOR to next meeting not to waste time by bringing them to the next
128 meeting. They realised for themselves that it may work better if they take the
129 whole document rather than trying to each look at a bit of it. Need to see if they
130 keep to the clear deadline they have set, that being November 3rd.

131
132 Requests for the Orientation Pack bits from other councils was requested by D
133 after the June meeting where we suggested this. Replies from other councils still
134 have not materialised despite reminders. Issue of not taking responsibility here
135 and is holding up the HR council. The pack could have been completed and in
136 use easily by now.

137
138 Again A guiding them into what to do with the pack once done ie circulate to
139 others before finalising.

140
141 B not clear as thinks there is some info outstanding from x but she gave verbal
142 feedback as requested and B is muddled up. If she had clear notes and brought
143 them she would know what was previously agreed. Pro-forma has previously
144 helped her with this but not referred to today. Did in PC later this week although
145 forgot to ask directorate managers again to nominate writers for each directorate

146 info in Recruitment Pack.

147

148 Have taken responsibility with the Communication issue that they recognised
149 themselves and from research feedback. A encouraging them to build on what
150 they have done and to clarify what the problem is ie what specifically in the
151 findings can they act upon. A couple of suggestions being made prior to
152 discussion of the problem. F expressed unfairness that Chair does so much work
153 and took on Info Sheet (responsibility) and G took on publicity role as suggested
154 in research feedback (responsibility).

155

156 Haven't really progressed on the problem of time. B to seek ideas at SG
157 conference next week and bring back. Need to be clear about problem and seek
158 solutions. Whilst mentioned it at this weeks PC it was just skirted round again so
159 no discussion evolved. In feedback at PC I said the issue was around sharing
160 work and having leads to share work and be responsible for items, rather than
161 just wanting more time.

162

163 Still no VICE. ?Not appropriate to look at new members to do this they have
164 enough on coping as a CM from what we have seen in other councils.

165

Appendix 11 - Individual Interview Consent Form

**Decision-Making Within Shared Governance in an
Integrated NHS Trust.**

I HAVE READ AND UNDERSTAND FULLY THE CONTENT OF THE EXPLANATORY LETTER I HAVE BEEN GIVEN.

I AGREE TO TAKE PART IN A CONFIDENTIAL TAPE-RECORDED INTERVIEW, AND UNDERSTAND THAT THE TAPE WILL BE DESTROYED AT THE END OF THE STUDY.

I am aware that I can change my mind at any time and am free to withdraw prior to or during the interview without question. If I do choose to withdraw, I understand that this will not compromise me in any way.

Signature.....

Date.....

Appendix 12 - Individual Interview Guide

~ DECISION MAKING ~

Interview Guide

- ❖ How did you come to be on the X Council?
- ❖ What do you see as that council's remit/purpose?
- ❖ Tell me about your council's activities to date.
- ❖ Describe your role within that council?
- ❖ How are new 'suggestions' from constituents dealt with in your council?

Prompt – what do you think about that?

- ❖ How are suggestions from the Policy council/PSMT dealt with by your council?

Prompt – what do you think about that?

- ❖ Last month your council looked at the issue of Z. Describe how you went about it and why.

(Eg. Sub groups, Brainstorm, Problem-solving model – why?)

- ❖ What does the term 'decision making' mean to you?
- ❖ What makes for 'good' decision making?
- ❖ How does your council ensure 'good' decisions are made?
- ❖ What factors are required to promote your council's ability to make good decisions?
- ❖ In your opinion are there any barriers which restrict your council's decision making ability?
- ❖ Has shared governance had any effect on your personal development?
- ❖ Has shared governance had any effect on your practice?
- ❖ Has the LEO course had any effect on your personal development?
- ❖ Has the LEO course had any effect on your practice?
- ❖ Are there any other factors affecting your personal development or practice at the moment?
- ❖ Do you think shared governance is having any effect on your sense of:
 - a) 'empowerment'?
 - b) 'responsibility'?
 - c) 'accountability'?
 - d) 'authority'?
- ❖ Do you think the LEO has had any effect on your sense of:
 - a) 'empowerment'?
 - b) 'responsibility'?
 - c) 'accountability'?
 - d) 'authority'?

Is there anything else you would like to add?

Appendix 13 - Focus Group Interview Guide

FOCUS GROUP GUIDE – *Councils*

What understand by TERM ‘decision making’.

What makes for GOOD decision making. What BASED on.

EXAMPLES.

What makes POOR decisions. Have you made any as a council.

BARRIERS to good decision making.

What needed to HELP/FACTORS to ensure good decisions are made.

What SORT of decisions do the council have to make.

HOW are council decisions made. PROCESS/MODELS USED. WHY.

How is AGREEMENT reached if different views on the best decision.

Is the BEST decision always the RIGHT one

Are there any ETHICAL issues around decision making.

How CONFIDENT are you about decision making?

Any CONCERNS about decisions made as a council.

How confident that RIGHT decisions are made?

Do all council decisions have positive OUTCOMES?

What are council’s STRENGTHS at decision making

How does SG AFFECT decision making – *council, practice area*

How does LEO AFFECT decision making– *council, practice area*

What is EMPOWERMENT all about

Are you EMPOWERED as a council. HOW.

What issues are there around AUTHORITY.

Who is RESPONSIBLE/ACCOUNTABLE for council decisions.

What PRIOR SKILLS/KNOWLEDGE got for decision making

How EQUIPPED are you for decision making.

What are your DEVELOPMENT needs around decision making.

Appendix 14 - Data Sets

DATA SETS

Section A

Human Resources Council

Fieldwork DM HR/2-00
Fieldwork DM HR/3-00
Fieldwork DM HR/5-00
Fieldwork DM HR/6-00
Fieldwork DM HR/8-00
Fieldwork DM HR/8-00
Fieldwork DM HR/10-00
Fieldwork DM HR/11-00

Interviews

Decision Making Interview Transcripts nos: 2, 6, 8.

Section B

Mental Health Council

Fieldwork DMMH/1-00
Fieldwork DMMH/2-00
Fieldwork DMMH/3-00
Fieldwork DMMH/4-00
Fieldwork DMMH/5-00
Fieldwork DMMH/7-00
Fieldwork DMMH/8-00
Fieldwork DMMH/10-00
Fieldwork DMMH/11-00
Fieldwork DMMH/1-01
Fieldwork DMMH/2-01
Fieldwork DMMH/4-01
Fieldwork DMMH/5-01

Interviews

Decision Making Interview Transcripts nos: 5, 7.

Mental Health Council Decision Making Focus Group Interview Transcript

Section C

Policy Council

Fieldwork DMPC/2-00
Fieldwork DMPC/3-00
Fieldwork DMPC/5-00

Chairs Meetings

Fieldwork DMChairs/2-00
Fieldwork DMChairs/3-00

Fieldwork DMChairs/9-00
Fieldwork DMChairs/10-00
Fieldwork DMChairs/11-00

Decision Making Workshop June 2001

Interviews

Ward Managers Decision Making Focus Group Interview Transcript
Clinical Professional Services Decision Making Focus Group Interview Transcript

Section D

Decision Making Data – non-Case Studies

Practice Development Council

Fieldwork DMPD/1-00
Fieldwork DMPD/2-00
Fieldwork DMPD/3-00
Fieldwork DMPD/4-00
Fieldwork DMPD/5-00

Interviews

DM Transcripts nos: 3, 4.

Research & Education Council

Fieldwork DMRE/3-00
Fieldwork DMRE/5-00
Fieldwork DMRE/6-00

Interviews

DM Transcripts nos: 1

Evaluation Study Data - Case Studies

Human Resources Council

Fieldwork CMHR/7-99
Fieldwork CMHR/8-99
Fieldwork CMHR/9-99
Fieldwork CMHR/10-99
Fieldwork CMHR/11-99
Fieldwork CMHR/4-00
Fieldwork CMHR/7-00

Mental Health Council

Fieldwork CMMH/7-99
Fieldwork CMMH/8-99
Fieldwork CMMH/9-99
Fieldwork CMMH/10-99
Fieldwork CMMH/11-99
Fieldwork CMMH/6-00

Fieldwork CMMH/9-00

Policy Council

Fieldwork CMPC/7-99

Fieldwork CMPC/8-99

Fieldwork CMPC/9-99

Fieldwork CMPC/10-99

Fieldwork CMPC/11-99

Fieldwork CMPC/6-00

Fieldwork CMPC/8-00

Fieldwork CMPC/9-00

Working Party

Fieldwork WP/7-99

Fieldwork WP/8-99

Fieldwork WP/10-99

Fieldwork WP/11-99

Workshops

SG Workshop 11-99

Evaluation Study Data – non-Case Studies

Practice Development Council

Fieldwork CMPD/7-99

Fieldwork CMPD/8-99

Fieldwork CMPD/9-99

Fieldwork CMPD/10-99

Fieldwork CMPD/11-99

Fieldwork CMPD/1-00

Fieldwork CMPD/3-00

Fieldwork CMPD/4-00

Research & Education Council

Fieldwork CMRE/7-99

Fieldwork CMRE/8-99

Fieldwork CMRE/9-99

Fieldwork CMRE/10-99

Fieldwork CMRE/11-99

Fieldwork CMRE/3-00

Fieldwork CMRE/5-00

Fieldwork CMRE/6-00

Interviews

Council Members Transcripts nos: 1-9

Non-council Members Transcripts nos: 1-12

Additional sources

Shared Governance Survey Reports 2000 & 2001

Secondary data - (Appendix 15 - Secondary Data Sources)

Appendix 15 - Secondary Data Sources

Secondary Data - List of Key Documents

Below is a selection of the documents located and stored throughout the research study and referred to during analysis of the decision making data. These key documents form a small part of an extensive collection including agendas, minutes of all council meetings and related meetings and outputs from the councils. These key documents have been identified, located and subsequently stored separately in the following order to facilitate easy retrieval. Less pertinent documents remain with field notes and are stored in the chronological order in which they were obtained.

1. RHT Leadership & Development Strategy 1997
2. Trust Board Paper 1998 – Proposal for Shared Governance
3. SG Implementation – Timetable of key action areas
4. Policy Council (Designate) – minutes 1998
5. Practice Based Councils Workshop January 1999 – field notes
6. Personal Communication January 1999 re Council Activity Sheets
7. Papers from first meeting – HRC – January 1999
8. Papers from first meeting – REC - January 1999
9. Papers from first meeting – PDC - January 1999
10. Papers from first PC meeting - January 1999
11. Papers from first observed MHC meeting – March 1999
12. Council aims – REC
13. Council aims - HRC
14. Council rules – HRC
15. Council rules – MHC
16. MHC Planning document – September 1998
17. Mission Statement – MHC
18. Terms of Reference – MHC
19. PSMT July 1999 – field notes
20. Rover Newsletter
21. MHC Member Roles – Oct 2000
22. MHC – Self Evaluation – workshop 2000
23. Business Case Proposal to Support Magnet Accreditation
24. Magnet Objectives
25. Quarterly Progress report on Magnet Working Party 2001
26. Shared Governance Briefing Paper 2001
27. Clinical Governance Briefing Paper 2001
28. Suggestion sheet for Support Worker issue
29. Support Worker role – Briefing Paper for HR Planning Group May 1999
30. Support worker – Portfolio Sub Group minutes – October 2000
31. Support Worker – Briefing Paper for PC – HRC June 2000
32. Bank Nurse Training – Interim Briefing Paper – REC December 1999
33. Bank Nurse Training – Final Briefing Paper – REC December 2000
34. Bank Nurse Training – Briefing Paper – MHC
35. Fluid Balance documents
36. Humidification documents
37. Orientation Pack documents – November 2001
38. SG Workshop – formal minutes 2001
39. OARRRS model
40. Framework for Developing Practice
41. Report Guidelines for Councils - Autumn 2000
42. All Shared Governance Working party minutes
43. Council member profiles
44. All Shared Governance research findings summary sheets
45. Council comparison document – TW 2000
46. Council Activity Sheet analysis 2000
47. Shared Governance Interviews – Preliminary Findings 2000
48. Shared Governance Survey Report 1&2
49. Shared Governance Evaluation Interim Report – June 2001
50. LEO manual

Appendix 16 - Draft Coding Schemes

CODING SCHEME – January 2001

CATEGORY & LABELS	ASSIGNED CODE	SOURCE RESEARCH QUESTION
SHARED GOVERNANCE SYSTEM	SYST	
MODEL	SYST-MOD	1
CONTEXT	SYST-CON	1
REMIT	SYST-REM	7, 8
COUNCIL RELATIONSHIPS	REL	
INTRA COUNCIL	REL-INTRA	4
INTER COUNCIL	REL-INTER	5
INTRA ORGANISATION	REL-ORG	6
DECISIONS	DEC	
ISSUE IDENTIFICATION	DEC-ID	9
ISSUE SELECTION	DEC-SEL	10, 11
ACTIVITIES	DEC-ACT	12, 13, 15, 16
PROCESS	DEC-PRO	12, 13, 15, 16
STRATEGIES	DEC-STRAT	12, 13, 15, 16
BARRIERS	DEC-BAR	12, 13, 16
AIDS	DEC-AID	12, 13, 15
OTHER INFLUENCES	DEC-O-INF	3, 18
IMPACT	IMP	
SG - EFFECT ON PERSONAL DEVELOPMENT	IMP-SG-PERS	19
SG - EFFECT ON PROFESSIONAL DEVELOPMENT	IMP-SG-PROF	19
SG - EFFECT ON EMPOWERMENT	IMP-SG-EMP	20
SG - EFFECT ON RESPONSIBILITY	IMP-SG-RESP	20
SG - EFFECT ON ACCOUNTABILITY	IMP-SG-ACC	20
SG - EFFECT ON AUTHORITY	IMP-SG-AUT	20
LEO - EFFECT ON PERSONAL DEVELOPMENT	IMP-LEO-PERS	21
LEO - EFFECT ON PROFESSIONAL DEVELOPMENT	IMP-LEO-PROF	21
LEO - EFFECT ON EMPOWERMENT	IMP-LEO-EMP	22
LEO - EFFECT ON RESPONSIBILITY	IMP-LEO-RESP	22
LEO - EFFECT ON ACCOUNTABILITY	IMP-LEO-ACC	22
LEO - EFFECT ON AUTHORITY	IMP-LEO-AUT	22
OTHER - EFFECT ON PERSONAL DEVELOPMENT	IMP-O-PERS	23
OTHER - EFFECT ON PROFESSIONAL DEVELOPMENT	IMP-O-PROF	23
OTHER - EFFECT ON EMPOWERMENT	IMP-O-EMP	23
OTHER - EFFECT ON RESPONSIBILITY	IMP-O-RESP	23
OTHER - EFFECT ON ACCOUNTABILITY	IMP-O-ACC	23
OTHER - EFFECT ON AUTHORITY	IMP-O-AUT	3, 23
CAPABILITY	CAP	
GROUP - KNOWLEDGE	CAP-GR-KNO	14
GROUP - SKILLS	CAP-GR-SKI	24
GROUP - PREPARATION - FORMAL	CAP-GR-FOR	24
GROUP - PREPARATION - INFORMAL	CAP-GR-INF	24
GROUP - DEVELOPMENT NEEDS	CAP-GR-DEV	25
GROUP - OTHER INFLUENCES	CAP-GR-O	23, 24
INDIVIDUAL - KNOWLEDGE	CAP-IND-KNO	14
INDIVIDUAL - SKILLS	CAP-IND-SKI	24
INDIVIDUAL - PREPARATION - FORMAL	CAP-IND-FOR	24
INDIVIDUAL - PREPARATION - INFORMAL	CAP-IND-INF	24
INDIVIDUAL - DEVELOPMENT NEEDS	CAP-IND-DEV	25
INDIVIDUAL - OTHER INFLUENCES		23, 24
UNEXPECTED	UNEX	
MISCELLANEOUS	UNEX-MISC	23

CODING SCHEME – February 2001

CATEGORY & LABELS	ASSIGNED CODE	SOURCE RESEARCH QUESTION
SHARED GOVERNANCE SYSTEM	SYST	
MODEL	SYST-MOD	1
REMIT	SYST-REM	7, 8
COUNCIL RELATIONSHIPS	REL	
INTRA COUNCIL	REL-INTRA	4
INTER COUNCIL	REL-INTER	5
INTRA ORGANISATION	REL-ORG	6
DECISIONS	DEC	
ISSUE IDENTIFICATION	DEC-ID	9
ISSUE SELECTION	DEC-SEL	10, 11
PROCESS	DEC-PRO	12, 13, 15, 16
STRATEGIES	DEC-STRAT	12, 13, 15, 16
BARRIERS	DEC-BAR	12, 13, 16
AIDS	DEC-AID	12, 13, 15
OTHER INFLUENCES	DEC-O-INF	3, 18
IMPACT	IMP	
SG - EFFECT ON PERSONAL DEVELOPMENT	IMP-SG-PERS	19
SG - EFFECT ON EMPOWERMENT	IMP-SG-EMP	20
SG - EFFECT ON RESPONSIBILITY	IMP-SG-RESP	20
SG - EFFECT ON ACCOUNTABILITY	IMP-SG-ACC	20
SG - EFFECT ON AUTHORITY	IMP-SG-AUT	20
LEO - EFFECT ON PERSONAL DEVELOPMENT	IMP-LEO-PERS	21
LEO - EFFECT ON EMPOWERMENT	IMP-LEO-EMP	22
LEO - EFFECT ON RESPONSIBILITY	IMP-LEO-RESP	22
LEO - EFFECT ON ACCOUNTABILITY	IMP-LEO-ACC	22
LEO - EFFECT ON AUTHORITY	IMP-LEO-AUT	22
OTHER - EFFECT ON PERSONAL DEVELOPMENT	IMP-O-PERS	23
OTHER - EFFECT ON EMPOWERMENT	IMP-O-EMP	23
OTHER - EFFECT ON RESPONSIBILITY	IMP-O-RESP	23
OTHER - EFFECT ON ACCOUNTABILITY	IMP-O-ACC	23
OTHER - EFFECT ON AUTHORITY	IMP-O-AUT	3, 23
CAPABILITY	CAP	
GROUP - KNOWLEDGE	CAP-GR-KNO	14
GROUP - SKILLS	CAP-GR-SKI	24
GROUP - PREPARATION - FORMAL	CAP-GR-FOR	24
GROUP - PREPARATION - INFORMAL	CAP-GR-INF	24
GROUP - DEVELOPMENT NEEDS	CAP-GR-DEV	25
GROUP - OTHER INFLUENCES	CAP-GR-O	23, 24
INDIVIDUAL - KNOWLEDGE	CAP-IND-KNO	14
INDIVIDUAL - SKILLS	CAP-IND-SKI	24
INDIVIDUAL - PREPARATION - FORMAL	CAP-IND-FOR	24
INDIVIDUAL - PREPARATION - INFORMAL	CAP-IND-INF	24
INDIVIDUAL - DEVELOPMENT NEEDS	CAP-IND-DEV	25
INDIVIDUAL - OTHER INFLUENCES	CAP-IND-O	23, 24
UNEXPECTED	UNEX	
MISCELLANEOUS	UNEX-MISC	23

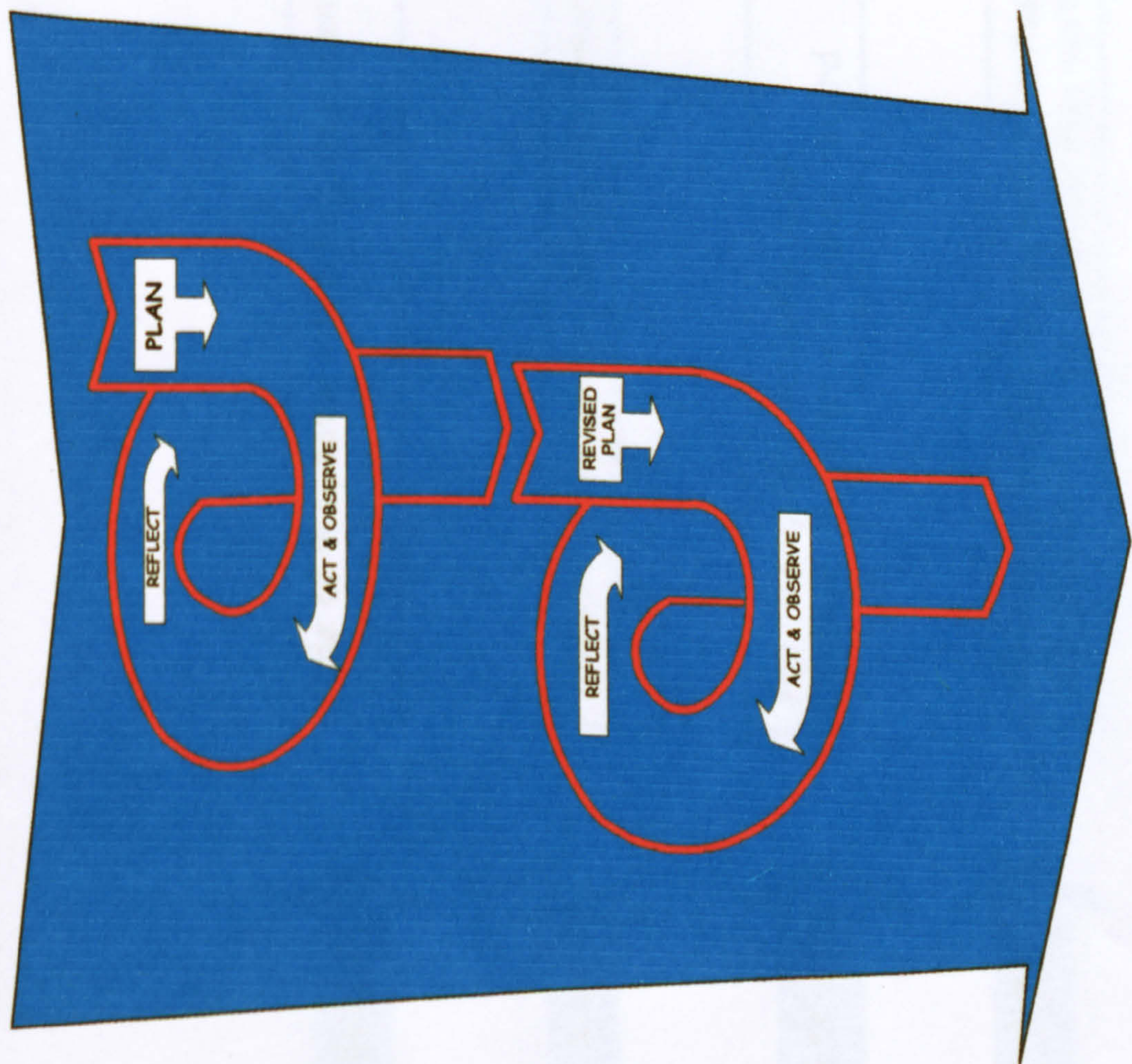
Amendments from January: Merged decision making Acts and Processes, deleted Context, and merged Personal and Professional Development

CODING SCHEME 3 – May 2001

MAJOR CATEGORIES, SUB-CATEGORIES & Labels			ASSIGNED CODE	SOURCE RESEARCH QUESTION
SHARED GOVERNANCE SYSTEM				
MODEL			SYST	
REMIT – Other's View, Own View, How Deliver Remit			SYST-MOD	1, 2
			SYST-REM	7, 8
COUNCIL RELATIONSHIPS				
INTRA COUNCIL – Influential Members, Roles			REL	
INTER COUNCIL			REL-INTRA	4
INTRA ORGANISATION – Common Language, Engagement, Insular, Other Groups			REL-INTER	5
			REL-ORG	6
DECISIONS				
ISSUE IDENTIFICATION – Constituents, Managers, Types			DEC	
ISSUE SELECTION – Clarify problem, Gain Further Info, Fit Remit, Issue Size, Subjective Selection			DEC-ID	9
			DEC-SEL	10, 11
PROCESS – Divide up, Act without Info, Monitor Progress, Time Management/Organisation, Allocate Sufficient Time, Lack of Capability, Gather Info, Pre-circulate			DEC-PRO	12, 13, 15, 16
STRATEGIES – CAT Model, 90 Minute Model, OARRRS Model, Brainstorm, Process Facilitator, Level of Authority, PDF, Consensus			DEC-STRAT	12, 13, 15, 16
BARRIERS – ?Where up to, Unclear Problem, Money, Time/scale, Problem Size, Lack of Management Support, Lack of Info, Other's Input, Level of Authority			DEC-BAR	12, 13, 16
AIDS – Appropriate time, Impact of Decision, Monitoring, Options, Gather Info, Informants/support, Discuss opinions, Clear Purpose, Level of Authority			DEC-AID	12, 13, 15, 17
OTHER INFLUENCES – Venue, Level of Authority, Implications, Personality, EBP, Who Present, Coaching/guidance, SG Research Findings			DEC-O-INF	3, 18
IMPACT				
SG - EFFECT ON PERSONAL DEVELOPMENT			IMP	
			IMP-SG-PERS	19
SG - EFFECT ON PROFESSIONAL DEVELOPMENT			IMP-SG-PROF	19
SG - EFFECT ON EMPOWERMENT			IMP-SG-EMP	20
SG - EFFECT ON RESPONSIBILITY			IMP-SG-RESP	20
SG - EFFECT ON ACCOUNTABILITY			IMP-SG-ACC	20
SG - EFFECT ON AUTHORITY			IMP-SG-AUT	20
LEO - EFFECT ON PERSONAL DEVELOPMENT			IMP-LEO-PERS	21
LEO - EFFECT ON EMPOWERMENT			IMP-LEO-EMP	22
LEO - EFFECT ON RESPONSIBILITY			IMP-LEO-RESP	22
LEO - EFFECT ON ACCOUNTABILITY			IMP-LEO-ACC	22
LEO - EFFECT ON AUTHORITY			IMP-LEO-AUT	22
OTHER - EFFECT ON PERSONAL DEVELOPMENT			IMP-O-PERS	23
OTHER - EFFECT ON EMPOWERMENT			IMP-O-EMP	23
OTHER - EFFECT ON RESPONSIBILITY			IMP-O-RESP	23
OTHER - EFFECT ON ACCOUNTABILITY			IMP-O-ACC	23
OTHER - EFFECT ON AUTHORITY			IMP-O-AUT	3, 23
CAPABILITY				
GROUP - KNOWLEDGE			CAP	
			CAP-GR-KNO	14
GROUP - SKILLS			CAP-GR-SKI	24
GROUP - PREPARATION - FORMAL			CAP-GR-FOR	24
GROUP - PREPARATION - INFORMAL			CAP-GR-INF	24
GROUP - DEVELOPMENT NEEDS			CAP-GR-DEV	25
GROUP - OTHER INFLUENCES			CAP-GR-O	23, 24
INDIVIDUAL - KNOWLEDGE			CAP-IND-KNO	14
INDIVIDUAL - SKILLS			CAP-IND-SKI	24
INDIVIDUAL - PREPARATION - FORMAL			CAP-IND-FOR	24
INDIVIDUAL - PREPARATION - INFORMAL			CAP-IND-INF	24
INDIVIDUAL - DEVELOPMENT NEEDS			CAP-IND-DEV	25
INDIVIDUAL - OTHER INFLUENCES			CAP-IND-O	23, 24
UNEXPECTED				
MISCELLANEOUS			UNEX	
			UNEX-MISC	23

Appendix 17 - Action Research Cycles

Action Research Spiral



PROBLEM

Role of facilitator - directing, dependency. Shown by -
language, behaviour

PLAN

Absence of facilitator, change facilitator

ACT/OBSERVE

Act - manipulate/naturally occur
Observe - difference it makes, record

REFLECT

Difference made? Improvement? Further refinement?
Repeat with other facilitators? Plan next cycle



Poor communication from Policy Council - vague instructions,
lack of feedback
Shown by - confusion, frustration, low productivity



Discuss with participants - identify possible solution



Act - request written instructions, minutes
Observe - difference it makes, record



Difference made? Improvement? Further refinement? Repeat
with other councils? Plan next cycle

Appendix 18 - OARRRs Model

OARRRs Model:

Process Facilitator – role to help organise the meeting

At each Council meeting a Process Facilitator is allocated to:

- ❖ sit back and let Chair do the chairing
- ❖ ensure following of the OARRR's model
- ❖ calculate time needed & ensure stick to time/prevent getting bogged down
- ❖ ensure the meeting process is clear and defined
- ❖ preferably not leading big items themselves but can contribute
- ❖ complete OARRRS proforma and record outcomes and any action plans *ie who is doing what and by when*

OARRRS model for managing meetings - this framework is used to help the flow of meetings either on a specially produced proforma, on a flip chart or simply organising the meeting around its principles:

- O = Outcome
- A = Agenda
- R = Rules
- R = Roles
- R = Results

OUTCOMES

- Announcements, Receive reports, Discussion, Recommendations, Consultation (Provide/Receive), Decision

AGENDA

- Define agenda issues
- Identify desired outcomes
- Assign lead person
- Allocate time

RULES

What are the underlying values and behaviour norms for conducting this meeting?

ROLES

- Timekeeper
- Recorder
- Chair
- Processor (Internal/External)
- Consultant

RESULTS

How well did you do?; Did you meet your outcomes?; Did you complete the agenda?; Did you honour the rules?; Were roles effective?

Appendix 19 - Council Activity Sheets

COUNCIL ACTIVITY RECORD SHEET

Council:

Name:

Week Ending:

Activity	Date	Time spent	Work completed WT or PT	Specific Details	Comments
Total Time Spent =					

ACTIVITY KEY - (Completion guide overleaf)

OM - Other Meeting AD = Paper work and administrative duties including word-processing, devising newsletters or posters, distributing information, completing activity sheets, writing letters etc
CS - Council Surgery
DN - Dissemination/Networking
LW - Library Work
AD – Administration

Completion Guide

1. When stating your name, please specify if you are also Council Chair or Vice-Chair.
2. Complete one form per week and hand in each month's forms at each Council meeting. If you are unable to attend the Council meeting, please send your forms to the Council secretary.
3. Indicate each activity you undertake using the key provided. If you are uncertain about which category to use, choose the most appropriate one and clarify the activity in the Details/Comments sections.
4. Specify whether the activity was done during *work time (WT)* or in your *personal time (PT)*. If done partly in work and personal time eg; the activity continues after the end of a shift, simply make this clear in the Comments section.
5. The Specific Details column is to allow you to give additional information. (*see example*)
6. Remember to add up your weekly total of time spent on Council activities.

Activity Key

CM = Any Council Meeting including the Policy Council meetings.
OM = Any other formal meeting eg; Directorate Meeting, Department Meeting, Trust Board Meeting.
CS = Time spent on liaising with staff regarding possible items for the Council's agenda.

Appendix 20 - OARRRs Pro-Forma

OARRRs Proforma

Council: Human Resources

Date:

Process Facilitator:

ITEM	LEAD	TIME NEEDED	DESIRED OUTCOME <i>eg info, decision, discussion</i>	ACHIEVED OUTCOME & ACTION
		Total needed:		

OARRRS:

O = Outcomes	What is desired for each item. (eg <i>a decision, for information, discussion</i>)
A = Agenda	Clearly defined agenda items, identify leads
R = Roles	Clear roles for Chair, leads, group members, Process Facilitator
R = Rules	Stick to any that have been agreed
R = Results	Evaluate meeting at the end – way forward - action

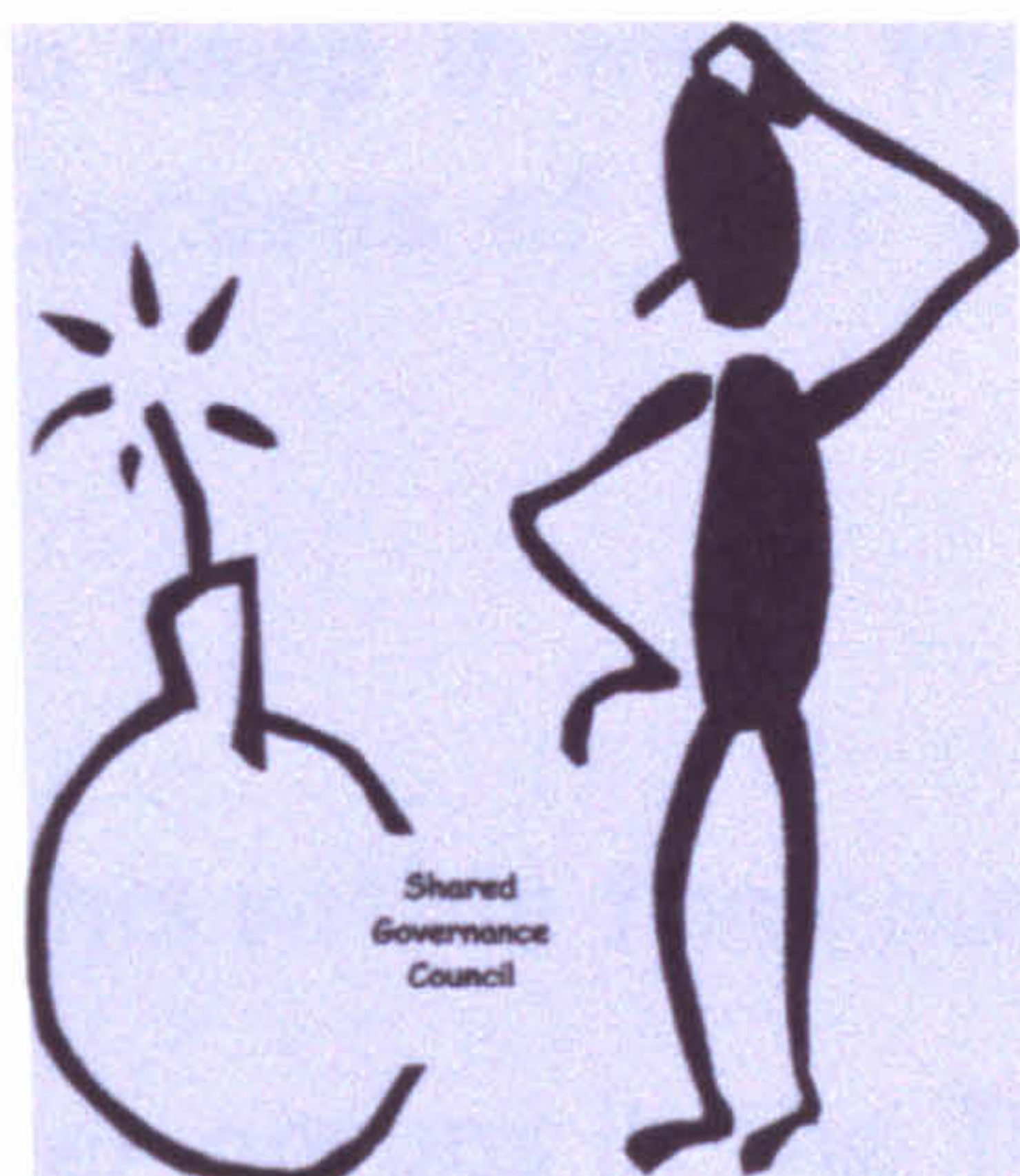
Process Facilitator role:

- ❖ sit back and let Chair do the chairing
- ❖ ensure following of the OARRR's model
- ❖ calculate time needed & ensure stick to time/prevent getting bogged down
- ❖ ensure the meeting process is clear and defined
- ❖ preferably not leading big items themselves but can contribute
- ❖ complete proforma and record outcomes and any action plans *ie who is doing what and by when*

Human Resources Council Ground Rules:

- ❖ Equal time
- ❖ Open minded – awareness of others
- ❖ Non-threatening – listen to what others say
- ❖ Supportive – respect – honesty
- ❖ No non-urgent calls
- ❖ No separate meetings within the council
- ❖ Responsibility

Appendix 21 - Good Practice Guide



"How to run rings around your Council"



Shared Governance Councils - Good Practice Guide

*Drawn from the Shared Governance
Evaluation Research findings 1999-2000
by Tracey Williamson
(Research Fellow - Rochdale Healthcare NHS Trust)*

Here are six themes to keep in mind that will help you make an even greater success of your council!

Communication:

- Plan how you will do this within the council, between councils and with other groups in the Trust
- Use a range of methods to communicate to constituents - newsletters, info sheets, e-mail notice board, intranet, road shows, team meetings, info sheet, newsletter etc
- However, remember you can only take a horse to water.....
- Try to let people know what you are addressing, where up to, who initially raised the issue & who is leading it on the council + contact details
- Helpful to have identified person/s to co-ordinate publicity
- Have a clear process for attracting suggestions/issues to address - perhaps give examples
- If you can't attend a meeting, forward info or update another member

Roles/responsibilities:

- At all times have both a Chair and a Vice Chair – even if only temporary
- Having an identified lead for all items helps them to keep moving forward and shares work load
- The lead can be anyone regardless of who brought the issue
- Leads can support Chairs by making sure background work is done for their item, with the help of others as needed
- Use a process facilitator to ensure times are set for items, keeping to time, maintain ground rules, ensure leads are identified, expected and actual outcomes are recorded
- Process facilitators should ideally not be leading an item so that they can concentrate on the job in hand
- Be clear about council role ie to ratify other's work, to do work, to do work with input from constituents, to facilitate constituents to do the work with council support
- All have a responsibility to attend or supply info so that an item doesn't grind to a halt in your absence
- Do your homework - eg if given a draft document, do take time to read it and bring your comments to the meeting or forward them in your absence
- If attendance (or motivation!) looks like becoming a problem – tell someone!

Remit/output:

- Councils not helped by unclear relationships with other groups – if unclear.....work it out
- Be clear about own council's purpose and remit – what are you there to do and what is not for you to do?
- Co-opt members or invite speakers to inform discussions
- Involve people whose work is impacted upon by the council
- Early consultation and involvement may prevent duplication of effort

Organisation:

- Having a Chair & a Vice Chair – who preferably want the job!
- Negotiate dedicated time for council meetings and associated activities
- If council work impacts negatively on your own time – tell someone!
- Use the OARRRS model as a framework to keep meetings focused
- Have a clear understanding of the issue/problem before you accept it
- Establish the councils level of authority at the outset

- If unsure whether an issue is fitting for the council – ask for advice!
- If necessary do some limited fact-finding in order to decide but without getting carried away
- If an issues isn't for the council, feed back to the constituent promptly with an explanation and suggested place for them to take it – a one-to-one, sensitive approach works best
- Have clear outcomes and note them down – who is doing what exactly and by when?
- Do as much preparation as possible before meetings rather than during them eg pre-circulate documents

Preparation/orientation:

- Where possible plan ahead for changes in membership
- Prepare new members well before they join the council
- Consider an orientation pack for new members that could also be used to recruit
- If stepping down, give as much notice as possible
- If possible, ensure new members shadow you for 2-3 meetings before you leave
- Ideally all new members should be LEO'd beforehand

- If you leave, make sure any issues you are leading on are handed over properly

Membership:

- Ensure all relevant professions are represented
- Some small sections of staff may not have a seat. As their representatives, ensure they are communicated with regularly
- Try not to focus agendas on certain profession's interests and be aware some issues may be difficult for some members to contribute to
- Invite or co-opt relevant people - their knowledge and expertise will help you make progress

Chair's Tips:

Good Chairing involves the following, although you may have a Process Facilitator to help you:

- To ensure agenda set - preferably circulated prior to meeting
- To ensure documents for reading are pre-circulated to save time reading
- To ensure minutes are taken by a group member/admin support
- To check minutes for accuracy prior to prompt distribution
- To take apologies - monitor attendance
- To identify how much AOB there is to fit at end of meeting and plan time
- To take members through previous minutes page by page for errors, updates on items previously discussed (unless are an agenda item later)
- To take the meeting through the agenda in order or in a flexible manner to accommodate invited speakers, late-comers etc
- To ensure quieter members get their say/control dominant group members

- To control the meeting ensuring it stays on track and doesn't become a general chat and sticks to time
- To set ground rules if desired eg minimal interruptions, no non-urgent bleep-answering etc
- To ensure leads are allocated for items - Chair not to get overloaded by leading many items themselves
- To ensure desired outcomes and then the achieved outcomes are made clear for each item
- To ensure members are clear about what they are doing by when ie set date for comments, responses etc making sure work is shared appropriately
- To ensure leads/members forward papers/verbal updates/info needed at the meeting if unable to attend
- To ensure invited speakers are definitely attending and are able to find the meeting and are introduced
- Identify items to go on following agenda
- Oversee that items don't get forgotten about over time
- To ensure a date for next meeting is set and to arrange a venue (& preferably biscuits!)

TKW April 2001

Appendix 22 - Time-Ordered Meta-Matrix Diagram & Narrative

Issue Presented	Clear Issue	Fit Remit	Background Info	Clear Aim	Lead Person	Level of Authority	Engage Informant	Consultation	Decision Model
HR 1	* YES	* YES	*YES	*YES	**YES		***YES	*YES	
HR 2	**YES	*YES	*YES				***YES	*YES	
HR 3	*YES	*YES			*YES		**YES		
HR 4	*YES	*YES	*YES	*YES	*YES		** YES	***YES	
HR 5	*YES	*YES	*YES	*YES					
MH 1	*YES	*YES	*YES	*YES	*YES		**YES	**YES	
MH 2	*YES	*YES	*YES	*YES	*YES	**YES		*YES	*YES
MH 3	*YES	*YES	*YES	*YES	*YES	**YES			
MH 4	* YES	*YES			*YES				**YES
MH 5	* YES	*YES	*YES		**YES			*YES	
MH 6	*YES	*YES		*YES	*YES				
MH 7		***YES	**YES		**YES				**YES

Time Ordered Meta-Matrix Diagram (HR & MH Council Issues)

KEY – Timing of key events in process of addressing council issues
 * = early stage, ** = intermediate stage, *** = late stage

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Narrative – Time Ordered Meta-Matrix – revised October 2001

In the HR Council, all but one issue (HR2) began with a clear issue being presented to the council to address. This latter issue was clarified in the intermediate stage of its lifetime on the council agenda and the issue was finally resolved. Most MH Council issues were clear at the outset but not all (MH7). This latter case was never clarified and the issue never satisfactorily resolved during its lengthy duration. Both councils established that issues fitted their remit within the early stage except for MH7. Lack of a clear issue meant that it was not possible to ascertain the fit of MH7 until the late stage. However having a clear issue presented did not necessarily lead to a clear aim being agreed. Two of the clear HR issues did not develop a clear aim and three MH issues did not develop a clear aim despite three of these having started with a clear issue. All of the HR and MH issues that had a clear aim had this determined during the early stage.

Another means of clarifying what to aim for with an issue was to ask for a level of authority. For only two issues was a level of authority sought (MH2 & MH3). Thus lack of a clear aim resulted in a tendency to 'work it out as they went along' rather than having a clear objective against which to plan action. A further means of keeping a degree of focus on issues was the allocation of a lead person for each item. This was done in three HR cases, two in the early stage and one in the intermediate stage (only by a month). All MH issues were allocated a lead person in the early stage apart from two that were allocated in the intermediate stage. Early allocation of leads appeared to help keep issues moving although issues around attendance and change over of leads are highlighted in the Causal Network narratives. A further aid to clarifying the issue was to seek background information that was done in the majority of cases for both councils and also in the early stage (except MH7). As MH7 never had a clear issue or aim this seemed to cause a delay in seeking background information as it correspondingly wasn't clear what information was needed. Another source of additional information was by way of staff consultation. This was done for three issues per council at varying stages and usually to seek views on drafts or views in general. For HR3 a specialist informant rather than seeking other background information was seen as most appropriate. For MH4 it was considered sufficient to pool knowledge by way of a subgroup whilst for MH6 background info was not required. Engagement of specialist informants was done by the HR Council for four of its five issues (2 intermediate and 2

late stage). Rather than engaging them early to inform the issue they tended to be engaged late when the council was experiencing difficulties progressing. The HR issue without an informant did not require one as the necessary skills were around the table (Council Orientation Pack). The MH Council utilised a specialist informant once, as they tended to believe they had the requisite knowledge around the table being a directorate based council. The HR Council never used decision-making models although they were used for three MH Council issues. The prompt for these appeared to be when trying to make large complex issues more manageable by simplifying them into smaller parts for easier analysis. The MH Council used a model from the LEO course (90 minute model) and one that a council member had knowledge of from a different leadership course (CATS). The models were used in the early and intermediate stages when the magnitude of the issue became apparent. Although the HR Council had similarly undertaken the LEO its decision making content was not drawn on in this way.

Of the issues that progressed and/or concluded satisfactorily most had certain factors in common. Namely clear and remit-fitting issues with an early clear aim showed a pattern of progressing well. Progress was also impacted upon by the input of a lead person, which was variable dependent on the person and their attendance, and engagement of an informant, which was always positive. The presence of a lead therefore did not ensure satisfactory progress, because of their variable skills and abilities as a lead.

The absence of a clear aim was key in resulting in a poorly progressed issue regardless of other aids such as a lead. Conversely, just because there was a clear aim did not mean that good progress was necessarily made. It was necessary to have a clear issue initially in order to be able to identify a clear aim, although a clear aim did not always result. Mostly, clear aims were driven by leads but not always. The issues that had a clear aim but no lead floundered (HR5) as no-one was keeping its momentum going. Yet three issues with leads failed to have their aims clarified by them or any other council member. It would appear that the leads were most effective when carrying forth an issue that has been appraised and had an aim set by the group beforehand.

The presence of an informant was always positive yet issues progressed on occasion without them. This seemed to be because there was sufficient expertise within the council without involving outsiders.

Ultimately what is emerging is a sense that issues fare better with an clear issue initially that fits the council remit, followed by earlier agreement on an aim and allocation of a lead and early engagement of an informant where council member's knowledge is insufficient. Additionally background information and a level of authority can add to the clarity of the issue when sought. Whilst there are only two examples of level of authority being sought, the process is one of negotiating what to do and how far to go with it and so is expected to add clarity. (This is something identified by interviewees as potentially helpful so is not mere assumption). Use of decision-making models did enable some clarity to be reached (MH2) and make complex problems more manageable (MH4) yet didn't always result in improved decision making (MH7) seemingly as their effectiveness was dependent on the familiarity and skills of the users (see Causal Network narratives). MH7 has been an extreme case as not only was there never a clear issue or aim identified but discussion and agreement that it did indeed fit the Council's remit was not made until the late stage

**Appendix 23 - Time-Ordered Matrix Diagrams & Narratives and
Causal Network Diagrams & Narratives**

Time-Ordered Matrices - Diagrams
2 – 5 (HRC)
7 – 12 (MHC)
& Narratives

Causal Networks - Diagrams
2 – 5 (HRC)
7 – 12 (MHC)
& Narratives

EVENT	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	SPECULATIONS
Clarify Issue	NO – from HR Planning Group via PC			Facilitator clarified original issue to for views on childcare									PC trying to ensure they have issues to tackle but not clear to council how they fit with JNCC who are sorting this issue. Supposedly council to seek staff views and ensure are covered at JNCC. Does little to
Fit Remit	YES – but ill fit as being done at JNCC												Apparently fits remit as via PC but not a good fit
Background Info	To get views in own areas												Did ask for views but minimal response and JNCC see that as their role
Consultation	Seek colleagues views												
Clear Aim	NO – ?to see if council has a role in Millennium work												No meaningful objective – just to check out if any role for council. Just resulted in frustration.
Lead Person	NO – fell to Chair												Chair coping for work again
Level of Authority	NO												Would have helped to make clear what authority they have and to do 'what' with it!
Engage Informant				Invite sent to key informant	Informant chose not to attend. To ask another	Second informant chose not to attend but will attend for another item							Understandable reluctance to engage with council due to overlapping group remits. Not helpful to council. Could have come & explained role and forged a relationship. Put a lot of strain on council. Poor behaviour of senior Trust staff.
Decision Model	NO												May have helped with problem id and L of A. clear remit etc
Work Process	To find out local staff issues.	Discussion. To invite Millennium lead if needed in Month 4	Awaiting PC feedback in Month 4	Brainstormed list of questions to ask key informant next time	Discussion re different informant. To ask staff views via newsletter	Not sure how to progress. Facilitator absent. Views were sought but no further role for council							Duplication of effort. Groups unwilling to come and explain remit. Confusion as to where council fits in. PC promoting the consultation as good work but council felt it demoralising and a waste of effort.
Approval Sought													
Completed						Taken off Agenda							

Time-Ordered Matrix Diagram 2 – Human Resources Council Millennium Issue (HR2)

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EVENT	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	SPECULATIONS
Clarify Issue	CLEAR as from council member												Clear as self generated.
Fit Remit	YES												Seems relevant to all members and one that they can contribute well to
Background Info	NO – Council members already knowledge												
Consultation													
Clear Aim	NO ?to see if council has a role												Needed to clarify purpose of their involvement early on
Lead Person	Yes - proposer												Good to have a lead to drive forward
Level of Authority	NO												Needed to establish how far to go with it before setting out
Engage Informant					Key informant agreed to attend later meeting		Not remit of first key informant – suggested a 2 nd	2 nd Key informant attended					Needed informant engaged late in the day. Recurrence of problem of initial informant not engaging with council – not helpful (morale, process)
Decision Model	NO												
Work Process	Discussion of problem and who to invite for more info	Not on agenda	On hold – Busy agenda - other informants meant to be coming for other issues	On hold – Busy agenda - other informants meant to be coming for other issues	To ask HR Dept what role council can play	No meeting – many apologies	Unable to progress. To invite different informant	Invited key informant who will update them if any council involvement needed.					Difficult to see a role for council at present re this issue. Involvement not encouraged eg to promote wider use of PDPs despite PC stressing importance of a Trust approach in view of CG. Council could have been helped to input into PDP issue more than has happened. Good rapport with informant reassuring.
Approval Sought													
Completed								Taken off agenda					

Time-Ordered Matrix Diagram 3 – Human Resources Council Personal Development Plan Issue (HR3)

EVENT	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	SPECULATIONS
Clarify Issue	Clear – From facilitator												Verbal but facilitator able to keep council clear and focussed.
Fit Remit	YES												Potentially good joint work opportunity with HR Dept
Background Info	Given by facilitator												Maintained by presence of informant
Consultation													
Clear Aim	YES – to develop a Recruitment package				Became unclear								
Lead Person	YES – fell to Chair	Lead absent											Lead not good at keeping a clear focus or remembering where up to/organisation skills – not helped.
Level of Authority	NO												No but not detrimental as close working with HR rep. Would have led to L of A being established.
Engage Informant	YES Have appropriate co-opted member now at every meeting	Other informants identified – not invited		Other informants present	Further informant present								Absence of lead at meeting/representative at PC not helpful and slows progress. Presence of informant very helpful but still got confused (lead not very organised/junior). Unfortunate that not resolved during this council's life time.
Decision Model	No												
Work Process	To bring any packs from own areas	Discussion of issue. Looked at existing packs. Deciding who to invite as informants. To get costings	Further discussion of how far to take it. To invite informants	Insights from informants. Discussion of contents Key informant to gain views of new staff	Muddled between induction and recruitment. Decided need more info gathering	Discussion of gathered info. To ask PC for help getting info re each directorate for inclusion – not asked as no HR rep attended	Recap only – to forward any more info for inclusion. At PC directorate managers were asked for bit from their areas	Info looked at again. Set of info collected to go out for comments. No HR rep at PC	No meeting/ Xmas/Many apologies Council ceased to meet from here on				
Approval Sought													
Completed													

Time-Ordered Matrix Diagram 4 – Human Resources Council Recruitment Package Issue (HR4)

EVENT	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	SPECULATIONS
Clarify Issue	CLEAR-SG findings/ Working Party												Clear as from findings and reiterated by WP
Fit Remit	YES												
Background Info	YES – rationale from SG research												Co-ordinating O pack development for all councils. Quick hit – easy to develop.
Consultation			Written to councils										
Clear Aim	YES – to develop pack for new members												
Lead Person	No												No lead not help keep focus and drive it forward.
Level of Authority	No												Not really need approval as for selves so assumed level 4 in effect
Engage Informant	No												No real need. May have needed one at design stage but not get that far.
Decision Model	No												Sufficient to brainstorm contents
Work Process	Discussion of contents. To gather info for inclusion	Brainstorming exact contents to be obtained	Collating info. In liaison with other councils for their bit to include. Copy then to be circulated to them for comments.	Awaiting council's replies. No action	Awaiting council's replies. No action except to write to them again	Awaiting council's replies. No action. To chase up at PC but HR did not attend	Awaiting council's replies. Draft to go to them all for comments anyway.	Proposed contents brought here not circulated. To pull together into a draft and bring next time	No meeting/ Xmas/Many apologies Meetings ceased from here on				Slow progress. Little done away from councils. Having an identified lead would have helped to get things done. Instead dragged and lack of input from other councils hasn't helped. Could have been done and dusted in 3 months. Needed too as new members soon to be joining councils and needed to generate interest and orientate new members with.. Lost a month's progress as rep not at PC
Approval Sought													
Completed													

Time-Ordered Matrix Diagram 5 – Human Resources Council Orientation Pack Issue (HR5)

EVENT	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	SPECULATIONS
Clarify Issue	CLEAR – idea from council												Clear as self generated
Fit Remit	YES												Yes local issue
Background Info	Provided by proposer initially	All to collect further info											As local, problems known to all already
Consultation		Various views sought				Some areas sent a draft for comments	Further consultation				Staff to come on sub group		Easy to consult colleagues in own areas. Large number of council members (13) for size of constituency
Clear Aim	To review case notes system												Great potential as an issue practitioners can inform and develop
Lead Person	YES - Proposer	New lead allocated											Strong lead pushed issue forward and kept focus.
Level of Authority	NO												One of two models used by council. Very helpful at clarifying problem and developing action plan
Engage Informant						Informant to be contacted							
Decision Model		90 Problem Solving Model											
Work Process	Discussion whether to take on./ Agenda next time.	Brainstormed problem via mind map. Divided up collection of background info	Reviewed sets of notes Fed back info gathering Divided up outstanding info gathering to forward so that action plan can be developed by lead	On agenda. Deferred as lead absent	Lead gave 2 options: multi or uni proff notes. Discussed pros and constringing to reach a consensus. Agreed option 2. Split 2 groups to generate contents. To type up and send for comments	Not circulated fully by accident. Costing implications. Decided need a pilot and level of authority from PSMT. Agenda next time. More comments to be sought	Feed back from wider consultation. Lead absent but proposer to organise a pilot in own area	Costings being sought. Pilot being sorted	Training booklet developed & distributed to help staff complete pilot notes	No meeting/ Xmas	Sub group formed to address staff teething problems with training to use pilot notes	Agreed to get views from own areas prior to pilot starting	Discuss whether to take on in first place rather than blind acceptance. Clarify problem early prevents meandering. Absence of lead unhelpful as info not usually forwarded and item deferred. Recognised need for L of A late in the day but at least did so. Pretty much assume Level 4 unless costs involved and only then see it necessary to clarify L of A. Lots of consultation and work away from council helpful.
Approval Sought													
Completed													

Time-Ordered Matrix Diagram 7 – Mental Health Council Case Notes Issue (MH2)

EVENT	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20	Month 21	Month 22	Month 23	Month 24	SPECULATIONS
Clarify Issue													
Fit Remit													
Background Info													
Consultation													
Clear Aim													
Lead Person												Lead left council	
Level of Authority													
Engage Informant													
Decision Model													
Work Process	Not on agenda	Lead fed back. Being piloted.	Not on agenda	Not on agenda	Not on agenda Extra ordinary meeting to re-focus council as confused where up to	Not on agenda Extra ordinary meeting to re-focus council as confused where up to New Chair today as old Chair leaves council	Not on agenda Extra ordinary meeting to re-focus council as confused where up to	Update from lead. Still being piloted	Update from original proposer doing the pilot (no longer a council member) Pilot finished. Will get feedback on pilot and attend council in six months time to feed back	No meeting/ Xmas	Not on agenda	Lead to assist proposer with audit being done. No further feedback over next 3 months then: END OF FIELD WORK	Like V&A policy went into the background as council tried to re-establish where it was up to with numerous big issues and mostly new membership. Hard to keep updated once lead left council.
Approval Sought													
Completed													

Time-Ordered Matrix Diagram 7 – Mental Health Council Case Notes Issue (MH2) (continued)

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EVENT	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	SPECULATIONS
Clarify Issue	CLEAR – idea from council												Clear as self generated
Fit Remit	YES												
Background Info	By proposer initially												
Consultation													
Clear Aim	YES – to develop bank training												All aware of the issues from own practice. Relevant and worthwhile issue
Lead Person	YES - proposer												Clear lead helped drive it
Level of Authority				Yes	Clear objective agreed with PSMT								Not established until later when realised needed approval for the cost implications
Engage Informant													
Decision Model	90 decision model done pre council												Idea from and analysed on LEO course. Council able to adopt the workings done there as use model themselves – common language
Work Process	Issue arose with colleagues on a course. Agreed to take on as a council issue. Agenda next time	Deferred to next meeting – big agenda today	Lead presented problem on flip chart and recommendations made on original course. ie need training course for bank nurses Sub group to meet, and identify level of authority	Not on agenda	Not on agenda as being presented to PSMT this month. Business case to be drawn up	Not on agenda	Training being implemented					Lead fed back on Month 13 around evaluation of training done to-date	Good as giving it adequate time. Also a sign that they have a lot on. As usual, big problems get a sub group set up. Seem to have time and approval to have these in this directorate. Use of model meant clear task at the outset. Clear objective from PSMT helpful and their commitment to the issue got it approved and implemented. Knock on implications for rest of Trust – reluctant to go to other councils but waited until they came here. Did help them look at bank training trust wide but keeping very much to themselves risked duplication.
Approval Sought					Presented to PSMT								
Completed						Accepted							

Time-Ordered Matrix Diagram 8 – Mental Health Council Bank Nurse Training Issue (MH3)

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EVENT	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	SPECULATIONS
Clarify Issue	CLEAR – from council member									Re-clarified what council aim was			Clear as self generated
Fit Remit	YES												Local & relevant
Background Info													All quite knowledgeable on the issue. May have helped to get wider Trust info earlier
Consultation					Various staff on sub group								
Clear Aim	No – to look at user involvement generally												Very broad aim. Not got a specific thread to work on
Lead Person	YES - Proposer												Has a clear lead but unclear focus to drive forward
Level of Authority	NO												Asking re L of A may have pre-empted a clear focus
Engage Informant	To ask key person and other trusts	To ask another informant											
Decision Model	NO										Using 90 minute model		Major problem. Set out with no clear problem or objective. Potentially never ending. Model could have prevented that
Work Process	Proposer outlined issue. To fact find. Member to draft a strategy on user involvement	Info shared. Brainstormed issues. Strategy to be drafted for next meeting. Other informant to be contacted	Unable to get feedback on strategy as member absent. Deferred next month	To set up a sub group to look at it further	Sub group have met to collate info and decide options – to be discussed at next council meeting. Member with info not present	Summary given of sub group work on identifying means of user involvement. Sub group to carry on	Update from sub group. List to be sent out of all user involvement in directorate. Council to send blank suggestion forms to key forums. 3/12 target set	No meeting/ Xmas	Sub group not met for 2/12. Feedback next time. Identified another possible informant	Sub group feedback. Objective group had to fact find met. Now asking what council objective was. Agree want to look at user involvement on council only, as massive topic. Agenda next time	Split into 2 to analyse problem. Developed action plan to target users. Realised strategy was never done (member had left council) To invite users to an open day. Vise to keep users in mind for all items	Not on agenda	Set out to develop a strategy which wasn't the problem. Not done as member left anyway. Not taken over (as was not the council objective anyway). Held up when lead/members with info absent – not forwarded info. Big and muddled so threw time at it – sub group set up. Useful if a big task but not a big muddled one! Aim not clarified until month 10. Then used model to analyse problem but developed action plan when problem still unclear.
Approval Sought													
Completed													

Time-Ordered Matrix Diagram 9 – Mental Health Council User Involvement Issue (MH4)

EVENT	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20	Month 21	Month 22	Month 23	Month 24	SPECULATIONS
Clarify Issue													
Fit Remit													
Background Info													
Consultation													
Clear Aim													
Lead Person			Left council								New lead agreed		Lead left without clear hand over – not helpful.
Level of Authority													
Engage Informant													
Decision Model													
Work Process	Not on agenda	Not on agenda	Not on agenda Extra ordinary meeting to re-focus council as confused where up to	Not on agenda Extra ordinary meeting to re-focus council as confused where up to New Chair today as old Chair leaves council	Not on agenda Extra ordinary meeting to re-focus council as confused where up to	Council re-focussed Remaining lead leaving – will hand over to new member. Awaiting suggestion forms to be revamped & sent to users	Not on agenda	No meeting/ Xmas	Not on agenda	Not on agenda Member noticed no clear outcome achieved yet – agenda next time	User conference being planned by directorate. To work on this with council. Questionnaire being designed that will come via council.	Conference plans discussed. Members to see draft questionnaire. Council to continue working on this issue. END OF FIELD WORK	Got waylaid with other big issues and lead left so remained unclear. Not kept tabs on or new leads allocated so problem worsened. Issue re-addressed by default when noticed going nowhere instead of reallocating a new lead as the old lead leaves. At end are achieving a positive outcome ie a conference but not directly related to original objective as unclear at start what doing.
Approval Sought													
Completed													

Time-Ordered Matrix Diagram 9 – Mental Health Council User Involvement Issue (MH4) (continued)

EVENT	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	SPECULATIONS
Clarify Issue	CLEAR – from staff member												Clear as recommendations from a MH Commission report
Fit Remit	YES – not decided to accept yet												Not accepted just because is relevant to their remit – checking it out first
Background Info	To gather info from own areas												
Consultation		Comments on map to be sought from staff				Survey to elicit views of staff & patients							Wide and easier to manage consultation again
Clear Aim	NO												Ran way with it at first but then recognised need clear problem
Lead Person					Joint leads appointed						One lead has left		Needed earlier but hand in hand with no clear problem, L of A or model used
Level of Authority	NO												Would have led to problem clarification
Engage Informant													May have been helpful
Decision Model	NO												Would have led to L of A and clear problem. Slow progress as a result
Work Process	Suggestion discussed. To see what done in own areas prior to accepting as a council issue	Not on agenda	Brainstorming and mind mapped how to improve face to face contact with patients To send out map for comments and additions	No meeting/ Xmas	Recognised solving issue before have a clear problem. Started again – defined problem, agreed leads. To plan audit of current practice.	Leads chose to develop and do staff & patient survey since last meeting. To be analysed and fed back 2/12	Not on agenda	On agenda. Deferred – leads absent	Recapped issue and decided to set up sub group to take further	Survey inconclusive to refine and re-do	Not on agenda Extra ordinary meeting to re-focus council as confused where up to	Not on agenda Extra ordinary meeting to re-focus council as confused where up to New Chair today as old Chair leaves council	Lost several months as muddled. Less progress when leads absent – not forwarded info. Muddled and big so... throw more time at it – sub group set up! Not engage informant or help re survey and unsurprisingly findings inconclusive – more lost time.
Approval Sought													
Completed													

Time-Ordered Matrix Diagram 10 – Mental Health Council Face-to-face Patient Contact Issue (MH5)

EVENT	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20	Month 21	Month 22	Month 23	Month 24	SPECULATIONS
Clarify Issue													
Fit Remit													
Background Info													
Consultation													
Clear Aim													
Lead Person		No lead					New lead allocated						
Level of Authority													
Engage Informant													
Decision Model													
Work Process	Not on agenda Extra ordinary meeting to re-focus council as confused where up to	Council re-focussed Not know where up to on this Second lead has left the council. To write to one of them for an update.	Ex-lead /member attended meeting to update. No replies to survey received. To forward analysis previously done, ask views in own areas and look at next month	No meeting/ Xmas	Not on agenda	Member noticed unfinished. Agreed need to re-do questionnaire. No one taking forward	To bring some relevant audit info to next meeting. Ex-lead to be contacted for an update on work being done outside of the council.	On agenda – new lead absent. Defer to next month	To invite ex-lead/member to council for an update. To see whether they are to continue or council to take forward. END OF FIELD WORK				Leads leave and not handed over so more muddle. Noticed by accident after some time so a while had passed before new lead allocated. New lead driving it. No progress though when absent and not forwarded info. More difficulty keeping tabs on work being done away from council. Issue of whose is it when lead has left – theirs or the council's. Ensuring council is updated is proving a problem.
Approval Sought													
Completed													

Time-Ordered Matrix Diagram 10 – Mental Health Council Face-to-face Patient Contact Issue (MH5) (continued)

EVENT	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	SPECULATIONS
Clarify Issue	CLEAR- from council												Clear as self generated
Fit Remit	YES												Yes human resource issue in MH
Background Info													Liaison with HR Dept in view of staff survey may have helped
Consultation													
Clear Aim	YES - to survey staff motivation								NO - unclear now				Clear what wanted to do but not what will do with findings
Lead Person	YES - proposer										Lead left council	New lead	Clear lead driving it
Level of Authority	NO												No - needed to establish what to do with results
Engage Informant	NO												Survey advice would have been very helpful. Only asked for help with analysis
Decision Model	NO												Would have helped to clarify an objective and how far to take it
Work Process	Proposer outlined small survey done and suggested wider one done in directorate. Agreed. Members to distribute questionnaire in own areas by next month	No meeting/ Xmas	Good survey response. Forwarded for analysis by Research Assistant	Findings presented & discussed. Members to communicate findings in own areas & feed back next month. Copy to go to unit manager	Not on agenda	Members fed back staff comments. Unsure what to do next. Agreed to write to Heads of Departments to ask then to write local objectives as a result of the findings	Not on agenda	Not on agenda	Not on agenda Extra ordinary meeting to re-focus council as confused where up to	Not on agenda Extra ordinary meeting to re-focus council as confused where up to New Chair today as old Chair leaves council	Not on agenda Extra ordinary meeting to re-focus council as confused where up to	Council re-focussed Think managers had wanted survey to be repeated in 12/12. New lead to liaise with ex-lead/member re doing an audit of motivation	Findings interesting but of what use? Needed L of A to ensure action on findings. Poorly written letter asking managers to write local objectives not too effective. Council needed to make recommendations and follow through. Further compounded by lead leaving and no proper hand over although new lead allocated promptly.
Approval Sought				Manager informed of findings									
Completed													

Time-Ordered Matrix Diagram 11 – Mental Health Council Staff Motivation Issue (MH6)

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EVENT	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20	Month 21	Month 22	Month 23	Month 24	SPECULATIONS
Clarify Issue													
Fit Remit													
Background Info													
Consultation													
Clear Aim							YES						New lead able to get back on track (senior and experienced)
Lead Person					New lead								
Level of Authority							To be requested						
Engage Informant													
Decision Model													
Work Process	Not on agenda	No meeting/ Xmas	Not on agenda	Member noticed no clear outcome – needs to be on agenda	Not on agenda but new lead agreed to take forward.	Original questionnaire passed round. Approved it & to do survey next month. Not know who to send to so to liaise with new lead (absent)	Lead presented plans for survey. Design discussed. To go out next week and action plan from findings END OF FIELD WORK						Not progressing despite new lead. Again accidentally noticed it had been forgotten about. Further new lead able to get it moving. Not progress when absent though. Wastes room on agenda when no-one able to discuss item. Much of that due to their seniority and council experience. 'Taking over' from Chair in many ways yet things moving generally because of it.
Approval Sought													
Completed													

Time-Ordered Matrix Diagram 11 – Mental Health Council Staff Motivation Issue (MH6) (continued)

EVENT	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	SPECULATIONS
Clarify Issue	Unclear. Clarity not sought												Clarity of issue not sought
Fit Remit							Not sure. May be for Trust wide councils						Not established early on. Would fit Trust councils well. Not consulted.
Background Info Consultation							Members fact finding						Not sought
Clear Aim							BROAD – to improve ethnic minority services						No – muddled from outset
Lead Person						Lead identified	Different lead for today		New temporary lead allocated		Lead left		Lead late in the day hence muddled for so long initially
Level of Authority	NO												Would have helped clarify objective
Engage Informant	NO												Would probably have been useful
Decision Model							90 minute model						Would have been useful earlier to establish problem and aim etc
Work Process	Suggestion from staff member. Agreed to consider next meeting using the CATS decision making model	Not on agenda	No meeting/ Xmas	On agenda but not addressed as to reschedule with a lead person identified	Not on agenda	Not enough time to do CATS model. Defer a month	Big issue – using model to try & define problem – still unclear. To consider options once have further info. Divided up fact finding tasks.	Not on agenda	Fed back gathered info. Not sure if more info needed. No volunteer for lead. To address at an away day next month as stuck. Temporary lead agreed.	Not on agenda Extra ordinary meeting to re-focus council as confused where up to	Not on agenda Extra ordinary meeting to re-focus council as confused where up to New Chair today as old Chair leaves council	Not on agenda Extra ordinary meeting to re-focus council as confused where up to	Muddled from outset and clarification not sought. No lead for some time to clarify it and drive it. Many new members struggling to use unfamiliar model. Process of using it not helped on this occasion as jumping about and not following it properly. As not know what doing still, searching for more info not that helpful.
Approval Sought													
Completed													

Time-Ordered Matrix Diagram 12 – Mental Health Council Ethnic Minorities Services Issue (MH7)

EVEN	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20	Month 21	Month 22	Month 23	Month 24	SPECULATIONS
Clarify Issue		Invited proposer.											Thankfully invited proposer to clarify the
Fit Remit				YES									
Background Info		YES - from proposer		More fact finding									Even more info sought
Consultation													
Clear Aim		Remains unclear											
Lead Person				No longer has a lead. New one agreed. Level 2									
Level of Authority													Not negotiated – gave themselves level 2. Missed opportunity to ask PSMT about what doing
Engage Informant													
Decision Model				90 minute model									Again not used that well. Present members not that used to it. Only one original member remains.
Work Process	Council re-focussed Mostly new members don't know where issue up to. Going to invite the proposer to a meeting to explain.	Proposer present & explained suggestion. Discussed issue and to meet again to identify what part of it council can address.	No meeting/ Xmas	No lead – proposer explained that council had wanted more info. Agreed to use a dm model on it. Raised issue of authority - decided had level 2. Muddled analysis/ no clear problem. Accepted it as within remit. To gather more info & sub group to meet.	Not on agenda	On agenda – lead absent. To be contacted for an update of the fact finding. To put on agenda in 2/12	Not on agenda	On agenda – lead absent. Defer to next month					Not helpful when lead absent as wasted spot on agenda and can't progress. Big and muddled so to have a sub group!
Approval Sought Completed													

Time-Ordered Matrix Diagram 12 – Mental Health Council Ethnic Minorities Services Issue (MH7) (continued)

Data Analysis - HR Council Narratives

Below are narratives pertaining to the Time Ordered Displays for the Human Resource Council. The purpose of the narratives is to draw together the tables' contents and begin to make sense of them thus producing a plausible account of what happened (Miles & Huberman 1994:112).

TIME ORDERED DISPLAYS

Diagram 2 – Millennium Issue

This was an unclear issue indicative of attempts to try and identify a remit for the newly established HRC. Pretty much doomed from the start as not made clear what the council's role was in relation to the group formally charged with addressing the Trust's Millennium needs. Vaguely the HRC were to ensure staff views or concerns were being addressed. No level of authority was negotiated which would have made clear what, if any authority the council had to act on this issue. Whilst council members consulted staff, each item they raised was already being addressed by the Millennium group and so couldn't contribute further. This duplication caused the council more frustration at their lack of meaningful work although the Policy Council reassured them that ensuring the staff were fully consulted was valuable. This didn't sit well with members as they knew the role of the JNCC (Joint Negotiating Consultative Committee) was to consult staff views on such things and felt they were 'stepping on toes'. Not surprisingly, 'politics' prevented members of these other groups coming and explaining their work or to look for shared responsibility with the council leading to further frustration of council members. Again the members of these groups were often senior Trust personnel and managers able to disrupt council activity through non-involvement and withholding of information. Whilst the Facilitator was again able to give guidance about such things as which informants to invite, little was done to help the council deal with the difficulties with relations with other groups.

Diagram 3 – Personal Development Plans (PDP) Issue

Initial suggestion clear as from a council member, clearly fits council remit and an issue

that all council members have had some experience of. Actual aim vague as to see if council has a role with PDPs in the Trust. Again set out on issue without knowing what outcome they were aiming for whereas negotiation of a level of authority may have raised this as a problem earlier. Also the eventual required informant sits on the Policy Council so would have been privy to the discussion on where to go with this item if it had been raised and level of authority requested. Fortunately council recognised at outset that they needed a certain informant and attempted to engage them. Time wasted as that informant later decided they weren't the appropriate informant and so another was invited to attend. Engagement of a key informant greatly helped inform the council of related work and led to the resolution of the issue despite that being no further action in this case. For three months, the item purposefully wasn't on the agenda and so the issue was in fact addressed fairly efficiently. It is therefore suggested that the engagement of key informants early on in the decision making process is beneficial to the efficiency of the process and the outcome. In this case, no role was identified for the council at the present time and so was rightly taken off the agenda so no more time was spent on it. Another argument regarding the actual issue is that the council did have a role but that it wasn't identified. The Policy Council certainly said their involvement with PDPs was important for a number of reasons. Again this may suggest difficulty in identifying a meaningful remit of this particular council in the context of other groups and individual's remits. The impact of having a clear lead for this item is difficult to establish other than they ensured informants were contacted and invited and led the subsequent discussion when they attended.

Diagram 4 – Recruitment Package Issue

Clear suggestion as made by council Facilitator and as such fits the council remit well. Facilitator acted as informant in providing background information and key human resource informant now co-opted at every meeting anyway. Clear aim despite no level of authority being negotiated and a clear focus made more likely by having informant present as addressed as a joint project. Additional informants (recently recruited staff) were also noticeably useful at informing the council of things that needed to be in the Recruitment Pack. Lead identified, but has fallen to the Chair as has on other occasions. Chair being overloaded instead of sharing workload out has not helped as chair disorganised. Observation suggests this is lack of personal organisational/meeting management skills but added to by the unmanageable workload. Therefore overloading

of leads is problematic to the process of addressing issues. This became more apparent when members including the lead became unclear about the issue, due primarily to working on another similarly titled issue (Induction Pack). This general confusion slowed down the council's progress slightly as talking about induction one minute and recruitment the next. The Facilitator again helped in regaining a focus from amidst this confusion. Again no decision making model was used nor particularly needed. It is suggested that the Facilitator is used to complex problem management and decision-making without thinking. Therefore in this council the decision-making guidance is through a *person* rather than a *paper-based model*. Another hindrance was the lack of attendance by the lead at the Policy Council when advice from them had been needed. Hence no progress during those months. The council then dissolved without knowing the final outcome.

Diagram 5 – Orientation Pack Issue

Clear issue and background as arose from SG findings and were reiterated to the council following SG Working Party discussions, by the Facilitator. Potential 'quick hit' and needed as orientation of new members has been a particular problem. No level of authority needing negotiation as HRC devising packs for themselves and other Trust wide councils. Similarly no great need for staff consultation as issue pertinent to councils only so only requiring council involvement only. Initially appears to be a straightforward issue that can be quickly resolved. However, first difficulty presented appeared to result from not having an identified lead. No one person therefore leading the item at meetings, co-ordinating the collation of information for the pack or taking it away to pull a draft together for circulation. Some organisation imposed on the issue via a helpful brainstorming activity of proposed contents. Quite early attempts at engagement of other councils who were written to for contributions. Main problem with this issue was lack of response by other councils despite repeated requests for information to include. This held progress up for some months and the issue was then never completed prior to the council finally dissolving. If a lead had been allocated it could be assumed that they may have took responsibility to chase up other councils more vigorously so minimising the delay. Furthermore collation work could have been done away from the council meetings to save time. So lack of a lead and other council's input appeared to be the mitigating circumstances here.

KEY SPECULATIONS

- **Decision making guidance - via a Facilitator or paper based model.** Maybe MHC make use of senior & knowledgeable people in the absence of a Facilitator at their meetings?
- **Need for a clear problem at outset.** Whether that be by way of a clear suggestion form, verbal or written suggestion, clear self-generated issue. Where unclear, is this followed promptly by an attempt to make it clear? For example by taking it back to the proposer, seeking background/further info or by using a decision making model that instructs the identification of a clear problem statement. Having a clear problem early is apparently crucial if not wanting to waste time.
- **Knowledge and ability to function on strategic issues.** Is there sufficient knowledge around the table to deal with issues? Is this dependent on prior experience/level of seniority? Is this why informants are so helpful? Is the HRC helped to progress by the presence of a Facilitator who is effectively a well-informed general informant by nature of their role in the Trust? Are informants less needed at directorate council level because of the local nature of issues relevant to those members? Have they managed without a Facilitator because of senior/experienced members? How well have they managed in fact?
- **Individual skills.** Does the process of the meeting and decisions made depend on the skills of individuals in terms of organisational skills, steps in the decision making process and knowledge of the wider workings of the Trust eg politics and the remits/existence of other groups?
- **Methods of consultation.** Consultation of individuals has been helpful but wide consultation done by survey has not worked well. If consultation is a big part of SG then do councils need survey and/or research skills or advice to help them do it effectively? Is this a problem in other councils?
- **Monthly meeting structure.** Does the structure of having monthly meetings impose a constraint because these are the locus of the work? When issues are deferred it is

for a whole month, then if a lead is absent another month is lost thus making for long drawn out decision making processes. Why aren't more things done away from the council? Why aren't other opportunities sought to clarify an issue if no rep goes to the Policy Council instead of leaving them until the next one? Is that why Chairs meetings seem useful when attended and not when they are unattended as they are an opportunity other than the council meetings to move things forward?

- **Politics.** May be not a surprise but politics have been a hindrance due withholding info needed by councils and not helping to clarify their relationships. Additionally upsetting for council members so emotional response of being refused help by managers in such a spiteful way has impacted negatively on their progress.
- **Discussion.** Lots of time spent on this but it is suggested it has limited value. Not sure the council members think so but is evident from observation that it lacks focus/purpose and slows progress down. Much recapping and repetition of same discussions. (Elsewhere in the data it is suggested that the OARRRs model of managing meetings has helped keep a focus on items when used fully – time limited items, desired outcomes, actual outcomes and action plan etc).
- **HRC role.** Ultimately the presence of the HRC in the Trust SG model is ill fitting. No clear remit observed (and substantiated elsewhere by members). Other groups have all the HR bases covered. No surprise that HRC dissolved as a result of SG research findings and other influences eg trust merger, clinical governance needs, Magnet etc.
- **Level of Authority.** For clear issues, the main value is for agreeing how far to run with the particular issue and what to aim for as an outcome. For unclear issues, negotiation of L of A also helps clarify the problem statement prior to then establishing how far to go with it and the desired outcome. Close liaison with the Policy Council and Facilitator lessens the need for a L of A as guidance is via Policy Council members and the Facilitator. Do the MHC have close guidance via PSMT or by establishing L of A? (No) What is the result of this? (unclear outcomes).
- **Leads.** Presence of a lead needed to keep tabs on things but offset by Facilitator

who guides things through also. Need more on presence and absence of leads – see MHC

- **Other's input.** It is an issue where people don't do the work or make the required contribution that then holds up the council's work processes. True for council members and constituents eg when asked for feedback on drafts and not deliver makes for less informed decisions.
- **Theory & model of SG.** Shared governance aims to authorise clinical staff to engage in corporate decision making via councils of relatively 'junior' staff. The key drive for SG is that previously decisions were made by managers who were not in touch with the clinical setting hence their decisions were often ill-informed. The solution has been to defer decision making to the clinical staff. If managers were ill equipped to make decisions because of minimal clinical knowledge, clinical staff are equally at a disadvantage because they have little management know-how and so the locus of the problem has simply been relocated. Managers at least have some clinical background to draw upon and have the overview of the organisation so knowing where to go for information and have some knowledge of what is going on. Clinical staff have little management and decision making skills to draw upon and little idea of the goings on across the organisation, leaving them somewhat disadvantaged. To rectify this, measures can certainly be taken to address the process-related issues and develop council members in terms of steps in the decision making process, managing meeting skills etc. Yet essentially it is the structure that is inhibiting, not least as SG was aimed at junior staff whereas in the USA it is the senior clinical expert staff that sit on councils. It is suggested that RHT have pitched SG at too low a level and for it to be manageable need to roll out directorate based councils so that practitioners can deal with clinical nitty-gritty issues as done well by PDC, MHC. Rather than Trust wide councils, what is needed is senior clinical experts on the Policy Council for the Directorate Based councils to feed into. Such experts will be able to hold their own in a Policy Council arena eg Nurse Consultants. Other experienced clinicians need to be encouraged to join the DBCs and work with the junior clinicians in an empowering way, which should be realistic in view of the investment being made in developing an empowering culture and leadership development activities etc.

Data Analysis - MH Council Narratives

Below are narratives pertaining to the Time Ordered Displays for the Mental Health Council. The purpose of the narratives is to draw together the tables' contents and begin to make sense of them thus producing a plausible account of what happened (Miles & Huberman 1994:112).

TIME ORDERED DISPLAYS

Diagram 7 – Case Notes Issue

Clear idea self-generated by council again. Relevant to them all and have appropriate background knowledge already to quite an extent. Early allocation of a lead helps to drive the issue at and away from the council. The Facilitator left the council in month 7 with no apparent effect on this issue. Again use discussion to see whether issue should be accepted or not. Use of the 90-minute decision-making model covered on the LEO course for analysing the issue and breaking it down into a problem statement. For now the latter stages of this model (which is time consuming during meetings) are left (options and action plan). As is usual for this council all go and seek background information from their own areas. In this case information is forwarded to the lead to analyse away from the council so that options can be clearly presented at the next meeting. This work away from council speeds up items that would otherwise take a long time if done solely at council meetings. Hold ups are apparent though when item on the agenda to be worked on and the lead is absent and information hasn't been forwarded. Options presented and as usual this council attempt consensus decision making as they feel it is equitable (also covered on LEO which has had a strong influence on this council's working). Several months pass before wanting to establish a level of authority. It has been seen that the MHC assume level 2 or 3 authority and tend only to negotiate the actual level of authority when finances are involved when they then take the issue to PSMT for discussion. At first this made them seem autonomous but after observation, it is apparent that a number of issues seem never ending, as a desired end point wasn't established at the outset. Had a level of authority been negotiated at the outset, they would know the intended purpose of their work otherwise they risk their recommendations falling on deaf ears, as has been the case (Table 6 – Motivation

Survey).

Comprehensive staff consultation is manageable by this council. Use made of an informant with no apparent effect. Big issue being worked on behind the scenes with mostly updates at council meetings. The senior, skilled and knowledgeable lead helping this process to keep moving too. Issue becoming big to manage when training needs become apparent amongst directorate staff, so manage this by way of a sub group. Pattern here of big issues being given more time by whole council as previously eg away day, or by a sub group having additional meetings as in this case. Again are evidently able to find this extra time to do this, which is not so easy for staff from other directorates. Is a big issue to co-ordinate so taking much time in preparation, consultation and then piloting of new case noted format. Perhaps the time-scale is not so slow for such a big issue?

As previously, the MHC hit a trough of activity due to many new members who were poorly orientated whilst struggling to cope with many large-scale issues all at the same time. Once the council was refocused, the case notes issue was still in a pilot phase and subsequent audit was being worked on. The lead left the council and no new lead was allocated as the intention is to keep the council updated, rather than the council keeping issues on their agenda forever. Seems a bit 'hit-and-miss' how this will be effected. Fieldwork then ceased before the final outcome was achieved.

Diagram 8 – Bank Nurse Training Issue

Clear at outset as from a council member. Clear aim to develop bank training in Mental Health which was recognised by all as very needed. All knowledgeable about the topic and so able to contribute. Issues in MHC seem to be relevant to practice so relevant to all which is less apparent in the Research Education and Human Resource Councils but is similar to the Practice Development Council. Thus the topics the decisions are about seem to have particular relevance. Discussed at the outset to assess its appropriateness for the council and so don't take things on unthinkingly. Driven by a lead allocated at the outset. Big issue so time given to it by way of a sub group. No wonder they get bogged down, as these are sizeable issues not local nitty-gritty practice issues you would perhaps expect from a directorate based council. Cost implications so level of authority sought. Subsequent clear objective of the work agreed at PSMT so likely to be

implemented when the work is done as have an agreed desired outcome. Seeking an L of A helps this to happen. Bulk of work done away from the council as a sub group and council updated/approve the work. Issue quickly resolved and Bank Nurse training implemented. Facilitator present for this issue but progress seems to depend ultimately on a designated and committed lead and clear purpose. Proved to be a quick hit and this success raised the council's profile in the directorate and Trust significantly.

Diagram 9 – User Involvement Issue

Not needing clarification as brought by a council member yet very unclear council aim arrived at. Very broad objective to look at user involvement but not clear as to in what capacity. Relevant and topical to members and whilst they mention passing it to Trust wide councils don't seem to/want to acknowledge the opportunity for joint working. Again no level of authority, but have Facilitator present until month 5 at which time they left the council. This big vague problem would have benefited from a decision making model early as this (or L of A) would likely have led to a clear problem and desired outcome. As usual, discussion was followed by collection of back ground information from member's own areas. Oddly the Facilitator said they would draft a strategy on behalf of the council although in fact that never happened. This may have given the council the belief that development of a strategy was the aim of the issue but never made explicit. Don't think they knew what their intention was. Struggling to progress. Whilst has a lead early on, the lead doesn't have a clear objective so difficult to drive it forward. Absence of Facilitator in month 3 makes them anxious that it is going no where so typically decide to have a sub group to take it away. Absent member again causes a hold up as not able to update council in month 5 and no information (which they previously agreed to bring) was forwarded. Summary done by sub group merely lists the type of opportunities for user involvement generally so not that meaningful. Several months later informants have been utilised and lots of information gathered but little done with it as still not have a clear purpose. Recognised this and asked what the council's original objective was. Whilst the council had always sensed a degree of muddle with this item, they were so busy with their numerous large issues that they hadn't noticed earlier just how muddled they were. The Facilitator wasn't keeping them focused either as had their own objective to get a user strategy developed (Trust wide was actually their remit apparently). So no decision-making guidance from the Facilitator or paper based model to guide them. When sub groups are meeting and

information is being collected (ie when lots of activity) the council seem to interpret that as a sign that they are doing OK. Agreed to look at promoting user involvement on the council only. In month 11 decided to use a decision making model to define a problem statement, analyse, decide options and develop an action plan (90minute model). Paper based model enabled them to clarify their problem which was to engage users in the council. An action plan to do this was developed and users were to be invited to an open day. A decision made in passing, that the Vice be aware of potential user involvement for all future items, wasn't acted upon. This is because it was the idea of one member and the Vice Chair wasn't clearly made responsible for this and, as it was said in passing (yet minuted), it was never going to happen. So although model has helped, it has not made the issue fully clear. So the model only helps if it is followed closely and comprehensible. Incidentally this is the point where many members are changing and those using the model aren't that familiar with it and this showed. Shortly after came the 3-5 months refocusing the council as they had got muddled generally. One lead left and the other to leave by the end of the refocusing period. No hand over of the issue was apparent to the remaining council members. Whilst suggestion forms are being revamped to encourage suggestions from users for council to address, no clear outcome yet achieved. Not addressed then until someone noticed months later that it had never been completed and that there was no current lead for it. This reiterates that need a clear lead or issues don't go forward. Items 'shared' by council instead of having a designated lead are prone to fall by the wayside. New leads allocated but instead of looking for an initial objective, and noticing there wasn't one and addressing it, they fell upon the idea of getting involved with a user conference being organised by one of them. Members seem content that something positive is happening and don't seem aware that they have gone off on a tangent – a useful tangent but still a tangent.

Diagram 10 – Face-to-face Contact Issue

Clear suggestion from staff member to act upon the recommendations of a report that points out insufficient face-to-face contact by staff with patients in Mental Health. However MHC not clear about their intentions with it so begin by discussing it, accepting it as fitting of their remit and gathering background information from their own areas. No clarity sought by way of an L of A or a decision making model so set out doing work without a clear purpose. Absence of a lead added to this. No informant sought to add clarity either. Staff consultation was evident in person by members in own

areas and later by survey. Recognised after a couple of months that they had jumped to solutions prior to being clear about the problem so clarified a problem statement and allocated leads.

Unfortunately time and effort was lost as no survey advice sought and such skills lacking within the council (similar to HRC). Therefore survey poorly done (by the leads without council consultation) and findings were inconclusive. Survey later repeated and no replies received. No progress when item on the agenda but leads absent and no information forwarded to the council. Issues are therefore dependent on attendance of the leads or their thinking to send information instead (rarely done). Getting stuck so..... set up a sub group. Many new members had joined over the last few months and members were overloaded with big issues so had the 3-5 meetings then to sort out the muddle. During this time both leads left and a new Chair took over and the previous Chair left the council before the new one knew properly what they were doing. Hence never quite refocused properly. No proper hand over by the lead that left so invited back for an update. MHC is heavily lead dependent but should know where things are up to without the lead having to be present. Issue of not recording activities fully in addition to many new members that hadn't been present for much of the many issues and so didn't remember what had happened before. Still none the wiser so chose to ask staff views in own areas again – to achieve what? By accident realised a couple of months later that nothing more had been done, no-one had thought to feed back on the recent information gathering and they noted that no lead had been re-allocated, so the issue had ground to a halt. New lead allocated and an update to be sought again from the ex-lead. Time lost when lead absent at next meeting and information not forwarded. Finally decided to invite the ex-lead to update the council. Again difficult to keep a handle on work devolved from council into the directorate. To save time this could surely have been done weeks ago away from the council. Fieldwork then ended without knowing the final outcome.

Diagram 11 – Staff Motivation Survey Issue

No clarity needed as from council member who had done a survey as part of a course and wanted findings acted upon. Relevant to all and fitted council remit. Following discussion the council agreed a larger survey would be valuable and straight away agreed to distribute questionnaires. No level of authority sought so not clear how far

they felt they would be able to go with the findings. Lead straight away to drive it and so item progressing well. Survey well responded to and analysed promptly. However as they had no L of A they were merely thanked for the findings and no action resulted. Managers not necessarily sharing the council's view as to how important this issue is so council ground to a halt, not knowing what to do next. Recognised need to engage managers who would be impacted on if they are to respond to findings, but wrote to them instead of speaking with them, to tell them to write local objectives in response to the findings. Bit naïve of the council to think that this was going to be received well and no action resulted. This is the only time that the MHC are noticed to have a difficulty arising from their relation to other groups, in this case HODS (Heads of Department). Nothing more heard as councils attempted to refocus for 3-5 months and cope with a greatly changed membership. During this time the lead also left and no clear hand over given. New lead promptly allocated and to liaise with old one as HODS had wanted a repeat survey prior to acting on any findings. Council accepted this but I don't see what HODS hoped to achieve by this (or not achieve as training needs were highlighted ie resource implications!). Despite the new lead nothing happened at the council around motivation for several months so new lead took over. Progress seems dependent on who the lead is. Also whether lead present as item is again deferred when lead absent and unclear information forwarded only, in their absence. The survey is being refined and about to be re-done as fieldwork ends.

Diagram 12 – Ethnic Minorities Services Issue

Suggestion from staff member. Unclear at outset as to what exactly they want from the council with regards to Ethnic Minority services. No lead identified so everybody's (?nobody's) responsibility to take forward. If had a lead they may well have clarified issue with the proposer prior to getting embroiled in it. Opportunities to clarify the problem were missed as no L of A sought nor decision making model used. No Facilitator on this council now either to offer guidance. Whilst it made it back on to the agenda a couple of months later it was recognised as going nowhere as no lead, so deferred. Finally a lead was allocated and so on agenda but insufficient time to do CATS decision making model on it. Tend to use CATS for assessing new suggestions and 90-minute model for managing existing complex issues. Both very time consuming which is noticeably a problem and one acknowledged by members elsewhere in data, also that CATS is too complex although they agree that use of 'a' model is helpful. Too

full an agenda as many large issues on the go so deferred. Many new members by now and botched use of the 90-minute decision making model actually used. Unclear so ... more fact finding. This doesn't help much however as never got to a clear problem statement. Not sticking to a designated lead either but sharing it from meeting to meeting which doesn't help with continuity. No one wanting to be a permanent lead – all overloaded and not wanting a big muddled issue like this, especially not the new members busy finding their feet. May have been better not to take anything else on until more sorted. No real progress from the further fact finding and then decided to address it at an away day as tends to happen with big complex issues (or sub group). Therefore the next 3-5 meetings are set aside to refocus the council following the away day. Giving it more time clearly not helped as working on it whilst still unclear what meant to be doing. Finally after 12 months are to invite the original proposer to explain what was wanted. Discussion of issue follows with the proposer and the following month decide to use the 90 minute decision making model on it again which prompted an L of A to be questioned. Instead of negotiating it and so clarifying their purpose in PSMT's eyes, they gave themselves level 2 (to gather info and recommend). Still unclear what doing so.... to set up a sub group to work on it away from the council. Council not then kept updated and whilst on agenda twice, the lead was absent and information not forwarded. No more news on where this item was up to by end of fieldwork.

KEY SPECULATIONS

- **Directorate remit.** Local practice issues affecting MH directorate only, make for easier decision making as topics are familiar, pertinent and members know the workings of the directorate, who is who etc
- **Capability.** MHC members tend to be F & G grades and a couple of them are more senior hence used to complex decision making and project management. Less senior members less able to cope especially with sizeable, complex projects.
- **Skills.** Lack of skills are evident as regards surveys so such means of consultation has failed. Recent Chair lacks skill in managing meetings, keeping informed as to where up to and keeping everything on track.

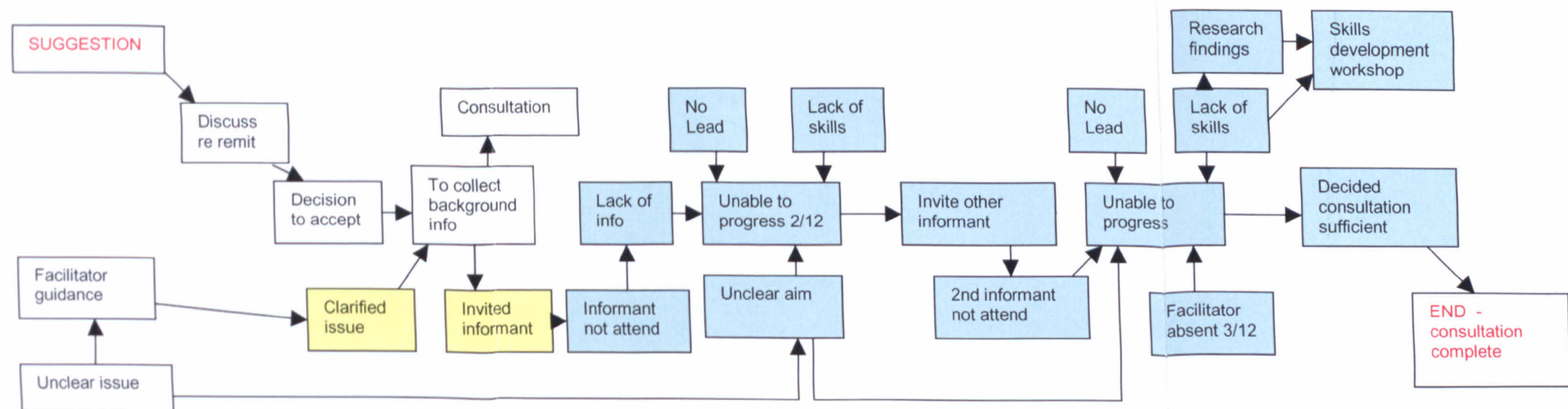
- **Decision making guidance.** It is beneficial to have decision making guidance via paper based models or by a person. In this case the Facilitator is not present on the council long but the other senior members act in a guiding/steering capacity hence this council has done reasonably OK without a Facilitator. However, there has been much muddle, which a facilitator may have helped alleviate but the cause of the muddle is dependent on other factors. Ideally need a simple decision making model that is more easily understood but ensures L of A and clear problem statement above all.
- **Level of Authority.** Not so big an issue as results of their work impact locally in all their practice areas unlike the Trust wide councils and their strategic decisions. However L of A seeking is an opportunity to clarify the problem and find out how far to go with it. Where no model is used and no L of A is sought, an unclear issue proceeds and gets confused and no clear end point is aimed for.
- **Muddle.** The huge trough in activity and focus in year 2 was primarily due to many new members not oriented, leads leaving without updating the council and new leads being allocated, combined with many large issues being addressed at any one time. Not helped by members leaving suddenly rather than being shadowed by new ones a few times ie new ones were simply left to it. Also new inexperienced Chair didn't help lead the council out of this difficult period. Previous Chair also left suddenly and left the new Chair to it. The rough change over of members has a lot to answer for.
- **Discussion.** Council values discussion and do very much of it. Is often rambling though and does not necessarily lead to a more clear purpose. Whilst they value it I would contradict that.
- **Fact-finding.** Similarly, MHC fact-find excessively and is often a strategy to try and make sense of something. For example not always clear what to fact find on exactly nor is the feed back on fact finding that focused. So tends to be lots of discussion and fact finding hand-in-hand.
- **Dealing with complexity.** Are generally good at recognising complexity and

breaking it down with a decision making model. However other tactics include sub groups and away days. Yes giving them more time may help, especially as agendas are so limited (3 hours for many big issues) but often resort to these measures when an issue is unclear. What they really need to do is think about the problem before jumping to actions/solutions. Have done this time and time again. I wonder if it has anything to do with a practice background ie is it asking a lot in trying to get practitioners to 'plan' and 'do' when used to focusing mostly on 'doing'? Or maybe just lack of awareness – although has been pointed out in SG research feedback.

- **Updates.** Prefer to get updates from ex-members by inviting them instead of saving time and getting these away from the meetings. Slows down the process that things are addressed. Similarly progress slowed by absent leads and info not forwarded in their absence and so agenda items deferred again and again. MHC is lead dependent. No system for ensuring devolved issues are followed up on.
- **LEO.** Are noticeably influenced by the LEO eg OARRRS model and 90-minute model. Also language used and principles adopted ie aiming for consensus decision making (covered elsewhere in the data).
- **Seniority.** Also on this the member who kept remembering issues had fallen by the way side was the only one who had been present since the outset of the council and was a particularly senior and knowledgeable manager. Without their presence more would have gone pot and so in some ways took the role of a Facilitator in keeping things on track. To have a council of junior staff and no Facilitator or senior staff would therefore seem detrimental. Suggesting that future directorate based councils have an adequate ratio of senior people especially if no Facilitator. Junior staff just don't seem have the ability to progress in the way needed. Unless this could be taught of course. Is it a skill? Is it experience?
- **Leads.** Have leads at outset mostly. Leads help issues to keep moving though not always focused and seems to depend on the lead. Shared items without a lead fare less well. OARRRs model indicates a lead to be allocated and is used fairly consistently by MHC suggesting that it is worth continuing with.

- **Relation to other groups.** Only for one issue was this noted to be a problem. This was the HODS (Heads of Department) although some members of the council sit on this too there seem to be a wariness of the MHC role in relation to the HODS by the managers. Don't think they liked being told what to do (motivation survey) by council hence asking for a repeat survey in 12 months.

Causal Network Diagram 2 – Human Resources Council Millennium Issue (HR2)



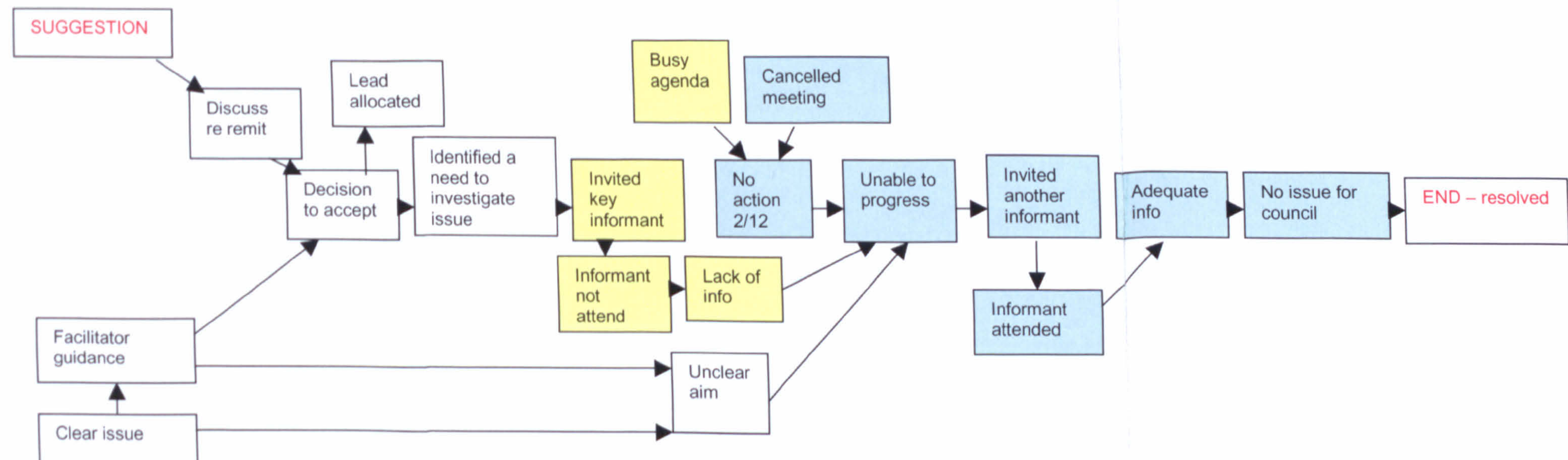
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Causal Network Diagram 3 - Human Resources Council Personal Development Plan Issue (HR3)



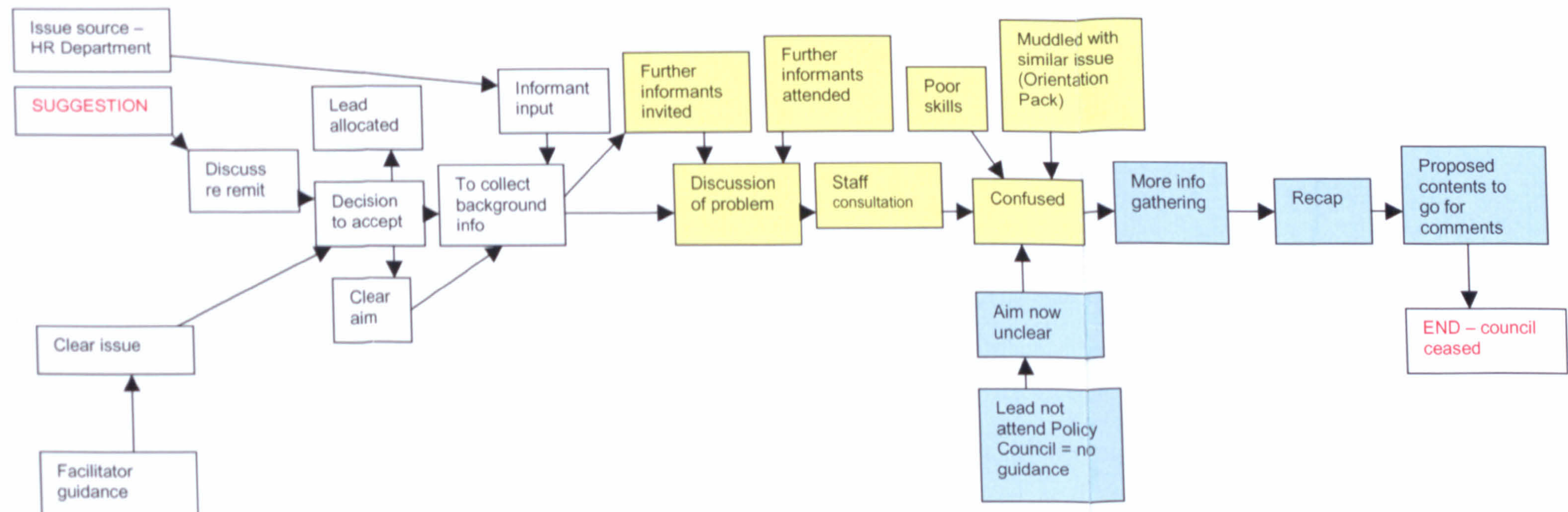
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Causal Network Diagram 4 - Human Resources Council Recruitment Pack Issue (HR4)



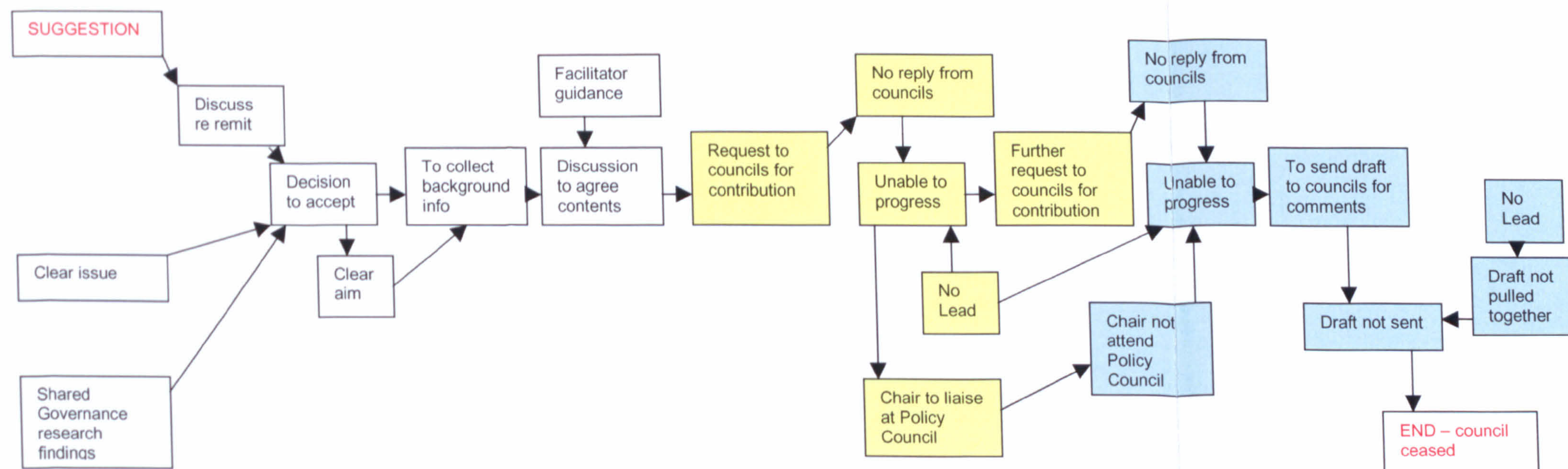
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Causal Network Diagram 5 – Human Resources Council Orientation Pack Issue (HR5)



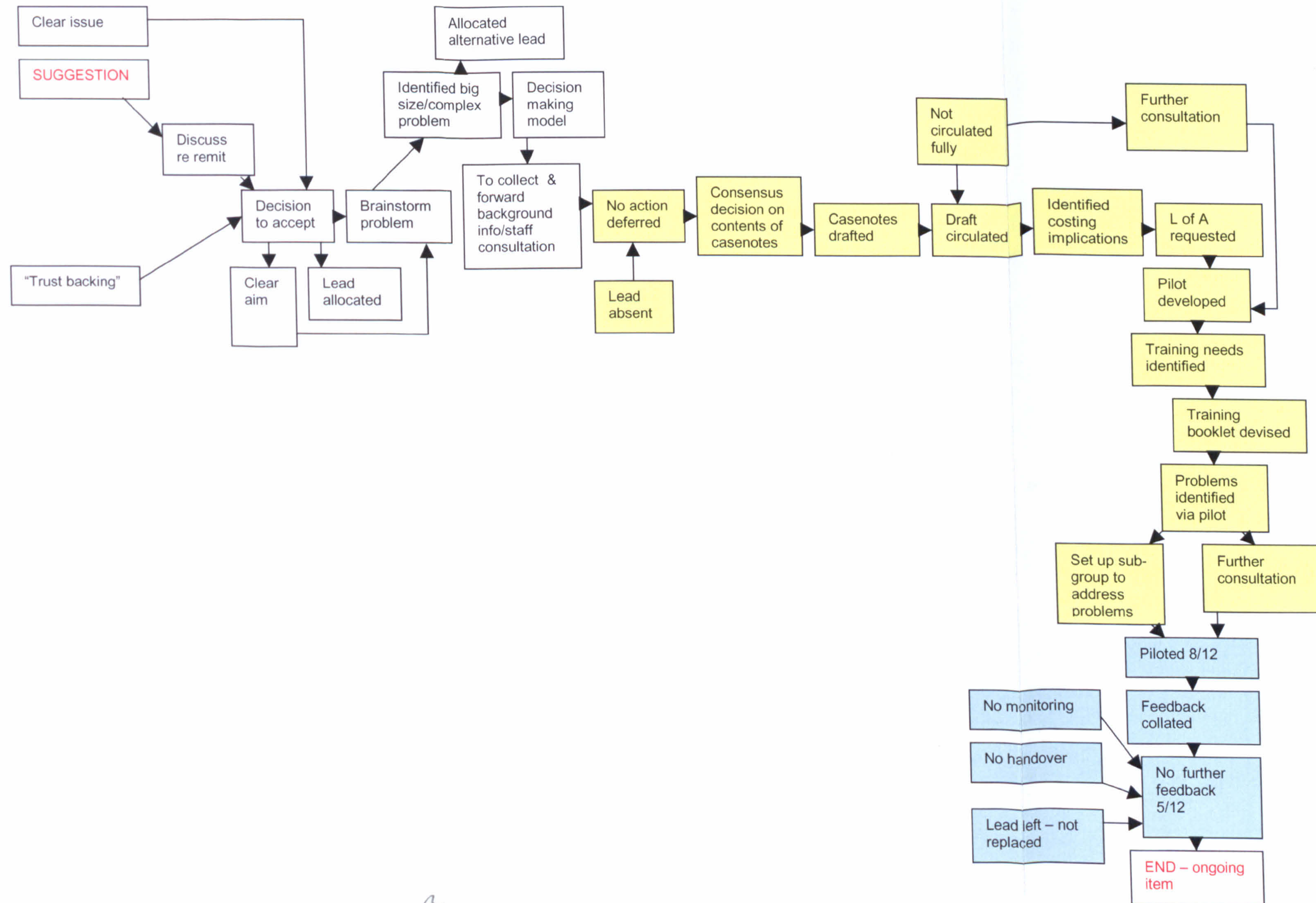
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Causal Network Diagram 7 - Mental Health Council Case Notes Issue (MH2)



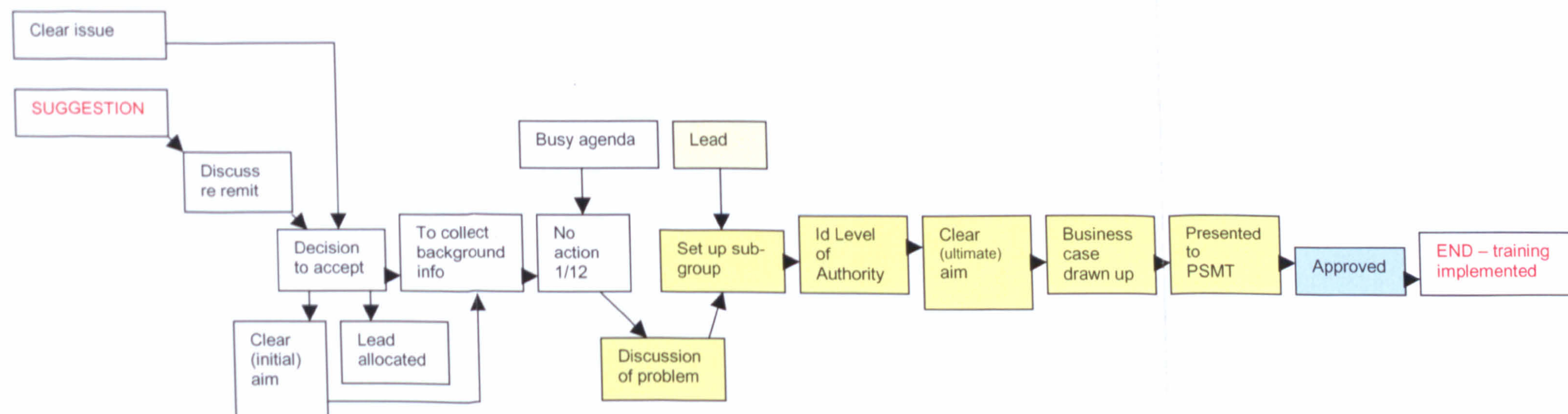
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Causal Network Diagram 8 - Mental Health Council Bank Nurse Training Issue (MH3)

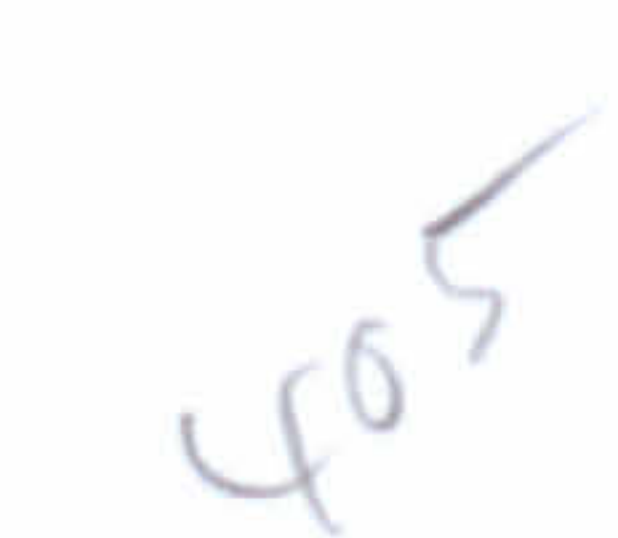


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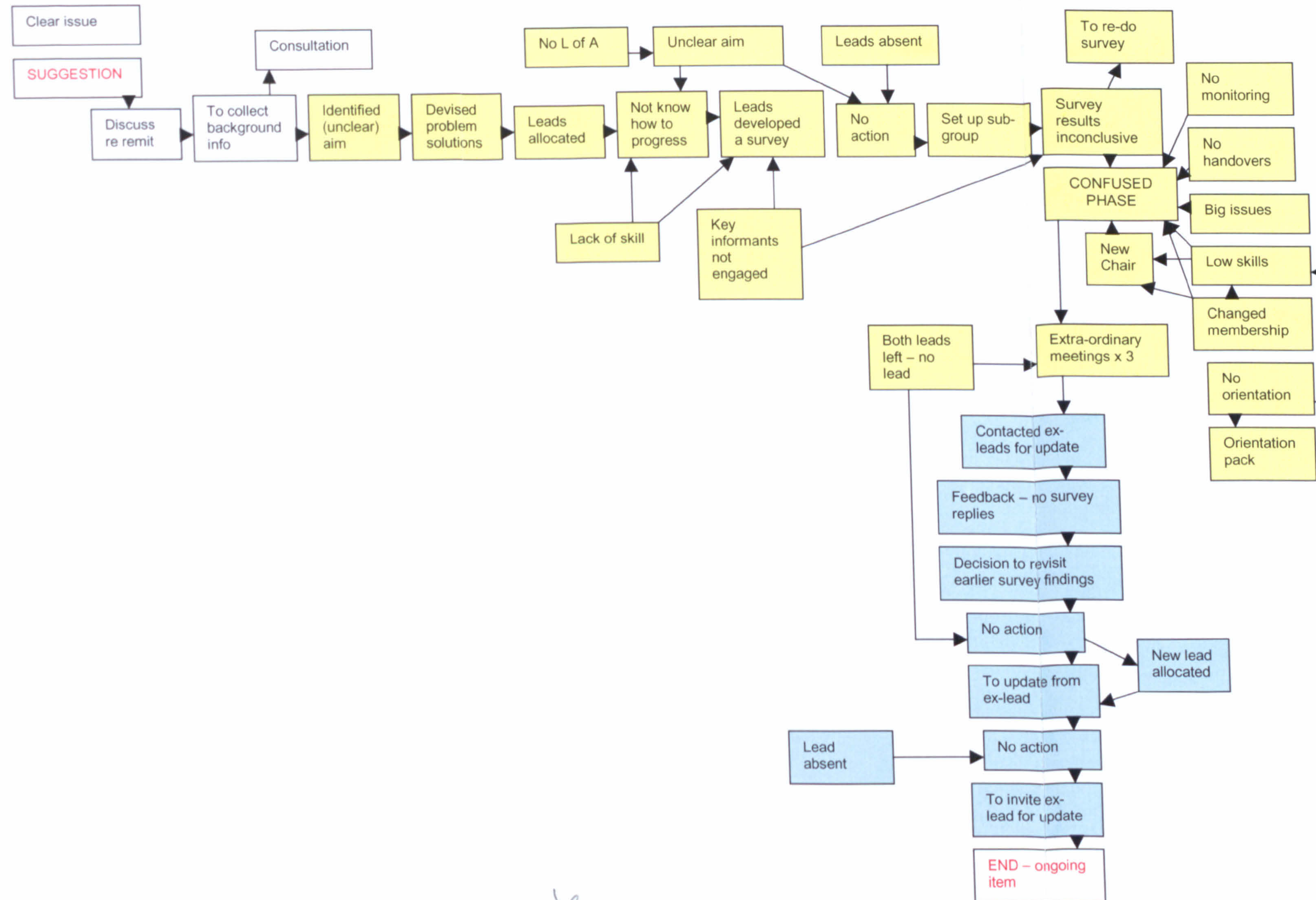
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Causal Network Diagram 10 – Mental Health Council Face-to-Face Contact Issue (MH5)

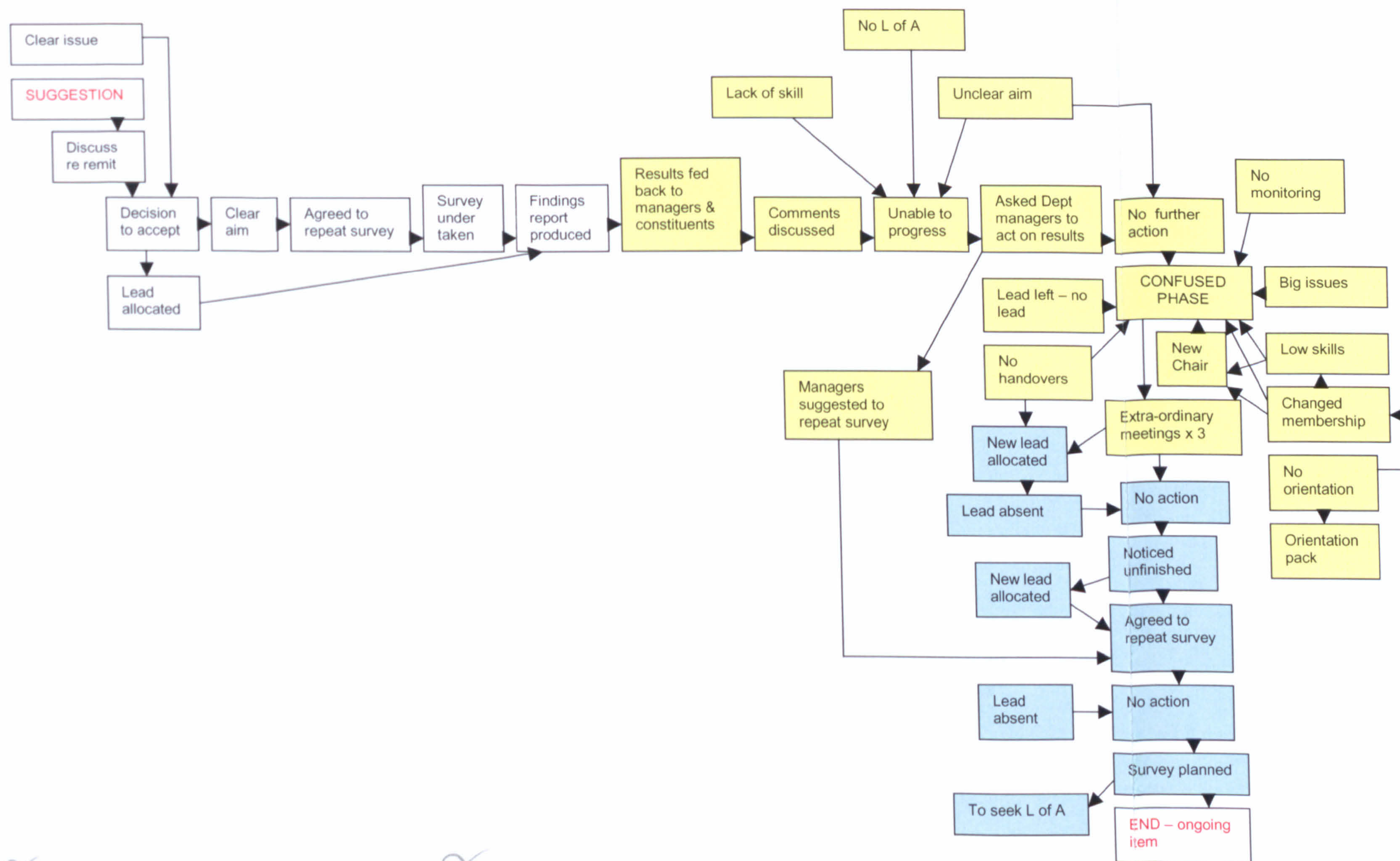


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Causal Network Diagram 11 – Mental Health Council Motivation Survey Issue (MH6)



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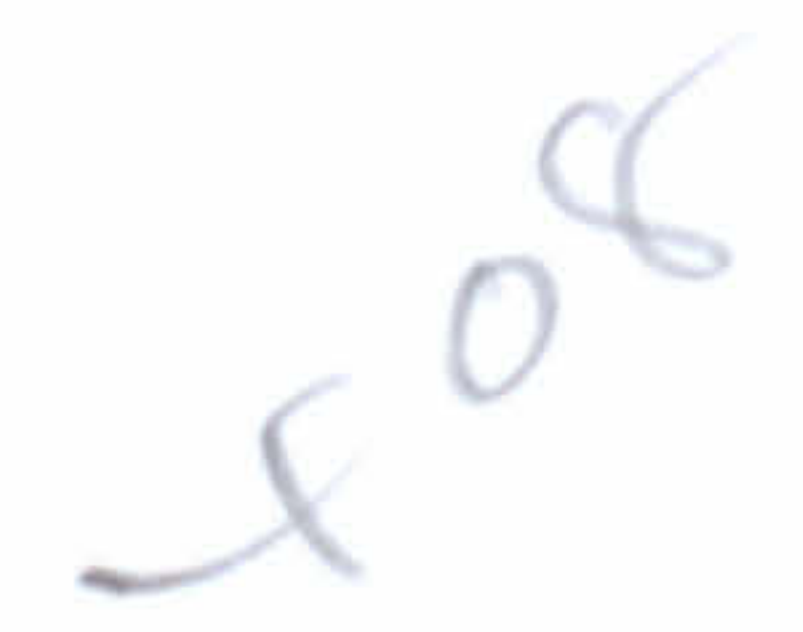


Diagram 2 - HR2 – Millennium Issue

Receipt of this issue from Policy Council led to discussion of whether it fitted the council remit. The issue was accepted despite it not being a clear issue initially which prompted collection of background information and it was agreed to consult staff in member's own areas. Further clarification of the issue by the Facilitator led the council to identify a key informant to help them and this person was subsequently invited. However the informant did not attend as requested which led to a lack of information on which to act and so the council was unable to progress. This inability to progress was further hampered by the absence of an allocated lead and lack of council members' skills at operating within a shared governance decision-making model. Further hindrance resulted from the fact that there wasn't a clear aim as to what to do with the Millennium issue. This lack of progress prompted the invite of another informant yet when they did not attend, the council again was unable to progress. Again there was no lead to drive the issue and necessary skills of council members were proving inadequate. A further contributory factor to this episode of being unable to progress was the absence of the Facilitator for 3 consecutive months so that the council had no direct support or guidance. Recognition of this adverse effect led to the running of a skills development workshop for members to meet their development needs and a decision never to leave the council without a Facilitator again. Before the effect of the workshop could be established the issue ceased as members decided that the consultation exercise they had undertaken was sufficient and that the issue was adequately addressed. End of issue/resolved.

Diagram 3 - IIR3 – Personal Development Planning

Receipt of the suggestion from a council member meant the issue was clear from the outset. Following subsequent discussion and encouragement from the Facilitator, it was readily accepted and a lead allocated. The council decided to investigate the issue to see if they had a role to play which prompted them to invite a key informant. The informant did not attend which resulted in the council having insufficient information and were subsequently unable to progress. Around the same time no action within the council

regarding the issue was as a result of them having a very busy agenda and a cancelled meeting. This inaction and the fact that the council had never established a clear aim also contributed to them being unable to progress. In response the council invited a further informant who did attend and so the council became suitably informed. However the information received highlighted that there was no role for the council with this issue after all and so it was considered resolved and taken off the agenda.

Diagram 4 - HR4 – Recruitment Pack

Receipt of this suggestion was from the co-opted HR Department member and so was clear from the outset. The Facilitator further clarified the relevance of it to the council and so following discussion it was agreed as fitting the council remit and accepted. This prompted the council to allocate a lead, agree an aim and agree to collate background information with which to familiarise themselves with the issue. The fact that the source of the issue was the HR Department representative meant that an informant was already present at the council and this impacted positively on the collection of required information. Appraisal of this information led to further informants being identified and invited for their unique perspective (new trust staff) and who subsequently attended a meeting. Discussion of the information with the invitees led to a decision to undertake a staff consultation exercise although this was immediately followed by the council hitting a period of being unable to progress. Reasons for this were in part the member's lack of skills at shared governance decision making and the fact that the initial aim had become blurred. Opportunity was lost to clarify the aim, as the lead did not attend Policy Council at this time as was agreed to ask for guidance. Further focus was lost because members were confused with another issue they were working on (orientation pack) and kept losing track as to which issue they were talking about. In order to refocus the council decided to gather more information which then lead to recapitulation of collated information and identification of the proposed pack contents that were intended to be circulated for comments. However the council ceased to meet at this point due to impending reconfiguration of councils and so the issue was suspended. End of issue.

Diagram 5 - HR5 – Orientation Pack

This suggestion was clear from the outset as it derived from the shared governance research findings. Following discussion as to whether it fitted the council's remit it was accepted and a clear aim agreed. The fact that it was a recommendation of the research study also contributed to it being accepted. Members agreed to seek background information and this led to discussion as to what material to include. The need for contributions from the other councils was identified and so a request was sent to them. No reply was forthcoming and so this led to the council being unable to progress. The fact that no lead was allocated added to the lack of progress, as nobody was responsible for driving it. Therefore it was letter decided to re-contact the other councils for their contribution in writing. No reply was received hence again unable to progress. It was therefore decided to approach the other council chairs in person at Policy Council yet this council Chair never attended so the opportunity was lost. In the absence of council replies it was decided to draw a draft together and send them a draft pack for comments anyway. However the draft was not pulled together as there was no lead responsible for doing so and the draft was never sent. Then the council ceased to exist due to the impending council reconfiguration. End of issue.

Diagram 7 - MH2 – Casenotes

This issue was presented by a council member and was clear at the outset. Discussion of whether it fitted the council remit led to it being accepted. The fact that it was a clear issue seemed to have some influence on its acceptance. Also the fact that it had ‘trust backing’ (as described by council members at interview) also influenced the decision to accept it as a council issue. Following acceptance a lead was allocated and a clear aim agreed. Brainstorming was instigated to examine the issue, which was subsequently analysed by use of a decision-making model due to the large scale and complexity of the issue. This led to a decision to collect background information including views from own areas and allocation of a lead to take over from the proposer to spread the workload out. No action ensued at the next meeting as a result of the lead being absent and so the issue was deferred. At the following meeting an agreement was reached as to the proposed casenotes contents that led to them being drafted. Circulation of the draft followed although not circulated fully by accident so further consultation was instigated. At the same time it was realised that the issue had cost implications and so a level of authority was agreed to be requested from PSMT. Feedback from consultation and asking for a level of authority prompted the development of a pilot and through this work, training needs were identified for directorate staff. To meet these a training booklet was developed although further problems became apparent through the pilot process. These problems prompted further consultation of staff and the forming of a sub-group to address the problems. These measures led to an eight-month pilot and collation of feedback at the end of this period. However no feedback was received during the next 5 months. This was attributed to the fact that the issue lead had left the council and hadn’t been replaced nor handed the issue over, neither was there a formal system for monitoring issues to keep track of them. Fieldwork then ended with the issue being an ongoing item.

Diagram 8 - MH 3 – Bank Nurse Training

This issue originated with a council member and was clear from the outset. Discussion as to whether it fitted the council remit led to it being accepted. The fact that it was a

clear issue seemed to have some influence on its acceptance. The decision to accept led to allocation of a lead, establishment of a clear initial aim and agreement to collect background information. However the issue was deferred at the next meeting due to a busy agenda. At the next opportunity the lead led a discussion of the issue which led to development of a sub-group to address the issue away from the council. The lead was influential in prompting this sub-group and keeping the issue moving. At the same time it was recognised to gain a level of authority so that the sub-group had a clear ultimate aim/objective. This was done leading to a business case being drawn up and presented to PSMT where it was subsequently improved. The issue ended successfully at this point and the training was implemented.

Diagram 9 - MH4 – User Involvement

This issue was brought by a council member and was clear from the outset. Despite no clear aim being set discussion as to whether it fitted the council remit still led to its acceptance, a lead being allocated and a member offering to write a user involvement strategy. The decision to accept further led to brainstorming of the problem and then agreement to collect background information. However a lack of information ensued and the fact that the original issue was unclear meant that the council was unable to progress. Factors affecting this inability to progress included a lack of input of an informant and the absence of the member who was to feedback on the strategy work. This inability to progress prompted the setting up of a sub-group to work on the issue away from the council. The sub-group collated further information to feedback to the council so as to inform plans to tackle the issue. However when due to feed back, the sub-group realised it had no clear aim and the council was unable to progress. This inability to progress was further hampered by not negotiating a level of authority that would have been opportunity to clarify the aim and the huge size and complexity of the issue. Furthermore the member developing the strategy had left the council. The council realised the scale of the issue was unmanageable and agreed to focus on user involvement within the council only. This aim and the complexity of the problem led to the council adopting a decision-making model to help them analyse the issue. This analysis led to a realisation that the strategy had never been done as a result of the relevant member leaving. The analysis further prompted an event to be planned to invite users to.

Following this was a period of inaction influenced in part by the lead having left the council with no planned monitoring of the issue or handover. This inaction contributed to a phase of confusion whereby the council floundered greatly on all its issues including this one. Further factors prompting this confusion was a lack of monitoring of where issues were up to and no hand over of issues by leads leaving the council. Added to this the council was addressing a big number of large and complex issues simultaneously that were challenging to manage. Additionally most members lacked skills in this kind of work which was added to by the recent change over of many members in that the new members had little experience of council working and so little opportunity to acquire the necessary skills. Furthermore new member's capability was hindered by the fact they received no orientation prior to joining the council. The changed membership also added to the general confusion as new members had little appreciation of what had happened with issues previously and ways of council working. The changed membership also brought a new Chair who took this role on at a challenging time for the council. To deal with this confusion it was decided to spend the next three meetings revisiting all issue and working out where they were up to. No action ensued following the extraordinary meetings in part due to the absence of a lead, no handover and no council monitoring system of issues. It was noticed by chance that the issue was unresolved which prompted allocation of a new lead. The new lead prompted the idea of involving the council in a user conference being planned already and this was seen as an appropriate next step. The fieldwork then ended and the issue remained ongoing in the background.

Diagram 10 - MH5 – Face-to-Face Contact

This issue was brought by a council member but and was clear from the outset. Despite no clear aim being set discussion as to whether it fitted the council remit still led to its acceptance. A decision to collect background information followed, as well as a staff consultation exercise. The information informed the attempt to clarify the objective but in fact ended with an unclear aim. The council started to identify solutions prior to establishing specific problems and this prompted them to allocate two leads. The council was unsure how to progress due in part to lack of skills on their part and the lack of a clear aim. Furthermore no level of authority had been negotiated that would have been an opportunity to clarify the aim. In response and away from the council, the leads chose to develop and undertake a survey to gain staff views as to what the issues

are. Then no action ensued in the absence of the leads and the issue was deferred. Subsequently the issue was recapped and it was decided that a sub-group was needed to progress the issue. The results of the survey were inconclusive due in part to lack of skills on the part of the leads when developing it and no informants being utilised to help in designing the survey. These inconclusive findings led to the decision to re-do the survey but also added to a phase of confusion whereby the council floundered greatly on all its issues including this one. Contributory factors included the fact that the council was addressing a big number of large and complex issues simultaneously that was challenging to manage. Additionally most members lacked skills in this kind of work which was added to by the recent change over of many members in that the new members had little experience of council working and so little opportunity to acquire the necessary skills. Furthermore new member's capability was hindered by the fact they received no orientation prior to joining the council. The changed membership also added to the general confusion as new members had little appreciation of what had happened with issues previously and ways of council working. The changed membership also brought a new Chair who had taken on this role at a challenging time for the council. To deal with this confusion it was decided to spend the next three meetings revisiting all issue and working out where they were up to. At the same time as the extra-ordinary meetings, both leads left the council so were not present to inform the discussions. Therefore this prompted the ex-leads to be contacted for an update, as they had not handed over the issue. The resulting feedback was that there had been no replies to the repeat survey hence a decision was taken to revisit the earlier survey findings. Yet no action followed in part due to there being no leads to take the issue forward which prompted allocation of a new lead who was to get another update from the ex-lead. No action followed in the absence of the lead and so it was decided to invite the ex-lead to attend the council. Fieldwork then ended with the issue remaining on going.

Diagram 11 - MH6 – Staff Motivation

This issue was clear at the outset as brought by a council member. Following discussion as to whether it fitted the council's remit it was accepted and the clear issue helped a clear aim to be agreed. Thus a repeat survey was to be done and was duly undertaken. The proposer acted as lead and was influential in effecting the survey promptly. A report of findings was subsequently produced and these were disseminated. Comments

received were discussed by the council at which point members felt unable to progress. This inability to progress was due to three main factors including the now unclear aim as to what was intended with the survey results, no level of authority was negotiated that may have clarified the council's ultimate aim and a lack of members' skill at managing the survey/findings. As a result it was decided to ask department managers to develop action plans from the results but this was not acted upon by the managers. There followed a period of inaction, as the council still had no clear aim. This contributed to a phase of confusion whereby the council floundered greatly on all its issues including this one. Further factors prompting this confusion was a lack of monitoring of where issues were up to and no hand over of issues by leads leaving the council as occurred in this council at this point. Added to this the council was addressing a big number of large and complex issues simultaneously that were challenging to manage. Additionally most members lacked skills in this kind of work which was added to by the recent change over of many members in that the new members had little experience of council working and so little opportunity to acquire the necessary skills. Furthermore new member's capability was hindered by the fact they received no orientation prior to joining the council. The changed membership also added to the general confusion as new members had little appreciation of what had happened with issues previously and ways of council working. The changed membership also brought a new Chair who had taken on the role at a challenging time for the council. To deal with this confusion it was decided to spend the next three meetings revisiting all issue and working out where they were up to. As a result of this phase and the lack of handovers, a new lead was allocated to pick up the issue. However no action ensued as the lead was absent and it was noticed that the issue was unresolved. A new lead was allocated in response, which led to an agreement to repeat the survey as suggested by department managers. No action ensued in the absence of the lead and at next meeting the lead agreed survey plans with council members and a decision was taken to negotiate a level of authority at this point. Fieldwork then ended and the issue remained ongoing.

Diagram 12 - MII7 – Ethnic Minorities

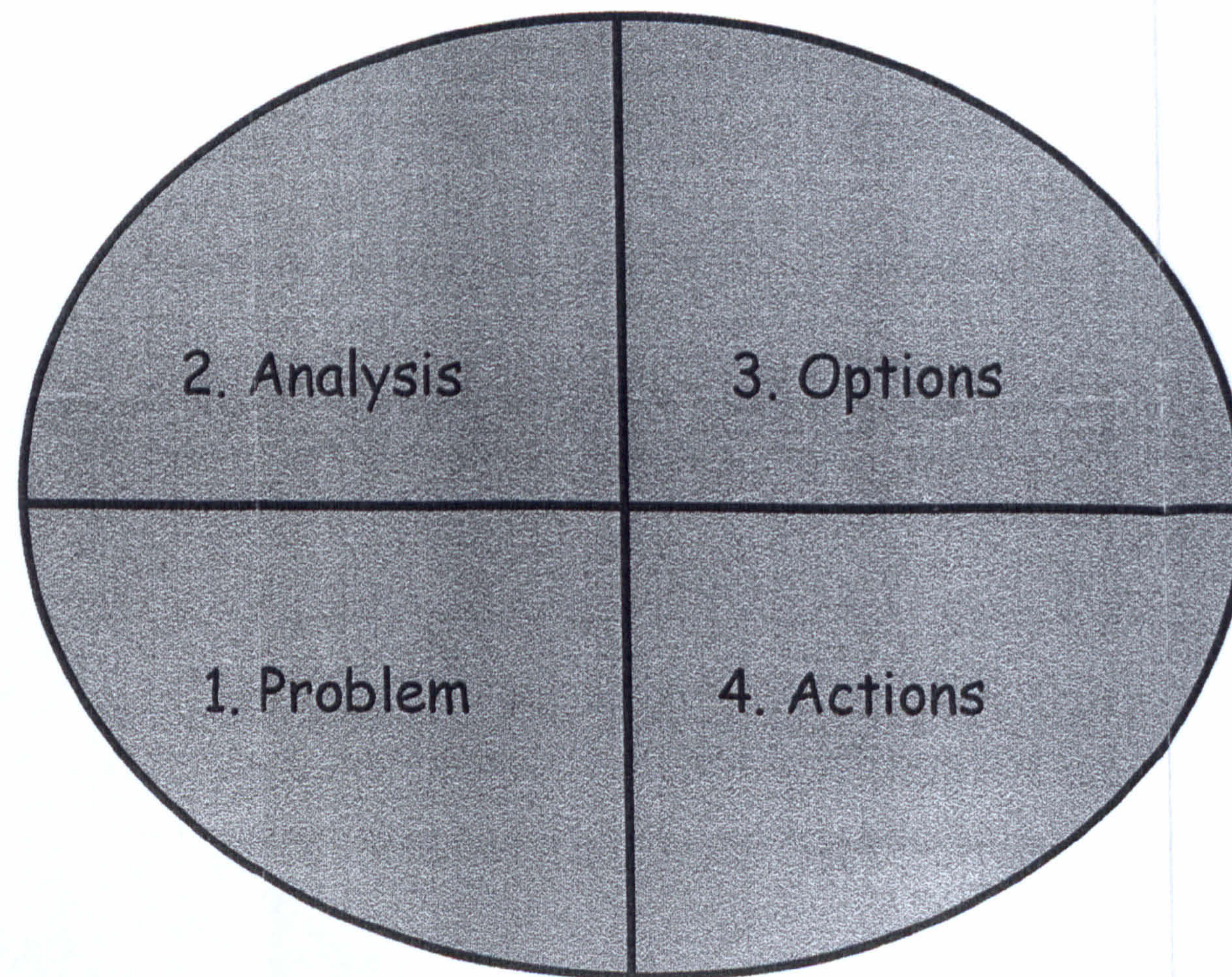
This suggestion from a staff member was unclear at the outset and with very little discussion was refused. By far the most significant factor causing this was the personality and views of a particular council member. However a few months later

another member's personality/views impacted positively by prompting the issue to be reconsidered. No discussion about remit occurred and the issue was put on the agenda. No action ensued due to a busy agenda and the large scale and complexity of the issue and so the item was deferred. A lead was allocated but the item deferred again due to insufficient time available to fit it into the meeting. The size and complexity of the issue prompted the council to adopt a decision-making model for use to break the issue down and analyse the problem. These resulted in an aim being agreed although this was in fact unclear due in part to a temporary lead standing in for this occasion as no-one could remember who the lead was, and also as the issue was never clear at the outset from which to identify an aim. In response the council decided to collect background information and then feed this back at a later meeting. However there was uncertainty as to whether there was adequate information due in part to another lead being temporarily appointed and no engagement of a key informant to inform the issue resulting in no action. This contributed to a phase of confusion whereby the council floundered greatly on all its issues including this one. Further factors prompting this confusion was a lack of monitoring of where issues were up to and no hand over of issues by leads leaving the council as occurred with the lead for this issue at this point. Added to this the council was addressing a big number of large and complex issues simultaneously that were challenging to manage. Additionally most members lacked skills in this kind of work which was added to by the recent change over of many members in that the new members had little experience of council working and so little opportunity to acquire the necessary skills. Furthermore new member's capability was hindered by the fact they received no orientation prior to joining the council. The changed membership also added to the general confusion as new members had little appreciation of what had happened with issues previously and ways of council working. The changed membership also brought a new Chair who had taken on the role at a challenging time for the council. To deal with this confusion it was decided to spend the next three meetings revisiting all issue and working out where they were up to. As a result the original staff member who proposed the issue was contacted for an update. A decision was taken to use a decision making model to analyse the problem because the issue was so large and complex and its use was prompted by a new lead allocated to pick up the issue. This model was not utilised very effectively due in part to a lack of skill of members using it and because there were many new members who were not familiar with its previous use at the council. The model resulted in an unclear aim being agreed and the council also decided its own level of authority so opportunity to negotiate a

clear aim was lost and added to the lack of clarity of the agreed aim. Yet the decision-making model led to acceptance of the issue as fitting the council remit and a subsequent decision to collect background information. As the issue was large and complex it was agreed to set up a sub-group to address it. However there followed no action and the item was deferred, as the lead was absent. Instead an update was to be requested from the lead yet the issue was again deferred as a result of the repeat absence of the lead that had been expected to give the update. Fieldwork then ended and the issue remained ongoing.

Appendix 24 - Problem-Solving Models

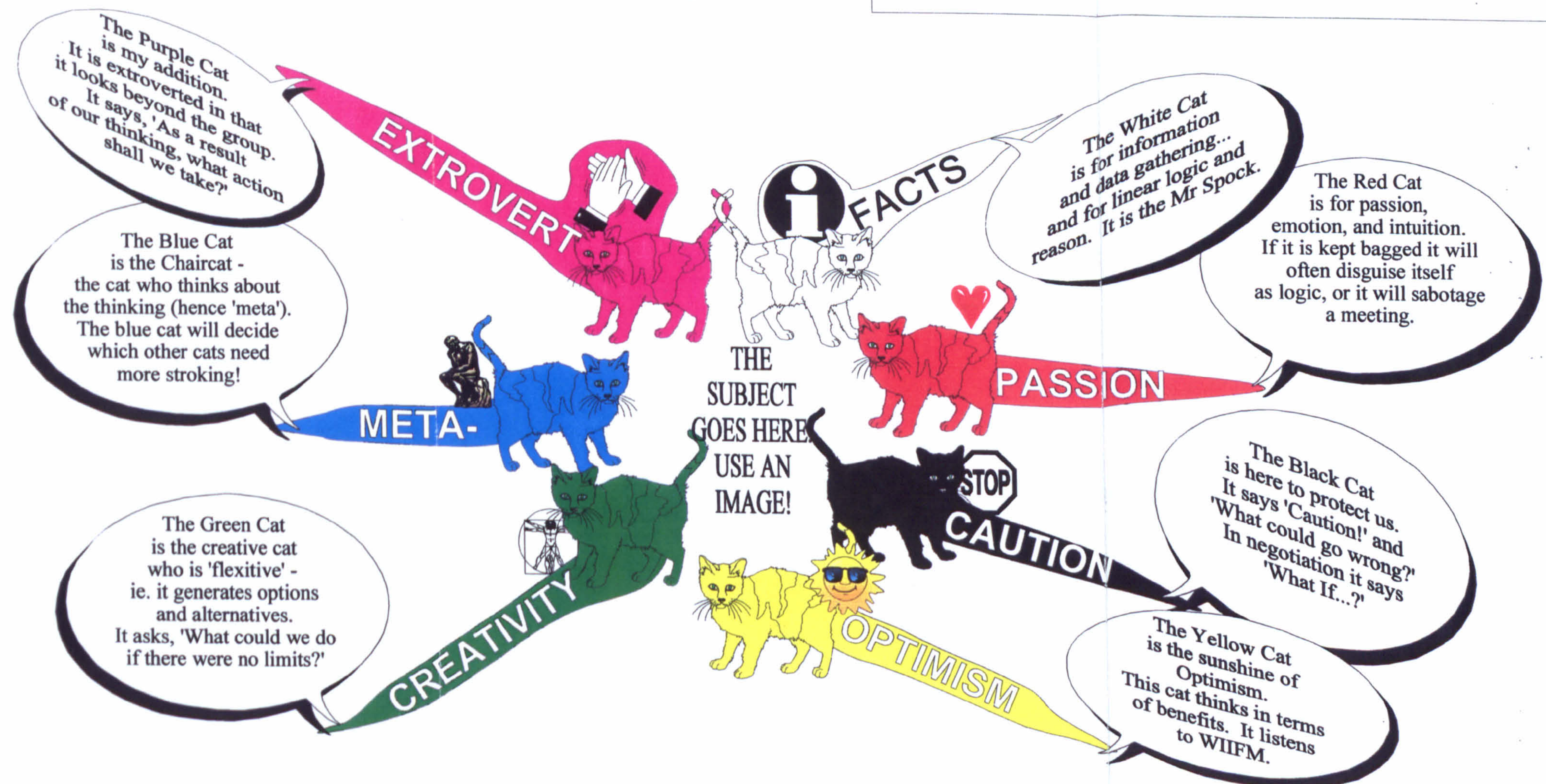
LEO Problem Solving Model



90 minute model - attempt to reach consensus

This technique, used to manage thinking processes, is a combination and development of Edward de Bono's 'Six Thinking Hats' with Tony Buzan's 'Mind Mapping'. Both of the techniques have much wider applications and I direct the reader to the aforementioned authors' books on the two subjects.

The order of the cats on the map is not indicative of the order you should proceed in - the order depends on the subject being debated. The benefit of the map is that you can see in any discussion which cat has been given undue attention, and so balance the map in terms of each cat getting a fair say, or Meeow!



Personally, I put an image of the subject in the centre, and then explicitly declare which cat we are letting out of the bag! When that cat's opinions are exhausted we deliberately return it to the bag and release the next chosen cat. If one of the other cats gets out without permission we can acknowledge that cat and return to the exclusive use of it, or we can bag it again until later.

Members of the team should be encouraged to identify with **ALL** the cats, rather than fixating on their dominant thinking preference. In this way the cats become tools to be used in an egalitarian manner, and so lead to the added benefit of developing each individual's thinking repertoire. The beauty of the technique is that you can direct somebody's thinking without being confrontational; it is easier on both parties to say, 'Can you give me the yellow cat's perspective on that?' rather than, 'Do you think you could stop being so damn negative all the time?'

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Decision making model - 7 Thinking Cats

7 cats are:

Extrovert, chair, creativity, facts, passion, caution and optimism

Derived from Edward De Bono's work on decision making

White - look at facts, data, numbers

Red - emotion, gut feeling, no apology

Black - caution, what if, hold on, risks

Yellow - best scenario, benefits, positives

Green - alternatives, ideas, options, what if

Blue - over above and beyond group, outside, implications

Purple - positive, 'applaudication', all suggestions end on a positive.

Appendix 25 - Decision-Making Workshop Materials

Shared Governance Councils Workshop

June 15th @ 9 am - 4 pm Ratcliffe Arms, Sandy Lane, Rochdale



The focus of the day will be on developing your **DECISION-MAKING SKILLS** in the light of the shared governance decision making research findings and **TEAM BUILDING**

The day will also mark the end of the Shared Governance Research Study!

This event is fully supported by your managers so we hope you will make every effort to attend. Please confirm your attendance by completing the reply slip below:

I WILL/WILL NOT be able to attend the Shared Governance Decision Making Workshop.

NAME

.....

COUNCIL

.....

PLACE OF WORK

.....

Please send replies to Tracey Williamson, Research Fellow, Maternity Offices, BHH as soon as possible. Thank you!

Evaluation Forms Summary

1. How enjoyable did you find the workshop?
Very x 5
Very enjoyable
Extremely x 2
Extremely enjoyable day
2. How well did it meet your expectations?
Very
Very well - gave me much needed motivation
Met expectations
I didn't know what to expect
Fulfilled all my expectations
Better than expected! Really relevant
More than expected
Above and beyond
3. Have you learnt anything about decision making that will help you in your council?
Yes x 3
Lots
Yes - now more clarified
Yes - where do I start - I need that flowchart now!!!
Yes, it seems much clearer
Yes. Tracey's chart 'switched on the light bulb' in our little group (*time ordered matrices*)
4. What key things have you learnt?
Need leads, aims, communicate
Decision making about councils and their work in general
Clarity/importance of other people's roles
Remit, leads, decision making model
How to be more focused
Only take on what we can deliver. Clarity/aims the essential ingredients
Listen, plan, be realistic
Yes the importance of being organised, structured, aware
5. Was the day pitched at the right level?
Yes x 5
Yes - motivating me ++
Yes - it refreshed, revisited and re-motivated me
Definitely
6. Would you recommend the workshop to a colleague?
Yes x 5
Definitely x 2
The world - or everyone in a council

7. Any other comments?

The whole day was extremely beneficial & I learnt a lot and feel much more positive about shared governance and further developments.
Enjoyable and useful.

Thank you for this very informative & enjoyable workshop
Good timing this workshop - going for a job interview next week- great revision.

Thanks it was great - the venue at the end was better than the Ratcliffe

Factors Affecting General Decision Making (Theory)

- Selfish - personal agenda, defending own corner, different view on 'best' decision, appearances
- Lack of consensus
- Easy decisions - limited options, know choice beforehand, familiarity with subject
- Risk element attached to decision, influence of past experience (if learnt from this), having choices & examining these
- Equity - having opportunity to be involved
- Too much choice - can be complex, time consuming, excessive consideration
- Time allowed to make a choice, pressure to make quickly
- Consequences - positive or negative, impact wider than actual decision, immediate or later, knock-on effects
- Time issues - time of day
- Back ground info - research
- Agenda - which agenda the issue is on, where placed on the agenda
- Decisions affected by emotions, peer pressure
- Numbers deciding - balance of people for or against, may need odd numbers
- Support
- Group decisions - large groups may not help, too small a group may not be enough to decide

Factors Actually Affecting Council Decision Making Generated Through Group Work (Matrix Analysis Exercise)

- Helpful - presence of a Facilitator, getting expert knowledge, increasing motivation & maintaining it
- Unhelpful - Lack of support, too much discussion without any outcome, poor attendance, lack of background knowledge, lack of time/manager's approval
- Other Issues - Weaknesses may stand out more than strengths, level of authority, evidence based practice, authority to delegate within council/equity/responsibility of members, responsibility to disseminate to all areas

Processes Affecting Council Decision Making

Issues discussed but not followed through

Deadlines/time scales not set

Importance of having a lead person/no lead identified - at first meeting

The right people around the table - then progress can be made

Appropriate expertise exists within council - if not seek advice early

Didn't invite an informant - at first meeting

Clarification of problem at start

Ensure wheel is not being reinvented ie being done elsewhere

Problems contacting people = delay

Lack of planning/brainstorming

Lack of decisions

No clear aim/no review

No responsibility/ownership

No outcome = reduced motivation

Lack of information/use of a decision making model

Attendance = delay

No continuity - lost momentum/not on agenda

Too vast a subject

Change over of staff - leads leaving

Not asking enough questions about purpose of items

Every time muddled/confused - gather info, have a sub-group or ignore it

ACTION PLAN - Practice Development Council

- **Away day - team building, update knowledge clarify: decision making, shared governance, remit of the council, roles of members**
- **Time - set aside one day, support from managers, support from peers**
- **To utilise the decision making flowchart within the meeting**
- **Chairs meeting - run through issues which council is involved in at moment: clarify/ascertain level of authority**
- **Identify factors that produce a 'snake & ladder' effect and ways of avoiding them**

ACTION PLAN - Educational Development Council

- Identify roles - set ground rules, familiarise, interests/experience, correct environment (non-threatening)
- Council remit - clarity, good communication, brainstorming, contact/support
- Clarify issues - identify (achievable) aims, set short term goals/dates, decision making model
- Identify lead - ?two
- Level of authority
- Informants - at start (background info)
- Leads must liaise with Chair
- Review aims & targets
- Resources/time
- Action - Policy Council, pass & complete

ACTION PLAN - Mental Health Council

For MHC to be very useful and not repeat past mistakes!!

- 'Tracey's chart' to monitor & evaluate progress
- Each green form - use decision making model
- Process facilitator for meaningful reflection & evaluation
- Walk before we can run!!
- Everything we do, we do it for you!!

Appendix 26 - Dissemination Activities

Conference Papers

Williamson T *Shared Governance Baseline Survey Findings*, Bury & Rochdale R&D Conference, Rochdale, May 1999

Williamson T *Practitioner as Researcher: the value of research training fellowships*, RCN Education Forums Conference, Harrogate, February 2000

Williamson T *Action Research: integrating findings into practice*, International Evidence Based Practice Conference, University of Coventry, May 2000

Williamson, T *Evaluation of Shared Governance: an action research approach*, Salford University Post-graduate Research Conference (SPARC), University of Salford, June 2000

Williamson T *Identifying the outcomes of shared governance*, 2nd Salford University Post-graduate Research Conference (SPARC), University of Salford, June 2001

Williamson T *The experience of being a research fellow*, NHS Executive Research Fellows Conference, University of Liverpool, September 2001

Williamson T *Shared Governance: Developing Learning and Practice through Action Research*, 4th RCN Joint Education Forums' Conference, Blackpool, February 2002

Williamson T *Identifying the Impact of LEO on Shared Governance*, Leading an Empowered Organisation Conference, University of Leeds, March 2002

Williamson T *Strengthening Shared Governance Decision Making Through Action Research*, RCN Annual International Nursing Research Conference, Exeter, April 2002

Williamson T *Data Displays as an Aid to Qualitative Data Analysis*, RCN Annual International Nursing Research Conference, Exeter, April 2002

Williamson T *Training for Research: the value of a research training fellowship*, RCN Jobs Fair, Reebok Stadium Bolton, June 2002

Williamson, T *Shared Governance: Final Findings*, Best Practice Day, Pennine Acute Hospitals NHS Trust, November 2002

Williamson, T *Shared Governance: empowering nurses to lead on decision making*, Health Care Events conference, London, January 2003

Williamson T *Data Displays as an Aid to Qualitative Data Analysis*, RCN Annual International Nursing Research Conference, Manchester, April 2003

Other Dissemination

Williamson T *Findings from the evaluation of shared governance in an integrated NHS trust (poster)*, R&D Half Day, Rochdale Healthcare NHS Trust, 20 January 2000

Williamson T *Evaluation of shared governance utilising an action research approach (poster)*, NHS Executive Research Fellows Conference, University of Manchester, 16 February 2000

Hulme C; Clarke S and Williamson T *The experience of being a PhD student (paper)*, Health Care Practice R&D Unit Open Afternoon, University of Salford, 23 March 2000

Williamson T *Findings from the evaluation of shared governance in an integrated NHS trust (poster)*, RCN Research Society Conference, University of Sheffield, 14 April 2000

Williamson T *Evaluation of shared governance (seminar)*, HCPRDU Seminar Series, University of Salford, 19 April 2000

Williamson T *Evaluation of shared governance (paper)*, 2nd Post-Graduate Research Forum, North West BSA Medical Sociology Study Group, Manchester Metropolitan University, 7 June 2000

Williamson T *Findings from the second shared governance survey (repeated paper)*, Rochdale Healthcare NHS Trust, 21 July 2000; 28 September 2000 and 2, 6 October 2000.

Williamson T *Survey to identify the outcomes of shared governance (poster)*, NHS Executive Research Fellows Conference, UMIST, 9 March 2001

Williamson T *Shared governance decision making workshop (full day workshop)*, Rochdale Healthcare NHS Trust, 15 June 2001

Williamson T *Shared governance research study findings (paper)*, Management Club meeting, Rochdale Healthcare NHS Trust, 21 June 2001

Williamson T *Survey to identify the outcomes of shared governance (poster)*, 2nd Salford University Post-graduate Research Conference (SPARC), University of Salford, 26 June 2001

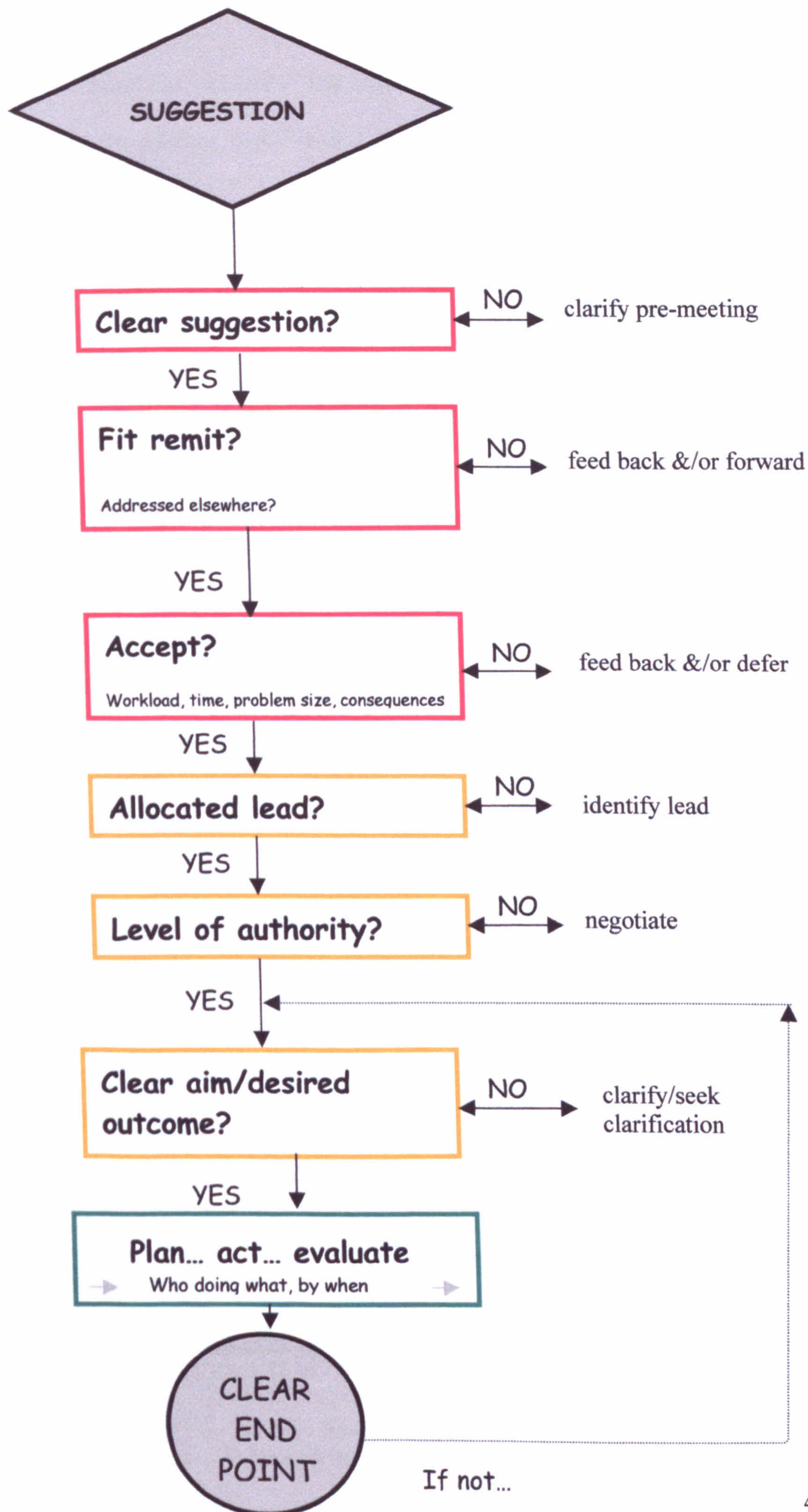
Williamson T *Survey to identify the outcomes of shared governance (poster)*, Salford Royal Hospitals Symposium, University of Salford, 5 July 2001

Williamson T *Developing Knowledge and Practice Through Action Research: the shared governance experience (paper)*, RCN Education Forums North West Network meeting, Bolton RCN HQ, 12 September 2001

Williamson T and Conway A *Spiralling Out of Control: Strengthening shared governance through action research (paper)*, Salford Royal Hospitals Symposium, University of Salford, 1 November 2001

Appendix 27 - Shared Governance Decision-Making Flowchart

Shared Governance Council Decision Making Flowchart



REFERENCES

- Adair, J (1988) *The Action Centred Leader*. The Industrial Society. London.
- Adair, J (1997) *Decision Making and Problem Solving*. Institute of Personnel and Development. London.
- Anderson, G (1990) *Fundamentals of Educational Research*. Falmer Press. London.
- Argyris, C; Putnam, R; and McLain-Smith, D (1985) *Action Science. Concepts, Methods, and Skills for Research and Intervention*. Jossey-Bass Publishers. San Francisco.
- Ash, D; Gavin, M; Wakefield, S; and Wroe, C (1998) *Shared Governance at Doncaster Royal Infirmary and Montagu Hospital NHS Trust: An Evaluation*. University of Sheffield.
- Ashbridge, J (2001) Share deal. *Nursing Standard*, Volume 15, Number 17: 17-18
- Atkins, S and Murphy, K (1993) Reflection: a review of the literature. *Journal of Advanced Nursing*, Volume 18: 1188-1192
- Atkinson, GB; McCarthy, JB; and Phillips, KM (1987) *Studying society: an introduction to social science*. Oxford University Press. Oxford.
- Averill, JB (2002) Matrix Analysis as a Complementary Analytic Strategy in Qualitative Inquiry. *Qualitative Health Research*, Volume 12, Number 6: 855-866
- Bailey, DM (1997) *Research for the Health Professional. A Practical Guide*. F.A.Davis Company. Philadelphia.
- Barbour, RS (1998) Mixing Qualitative Methods: Quality Assurance or Qualitative Quagmire? *Qualitative Health Research*, Volume 8, Number 3: 352-361
- Beck, R; Purdy, N; and Watt, V (1994) Shared governance: A strategy to evolve the profession of nursing. *Registered Nurse*, April/May: 34-35
- Belcher, JVR (1998) Shared Governance Measured by Organizational Culture Change. *The Journal of Shared Governance*, Volume 4, Number 3: 13-15
- Bernreuter, M (1993) The Other Side of Shared Governance. *Journal of Nursing Administration*, Volume 23, Number 10: 12-14
- Boeglin, MJ (1993) Shared Governance. In: Marriner-Tomey, A (Ed). *Transformational Leadership in Nursing*. Mosby-Year Book, Incorporated. St.Louis: 89-100
- Bond, S and Thomas, L (1992) Measuring patient's satisfaction with nursing care. *Journal of Advanced Nursing*, Volume 17: 52-53
- Bonner, A and Tolhurst, G (2002) Insider-outsider perspectives of participant observation. *Nurse Researcher*, Volume 9, Number 4: 7-19

- Bostrom, J and Suter, WN (1993) Research Utilization. Making the Link to Practice. *Journal of Nursing Staff Development*, Volume 9, Number 1: 28-34
- Bromley, DB (1986) *The Case Study Method in Psychology and Related Disciplines*. John Wiley & Sons. Chichester.
- Brooks, F; Mitchell, M; and Pugh, J (1998) Shared Governance as a way to involve staff in decision-making. *Nursing Times*, Volume 94, Number 46: 56-57
- Bryman, A (Ed) (1988) *Doing Research in Organizations*. Routledge. London.
- Buchan, J (1999) Good vibrations. *Nursing Standard*, Volume 13, Number 20: 22-23
- Buchan, J; Ball, J; and O'May, F (1998) *Beyond Hierarchy? An Assessment of the Early Phase of Implementation of the Beyond Hierarchy Initiative at North Staffordshire NHS Trust*. Queen Margaret College. Edinburgh.
- Buchanan, D; Boddy, D; and McCalman, J (1988) Getting in, getting out, and getting back. In: Bryman, A (Ed). *Doing Research in Organizations*. Routledge. London: 53-67
- Burnhope, C and Edmonstone, J (2003) 'Feel the fear and do it anyway': the hard business of developing Shared Governance. *Journal of Nursing Management*, Volume 11: 147-157
- Burrows, DE and McLeish, K (1995) A model for research-based practice. *Journal of Clinical Nursing*. Volume 4: 243-247
- Calnan, M and Gabe, J (2001) From consumerism to partnership? Britain's National Health Service at the turn of the century. *International Journal of Health Services*, Volume 31, Number 1: 119-131
- Caramanica, L and Rosenbecker, S (1991) A pilot approach to Shared Governance. *Nursing Management*, Volume 22, Number 1: 46-48
- Carr, W and Kemmis, S (1986) *Becoming Critical: Education, Knowledge and Action Research*. The Falmer Press. London.
- Carter, D (1996) Quantitative Research. In: *The Research Process in Nursing*. Cormack, D (Ed). Third Edition. Blackwell Science Limited. London: 135-144
- Chisholm, RF and Elden, M (1993) Features of Emerging Action Research. *Human Relations*, Volume 46, Number 2: 275-297
- Clarke, A (2001) Evaluation research in nursing and health care. *Nurse Researcher*, Volume 8, Number 3: 4-14
- Coffey, A and Atkinson, P (1996) *Making Sense of Qualitative Data. Complementary Research Strategies*. Sage Publications, Incorporated.UK.
- Coghlan, D and Casey, M (2001) Action research from the inside: issues and challenges in doing action research in your own hospital. *Journal of Advanced Nursing*, Volume 35, Number 5: 674-682

- Cole, RE (1991) Participant Observer Research. An Activist Role In: Whyte, WF (Ed). *Social Theory for Action. How Individuals and Organizations Learn to Change*. Sage Publications, Incorporated. London: 159-165
- Collins, ME (1996) Successfully Implementing Self-Directed Work Teams in Health Care: Things to Consider, Things to Know. *The Journal of Shared Governance*, Volume 2, Number 2: 17-21
- Conrad, R (2003) Shared Governance as the means to achieve true clinical governance: The Lothian University Hospitals' experience. In: Edmonstone, J (Ed). *Shared Governance: Making it Work*. Kingsham Press. UK: 73-80
- Cooke, S and Slack, N (1991) *Making Management Decisions*. Second Edition. Prentice Hall International (UK) Limited. Hertfordshire.
- Coyne, IT (1996) Parent participation: a concept analysis. *Journal of Advanced Nursing*, Volume 23: 733-740
- Culpepper-Richards, K; Ragland, P; Zehler, J; Dotson, K; Berube, M; Wittenauer-Tygart, M; and Gibson, RA (1999) Implementing a Councillor Model: Process and Outcomes. *Journal of Nursing Administration*, Volume 29, Number 7/8: 19-27
- Cutcliffe, JR (2003) Reconsidering Reflexivity: Introducing the Case for Intellectual Entrepreneurship. *Qualitative Health Research*, Volume 13, Number 1: 136-148
- Davis, PA (1992) Unit-based Shared Governance: Nurturing the Vision. *Journal of Nursing Administration*, Volume 22, Number 12: 46-50
- Dearden, CN and Foster, M (1994) Understanding Business. *Organizational Decision Making*. Third Edition. Longman Group UK Limited. Essex.
- Dearlove, D (1998) *Key Management Decisions. Tools and techniques of the executive decision-maker*. Pitman Publishing. London.
- DeBaca, V; Jones, K; and Tornabeni, J (1993) A Cost-Benefit Analysis of Shared Governance. *Journal of Nursing Administration*, Volume 23, Number 7/8: 50-57
- Delamont, S (1992) *Fieldwork in Educational Settings: Methods, Pitfalls & Perspectives*. The Falmer Press. London.
- Denzin, NK and Lincoln, YS (1994) *Handbook of Qualitative Research*. Sage Publications, Incorporated. London.
- Department of Health (1991) *The Patient's Charter*. HMSO. London.
- Department of Health (1997) *The new NHS – Modern and Dependable*. HMSO. London.
- Department of Health (1998) *A First Class Service – Quality in the New NHS*. HMSO. London.

Department of Health (1999) *A Health Service of All the Talents*. HMSO. London.

Department of Health (2000) *Research and Development for a First Class Service – R&D funding in the new NHS*. HMSO. London.

Department of Health (2001) *Involvement and Reform for NHS Staff – Taking Forward the NHS Plan*. HMSO. London.

Doherty, C and Hope, W (2000) Shared governance – nurses making a difference. *Journal of Nursing Management*, Volume 8: 77-81

Donaldson, LJ and Muir-Gray, JA (1998) Clinical governance: a quality duty for health organisations. *Quality in Health Care*, Volume 7 (Supplement): 37-44

Drisko, JW (2000) *Qualitative Data Analysis: Its Not Just Anything Goes!* Society for Social Work and Research Annual Conference, January 30 2000, Charleston. USA.

Dugger, B (1998) Magnet Recognition, JCAHO Commendation, and Shared Governance. *The Journal of Shared Governance*, Volume 4, Number 1: 11-14

Duncan, SM (1997) Shared Governance: An Innovative Approach to Work Redesign. *The Journal of Shared Governance*, Volume 3, Number 4: 13-16

Edgar, G; Martin, K; and Wilson, A (2003) Shared Governance: what's that? The Development of Shared Governance in Dumfries and Galloway. In: Edmonstone, J (Ed). *Shared Governance: Making it Work*. Kingsham Press. UK: 49-55

Edwards, GB; Farrough, M; Gardner, M; Harrison, D; Sherman, M; and Simpson, S (1994) Unit-Based Shared Governance Can Work! *Nursing Management*, Volume 25, Number 4: 74-77

Elden, M and Levin, M (1991) Cogenerative Learning. Bringing Participation into Action Research. In: Whyte, WF (Ed). *Social Theory for Action. How Individuals and Organizations Learn to Change*. Sage Publications, Incorporated. London: 127-142

Elliot, J (1991) *Action Research for educational change*. Open University Press. Buckingham.

Evan, K; Aubry, K; Hawkins, M; Curley TA; and Porter-O'Grady, T (1995) Whole Systems Shared Governance. A model for the Integrated Health System. *Journal of Nursing Administration*, Volume 25, Number 5: 18-27

Everitt, A; Hardiker, P; Littlewood, J; and Mullender, A (1992) *Applied Research for Better Practice*. Macmillan Press Limited. London.

Fagan, MJ (1991) Can Unit-based Shared Governance Thrive on its own? *Nursing Management*, Volume 22, Number 7: 104L, 104 N-P

Finlay, L (2002) "Outing" the Researcher: The Provenance, Process, and Practice of Reflexivity. *Qualitative Health Research*, Volume 12, Number 4: 531-545

- Fitzsimons, S (1995) Perspectives of a Chief Nurse Executive. *The Journal of Shared Governance*. Volume 1, Number 1: 11-12
- Fontana, A and Frey, JH (1998) Interviewing: The Art of Science. In: Denzin, NK and Lincoln, YS (Eds). *Collecting and Interpreting Qualitative Materials*. Sage Publications, Incorporated. London: 47-48
- Frenn, D and Schuh, D (1995) An Evolving Model of Shared Governance. *The Journal of Shared Governance*, Volume 1, Number 4: 15-20
- Frey, JH & Fontana, A (1997) The Group Interview in Social Research. In: Morgan, DL (Ed). *Focus Groups as Qualitative Research*. Second Edition. Sage Publications, Incorporated. London: 20-35
- Frusti, DK (1996) Perspectives of a Chief Nurse Executive. *The Journal of Shared Governance*, Volume 2, Number 1: 11-12
- Gavin, M; Ash, D; Wakefield, S; and Wroe, C (1999) Shared governance: time to consider the cons as well as the pros. *Journal of Nursing Management*, Volume 7: 193-200
- Geoghegan, J (1995) Caring and Sharing. *Health Services Journal*, 23 November: 33
- Geoghegan, J and Farrington, A (1995) Shared governance: developing a British model. *British Journal of Nursing*, Volume 4, Number 13: 780-783
- George, J (1997) Nurses' Perceived Autonomy in a Shared Governance Setting. *The Journal of Shared Governance*, Volume 3, Number 2: 17-21
- Gibson, CH (1991) A concept analysis of empowerment. *Journal of Advanced Nursing*, Volume 16: 354-361
- Gibson, JL; Ivancevich, JM; and Donnelly, JH (1997) *Organizations. Behaviour, Structure, Processes*. Ninth Edition. Irwin. USA.
- Gill, J and Johnson, P (1997) *Research Methods for Managers*. Second Edition. Paul Chapman Publishing Limited. London.
- Goode, W (2003) The continuing journey: Shared Governance at Kettering General Hospital NHS Trust. In: Edmonstone, J (Ed). *Shared Governance: Making it Work*. Kingsham Press. UK: 57-72
- Gore, C; Murray, K; and Richardson, B (1992) *Strategic Decision-Making*. Cassell. London.
- Graziano, AM and Raulin, ML (1993) *Research Methods. A Process of Inquiry*. Second Edition. Harper Collins College Publishers. New York.
- Greenwood, DJ; Whyte, WF; and Harkavy, I (1993) Participatory Action Research as a Process and as a Goal. *Human Relations*, Volume 46, Number 2: 175-192

Greenwood, J (1993) Reflective practice: a critique of the work of Argyris and Schön. *Journal of Advanced Nursing*, Volume 18: 1183-1187

Guidi, M (1995) Peer-to-Peer Accountability. *Nursing Management*, Volume 26, Number 10: 48R

Hamel, J; Dufour, S; and Fortin, D (1993) *Case Study Methods*. Second Edition. Sage Publications, Incorporated. UK.

Hammersley, M and Atkinson, P (1995) *Ethnography. Principles in Practice*. Second Edition. Routledge. London.

Harré, R (1979) Social Being. *A Theory for Social Psychology*. Basil Blackwell Publisher. Oxford.

Hart, E and Bond, M (1995) *Action research for health and social care. A guide to practice*. Open University Press. Philadelphia.

Heron, J (1996) *Co-operative Inquiry: research into the Human Condition*. Sage Publications, Incorporated. London.

Hess, R (1994) Shared Governance: Innovation or Imitation? *Nursing Economics*, Volume 12, Number 1: 28-34

Hess, R (1995) Shared Governance. Nursing's 20th-Century Tower of Babel. *Journal of Nursing Administration*, Volume 25, Number 5: 14-17

Hess, R (1998) Measuring Nursing Governance. *Nursing Research*, Volume 47, Number 1: 35-42

Hibberd, JM; Storoz, CE; and Andrews, HA (1992) Implementing Shared Governance: A False Start. *Nursing Clinics of North America*, Volume 27, Number 1: 11-22

Hicks, C (1995) The shortfall in published research: a study of nurses' research and publication activities. *Journal of Advanced Nursing*, Volume 21: 594-604

Hokanson-Hawks, J (1991) Power: a concept analysis. *Journal of Advanced Nursing*, Volume 16: 754-762

Holter, IM & Schwartz-Barcott, D (1993) Action research: what is it? How long has it been used and how can it be used in nursing? *Journal of Advanced Nursing*, Volume 18: 298-304

Horstman, P and Zlokas, M (1995) Policy, Procedure and Standards of Practice Development Through Shared Governance. *The Journal of Shared Governance*, Volume 1, Number 1: 21-24

Hundley, V; Milnes, J; Leighton-Beck, L; Graham, W and Fitzmaurice, A (2000) Raising Research Awareness among Midwives and Nurses: does it work? *Journal of Advanced Nursing*, Volume 31, Number 1: 78-88

- Hunter, A; Lusardi, P; Zucker, D; Jacelon, C; and Chandler, G (2002) Making Meaning: The Creative Component in Qualitative Research. *Qualitative Health Research*, Volume 12, Number 3: 388-398
- Ireson, CL and McGillis, G (1998) A Multidisciplinary Shared Governance Model. *Nursing Management*, Volume 29, Number 2: 37-39
- Jacoby, J (1995) Perspectives of a Chief Nurse Executive, *The Journal of Shared Governance*, Volume 1, Number 3: 9-10
- Jacoby, J and Terpstra, M (1990) Collaborative Governance: Model for Professional Autonomy. *Nursing Management*, Volume 21, Number 2: 42-44
- Jenkins, J (1988) A Nursing Governance and Practice Model: What Are the Costs? *Nursing Economics*, Volume 6, Number 6: 302-311
- Jenkins, J (1993) Organizational Community is Cost-Effective. *Seminars for Nurse Managers*, Volume 1, Number 2: 101-105
- Johnson, M (1999) Observations on positivism and pseudoscience in qualitative nursing research. *Journal of Advanced Nursing*, Volume 30, Number 1: 23-29
- Johnson, M; Long, T; and White, A (2001) Arguments for 'British Pluralism' in qualitative health research. *Journal of Advanced Nursing*, Volume 33, Number 2: 243-249
- Joiner, G (1996) Learning to Lead Through the Process of Shared Governance. *The Journal of Shared Governance*, Volume 2, Number 1: 19-21
- Jones, L (1995) Consultant's Corner. *The Journal of Shared Governance*, Volume 1, Number 4: 11-12
- Karlsen, JI (1991) Action Research as Method. Reflections from a Program for Developing Methods and Competence. In: Whyte, WF (Ed). *Social Theory for Action. How Individuals and Organizations Learn to Change*. Sage Publications, Incorporated. London: 143-158
- Kemmis, S and McTaggart, R (1988) *The Action Research Planner*. Third Edition, Deakin University Press. Australia.
- Kennerly, SM (1996) Author's Response. (Letter). *Nursing Economics*, Volume 14, Number 4: 255
- Kerfoot, KM and Uecker, S (1992) The Techniques of Self-Managed Teams: The Nurse Manager's Role. *Nursing Economics*, Volume 10, Number 1: 70-71, 78
- Kidd, PS and Parshall, MB (2000) Getting the Focus and the Group: Enhancing Analytical Rigour in Focus Group Research. *Qualitative Health Research*, Volume 10, Number 3: 293-308

- Kitson, A; Harvey, G; and McCormack, B (1998) Enabling the implementation of evidence based practice: a conceptual framework. *Quality in Health Care*, Volume 7: 149-158
- Kitzinger, J (1995) Qualitative Research: Introducing focus groups. *British Medical Journal*, Volume 311: 299-302
- Koontz, H and Weihrich, H (1990) *Essentials of Management*. Fifth Edition. McGraw-Hill, Incorporated. USA.
- Kvale, S (1996) *Interviews. An Introduction to Qualitative Research Interviewing*. Sage Publications, Incorporated. London.
- LaFoy, L (1993) Operational Restructuring: Implementing a Model Within a Shared Governance Framework. *Seminars for Nurse Managers*, Volume 1, Number 2: 84-90
- Lathlean, J (1994) Choosing an appropriate methodology. In: Buckeldee, J and McMahon, R (Eds). *The Research Experience in Nursing*. Chapman & Hall. London: 31-46
- Legg, S and Hennessey, M (1996) Fair shares in practice? *Nursing Management*, Volume 2, Number 8: 6-7
- Le May, A; Alexander, C; and Mulhall, A (1998) Research utilization in nursing: barriers and opportunities. *Journal of Clinical Effectiveness*, Volume 3, Number 2: 59-63
- Levy, P and Brady, T (1996) Learning through action and research. *The Learning Organization*, Volume 3, Number 5: 32-37
- Lewin, K (1946) Action research and minority problems. In: Lewin, GW (Ed) (1973). *Resolving Social Conflicts: Selected Papers on Group Dynamics by Kurt Lewin*. Harper and Row Publishers. USA: 201-216
- Lincoln, YS and Guba, EG (1985) *Naturalistic Inquiry*. Sage Publications, Incorporated. London.
- Lofland, J and Lofland, LH (1995) *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis*. Third Edition. Wadsworth Publishing Company. London.
- Lorange, P (1996) Developing learning partnerships. *The Learning Organization*, Volume 3, Number 2: 11-19
- Lyon, J (1998) Applying Hart and Bond's typology: implementing clinical supervision in an acute setting. *Nurse Researcher*, Volume 6, Number 2: 39-56
- Marrow, C (1998) Keeping above the surface in an action research study. *Nurse Researcher*, Volume 6, Number 2: 57-70
- Marshall, C and Rossman, GB (1989) *Designing Qualitative Research*. Sage Publications, Incorporated. London.

- Martin, PA (1995) Evaluation of Shared Governance. *The Journal of Shared Governance*, Volume 1, Number 3: 11-16
- Matta, CB (1998) Power: Effective Distribution. *The Journal of Shared Governance*, Volume 4, Number 1: 15-17
- Maurer, GM (1995) True Empowerment: from Shared Governance to Self-managed Work Groups on a Patient Care Unit. *The Journal of Shared Governance*, Volume 1, Number 1: 25-27
- May, T (1993) *Social Research: Issues, method and process*. Open University Press. Buckingham.
- May, T (1997) *Social Research: Issues, method and process*. Second Edition. Open University Press. Buckingham.
- Mays, N and Pope, C (1995) Qualitative Research: Rigour and qualitative research. *British Medical Journal*, Volume 311: 109-112
- McDonagh, KJ; Rhodes, B; Sharkey, K; and Goodroe, JH (1989) Shared governance at Saint Joseph's Hospital of Atlanta: A mature professional practice model. *Nursing Administration Quarterly*, Volume 13, Number 4: 17-28
- McDonnell, A; Lloyd-Jones, M; and Read, S (2000) Practical considerations in case study research: the relationship between methodology and process. *Journal of Advanced Nursing*, Volume 32, Number 2: 383-390
- McGarvey, HE (1993) Participation in the research process. *Action research in nursing. Professional Nurse*, March 1993: 372-376
- McGill, I and Beaty, L (1995) *Action Learning: A guide for professional, management and educational development*. Second Edition. Kogan Page Limited. London.
- McNiff, J (1988) *Action Research: Principles and Practice*. Macmillan Education Limited. London.
- McNiff, J; Lomax, P; and Whitehead, J (1996) *You and Your Action Research Project*. Routledge. London.
- Meade, RL (1995) *How to empower an organization: Unleash the latent power of our workforce from goals to action*. Lakewood Publications, Incorporated. Minneapolis.
- Merrell, J and Williams, A (1994) Participant observation and informed consent: relationships and tactical decision making in nursing research. *Nursing Ethics*, Volume 1, Number 3: 163-172
- Merriam, SB (1988) *Case Study Research in Education: a Qualitative Approach*. Jossey-Bass Publishers. San Francisco.
- Meyer, J (1993) New paradigm research in practice: the trials and tribulations of action research. *Journal of Advanced Nursing*, Volume 18: 1066-1072

- Meyer, J (2000) Using qualitative methods in health related action research. *British Medical Journal*, Volume 320: 178-81
- Meyer, J and Batehup, L (1997) Action research in health-care practice: Nature, present concerns and future possibilities. *NT Research*, Volume 2, Number 3: 175-184
- Miles, MB and Huberman, AM (1994) *An Expanded Sourcebook. Qualitative Data Analysis*. Second Edition. Sage Publications. Lodon.
- Miller, N (1997) How To Find The Organization That Fits, And Won't Give You Fits. *The Journal of Shared Governance*, Volume 3, Number 3: 5-8
- Miller, SJ; Hickson, DJ; and Wilson, DC (1999) Decision-Making in Organizations. In: Clegg, SR; Hardy, C; and Nord, WR (Eds). *Managing Organizations. Current Issues*. Sage Publications Limited. London: 43-62
- Minors, SP; White, JB; and Porter-O'Grady, T (1996) Assessing Shared Governance: An Example of Instrument Development in a Hospital Setting. *Current Topics in Management*, Volume 1: 187-198
- Mintzberg, H; Raisinghani, D; and Théorêt, A (1976) The Structure of "Unstructured" Decision Processes. *Administrative Science Quarterly*, Volume 21: 246-275
- Mitchell, M; Brooks, F; and Pugh, J (1999) Balancing nurse empowerment with improved practice and care: An evaluation of the impact of shared governance. *NT Research*, Volume 4, Number 3: 192-200
- Moore, L and Savage, J (2002) Participant observation, informed consent and ethical approval. *Nurse Researcher*, Volume 9, Number 4: 758-69
- Morgan, DL and Krueger, RA (1997) When to Use Focus Groups and Why. In: Morgan, DL (Ed). *Focus Groups as Qualitative Research*. Second Edition. Sage Publications, Incorporated. London: 3-34
- Morgan, G (1986) *Images of Organization*. Sage Publications, Incorporated. London.
- Morris, MA and Smith, S (1993) The Empowerment Investment: What is the Return? *Seminars for Nurse Managers*, Volume 1, Number 2: 74-76
- Morrison, RS and Peoples, L (1999) Using Focus Group Methodology in Nursing. *The Journal of Continuing Education in Nursing*, Volume 30, Number 2: 62-65
- Morse, JM (1994) Designing Funded Qualitative Research. In: Denzin, NK and Lincoln, YS (Eds). *Handbook of Qualitative Research*. Sage Publications. London: 220-235
- Morse, J and Field, P (1996) *Nursing Research. The application of qualitative approaches*. Second Edition. Chapman and Hall. London.
- Motz, D and Lewis, J (1994) Shared Governance: Is It a Catalyst of Change? *Journal of Burn Care & Rehabilitation*, Volume 15, Number 4: 375-385

- Mulhall, A (1997) Nursing research: our world or theirs? *Journal of Advanced Nursing*, Volume 25: 969-970
- Naish, J (1995) Give up your power. *Nursing Management*, Volume 2, Number 6: 6-7
- Naish, J (1997) Natural born leader? *Nursing Times*, Volume 93, Number 51: 58-61
- National Co-ordinating Centre for NHS Service Delivery and Organisation Research & Development (2001) *Managing Change in the NHS. Making Informed Decisions on Change. Key Points for Health Care Managers and Professionals*. NCCSDO. London.
- NHS Executive (1998) *Handling Inventions and other Intellectual Property: A Guide for NHS Researchers*. HMSO. London.
- Nisbet, JD and Watt, J (1984) Case Study. In: Bell, J; Bush, T; Fox, A; Goodey, J; and Goulding, S (Eds). *Conducting Small-scale Investigations in Educational Management*. Paul Chapman Publishing Limited. London: 72-92
- Nolan, M and Grant, G (1993) Action research and quality of care: a mechanism for agreeing basic values as a precursor to change. *Journal of Advanced Nursing*, Volume 18: 305-311
- O'Brien-King, M and Pettigrew, A (1996) How To Better Understand Yourself and Your Work Team for Effective Shared Governance. *The Journal of Shared Governance*, Volume 2, Number 4: 17-22
- O'Malley, J (1992) Organizational Empowerment: Moving Shared Governance beyond Nursing. *Aspen's Advisor for Nurse Executives*, Volume 7, Number 12: 1-5
- Paden, KK (1998) Decision Making and Shared Governance: Use of the Myers-Briggs Type Indicator. *The Journal of Shared Governance*, Volume 4, Number 4: 13-20
- Parahoo, K (1997) *Nursing Research. Principles, process and issues*. Palgrave Macmillan. Basingstoke.
- Parahoo, K (2000) Barriers to, and facilitators of, research utilization among nurses in Northern Ireland. *Journal of Advanced Nursing*, Volume 31, Number 1: 89-98
- Patton, MQ (1990) *Qualitative Evaluation and Research Methods*. Second Edition. Sage Publications, Incorporated. London.
- Pauker, SP and Pauker, SG (1999) What is a good decision? *Journal of Clinical Effectiveness*, Volume 2: 194-196
- Pearn, M; Roderick, C; and Mulrooney, C (1995) *Learning Organizations in Practice*. McGraw-Hill Book Company. London.
- Petts, S (2000) *Council Activity Sheet Analysis Report January 1999 to May 2000*. Rochdale Healthcare NHS Trust. Rochdale.
- Pheysey, DC (1993) *Organizational Cultures*. Routledge. London.

- Pinkerton, S and Schroeder, P (1988) *Commitment to excellence. Developing a professional Nursing staff*. Rockville, MD. Aspen Publishers.
- Polit, D and Hungler, B (1993) *Essentials of Nursing Research, Methods, Appraisals, and Utilization*. Third Edition. J.B.Lippincott Company. Philadelphia.
- Popay, J; Rogers, A; and Williams, G (1998) Rationale and Standards for the Systematic Review of Qualitative Literature in Health Services Research. *Qualitative Health Research*, Volume 8, Number 3: 341-351
- Porter-O'Grady, T (1987) Shared Governance and New Organizational Models. *Nursing Economics*, Volume 5, Number 6: 281-286
- Porter-O'Grady, T (1991a) Shared Governance for Nursing: A Model for Professional Growth. *Emphasis Nurse*, Volume 4, Number 1: 14-22
- Porter-O'Grady, T (1991b) Shared Governance for Nursing. Part 1: Creating the New Organization. *AORN Journal*, Volume 53, Number 2: 459-464
- Porter-O'Grady, T (1991c) Shared Governance for Nursing. Part 2: Putting the Organization into Action. *AORN Journal*, Volume 53, Number 3: 694-703
- Porter-O'Grady, T (1992a) Writing our own script: some thoughts about Shared Governance. *ACORN Journal*, September 1992: 43-46
- Porter-O'Grady, T (1992b) Of Quorums and Quality: Integrating Shared Governance and Continuous Quality Improvement. *Aspen's Advisor for Nurse Executives*, Volume 7, Number 10: 6-8
- Porter-O'Grady, T (1994a) A Systems Approach to Managing Transformation. *Seminars for Nurse Managers*, Volume 2, Number 4: 191-194
- Porter-O'Grady, T (1994b) Whole Systems Shared Governance: Creating the Seamless Organization. *Nursing Economics*, Volume 12, Number 4: 187-195
- Porter-O'Grady, T (1995a) From Principles to Practice: Whole Systems Shared Governance. *The Journal of Shared Governance*, Volume 1, Number 3: 21-24
- Porter-O'Grady, T (1995b) Guest Editorial. *The Journal of Shared Governance*, Volume 1, Number 2: 6
- Porter-O'Grady, T (1996a) Multidisciplinary Shared Governance: The Next Step. *Seminars for Nurse Managers*, Volume 4, Number 1: 43-48
- Porter-O'Grady, T (1996b) More Thoughts on Shared Governance. (Letter). *Nursing Economics*, Volume 14, Number 4: 254-255
- Porter-O'Grady, T (1997) Process Leadership and the Death of Management. *Nursing Economics*, Volume 15, Number 6: 286-293
- Porter-O'Grady, T (1998a) So You've Heard About Empowerment. *Journal of Shared Governance*, Volume 4, Number 2: 13-17

- Porter-O'Grady, T (1998b) *A Masterclass with Dr Tim Porter-O'Grady*. Rochdale Healthcare NHS Trust Conference. November 17 1999, The Village Hotel, Stockport.
- Porter-O'Grady, T and Finnegan, S (1984) *Shared governance for nursing*. Rockville, MD. Aspen, USA.
- Porter-O'Grady, T and Hess, R (1996) Perspectives on Shared Governance. *The Journal of Shared Governance*, Volume 2, Number 4: 11-15
- Porter-O'Grady, T and Tornabeni, J (1993) Outcomes of Shared Governance: Impact on the Organization. *Seminars for Nurse Managers*, Volume 1, Number 2: 63-73
- Powell, J (1991) Reflection and the evaluation of experience: prerequisites for therapeutic practice. In: McMahon, R and Pearson, A (Eds). *Nursing as Therapy*. Chapman & Hall. London: 26-42
- Prince, SB (1997) Shared Governance: Sharing Power and Opportunity. *Journal of Nursing Administration*, Volume 27, Number 3: 28-35
- Punch, M (1994) Politics and Ethics in Qualitative Research. In: Denzin, NK and Lincoln, YS (Eds). *Handbook of Qualitative Research*. Sage Publications. London: 83-98
- Rapoport, RN (1970) *Three Dilemmas in Action Research*. Human Relations, Volume 23, Number 6: 499-513
- Reason, P (1999) Integrating Action and Reflection Through Co-operative Inquiry. *Management Learning*, Volume 30, Number 2: 207-226
- Reason, P (2000) Inquiry & Participation in Search of a World Worthy of Human Aspiration. In: Reason P and Bradbury, H (Eds). *Handbook of Action Research*. Sage Publications: 1-14
- Reason, P and Marshall, J (1987) Research as Personal Process. In: Boud, D and Griffin, V (Eds). *Appreciating adults learning: from the learners' perspective*. Kogan Page. London. Pp 112-126
- Reis, D and Sturis, I (1995) Focusing Shared Governance on Patient Care. *Journal of Shared Governance*, Volume 1, Number 2: 11-15
- Robson, C (1993) *Real World Research. A Resource for Social Scientists and Practitioner-Researchers*. Blackwell Publishers. UK.
- Robson, C (2002) *Real World Research. A Resource for Social Scientists and Practitioner-Researchers*. Second Edition. Blackwell Publishers. UK.
- Rodgers, BL (1989) Concepts, analysis and the development of nursing knowledge: the evolutionary cycle. *Journal of Advanced Nursing*, Volume 14, Number 4: 330-335
- Rodgers, S (1994) An exploratory study of research utilization by nurses in general medical and surgical wards. *Journal of Advanced Nursing*, Volume 20: 904-911

- Rodwell, CM (1996) An analysis of the concept of empowerment. *Journal of Advanced Nursing*, Volume 23: 305-313
- Rolfe, G (1996) Going to extremes: action research, grounded practice and the theory-practice gap in nursing. *Journal of Advanced Nursing*, Volume 24: 1315-1320
- Rose, G (1982) *Deciphering Sociological Research*. Macmillan Education Limited. London.
- Rousseau, DM and Fried, Y (2001) Location, location, location: contextualizing organizational research. *Journal of Organizational Behaviour*, Volume 22: 1-13
- Rusch, L (1998) Shared Governance: Redefining Ourselves for the New Millenium. *The Journal of Shared Governance*, Volume 4, Number 1: 9-10
- Sánchez-Jankowski, M (2002) Representation, Responsibility and Reliability in Participant-observation. In: May, T (Ed). *Qualitative Research in Action*. Sage Publications Limited. London: 144-160
- Scally, G and Donaldson, LJ (1998) Clinical governance and the drive for quality improvement in the new NHS in England. *British Medical Journal*, Volume 317: 61-65
- Schön, DA (1991) *The Reflective Practitioner: How Professionals Think in Action*. Second Edition. Ashgate Publishing Limited. Aldershot.
- Schoonover-Shoffner (1989) Improving Work group Decision-Making Effectiveness. *Journal of Nursing Administration*, Volume 19, Number 7: 10-16, 30
- Scriven, M (1994) The Fine Line between Evaluation and Explanation. *Evaluation Practice*, Volume 15, Number 1: 75-77
- Seaquist, DR (1998) Perspectives of a Chief Nurse Executive. *The Journal of Shared Governance*, Volume 4, Number 2: 7-8
- Searson, F (2000) Introducing Bedside Handovers: changing practice on a coronary care unit. *Educational Action Research*, Volume 8, Number 2: 291-305
- Shadley, PK and Gossett, LM (1997) Unit Based Councils: An Evolutionary Process. *The Journal of Shared Governance*, Volume 3, Number 4: 17-20
- Sharp, K (1998) The case for case studies in nursing research: the problem of generalization. *Journal of Advanced Nursing*, Volume 27: 785-789
- Sibbald, B and Roland, M (1997) Getting research into practice. *Journal of Evaluation in Clinical Practice*, Volume 3, Number 1: 15-21
- Slevin, O (1995) Theories and Models. In: Basford, L; Slevin, O; Arets, J; Burgin, D; Gormley, K; Horton, R; James, J; Kirby, C; Maslen, B; Morle, K; Sinclair, M; Sines, D; and Vaessen, J (Eds). *Theory and Practice of Nursing. An Integrated Approach to Patient Care*. Campion Press Limited. Edinburgh: 188-205

- Smith, A (1998) Learning about reflection. *Journal of Advanced Nursing*, Volume 28, Number 4: 891-898
- Smith, G and Cantley, C (1985) *Assessing Health Care: a study in organizational evaluation*. Open University Press. Milton Keynes.
- Smith, MW (1995) Ethics in Focus Groups. *Qualitative Health Research*, Volume 5, Number 4: 478-486
- Smith, S (1990) Evaluating a Shared Governance Model. *Aspen's Advisor for Nurse Executives*, Volume 5, Number 9: 4-7
- Stake, R (1995) *The Art of Case Study Research*. Sage Publications, Incorporated. UK.
- Stake, R (1998) Case Studies. In: Denzin, NK and Lincoln, YS (Eds). *Strategies of Qualitative Inquiry*. Sage Publications, Incorporated. London: 86-109
- Strauss, A and Corbin, J (1998) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Second Edition. Sage Publications, Incorporated. London.
- Susman, GI and Evered, RD (1978) An Assessment of the Scientific Merits of Action Research. *Administrative Science Quarterly*, December 1978, Volume 23: 582-603
- Taylor, GA (1978) Decision making in Nursing: An Analytical Approach. *Journal of Nursing Administration*, Volume 8, Number 11: 22-30
- The Open University (1991) *Managing Health Services: Decision Making and Planning*. Book 2. The Open University. Milton Keynes.
- Thomson, MA (1998) Closing the gap between nursing research and practice. *Evidence-Based Nursing*, Volume 1, Number 1: 7-8
- Thrasher, T; Bossman, V; Carroll, S; Cook, B; Cherry, K; Kopras, S; Daniels, L; and Schaffer, P (1992) Empowering the clinical nurse through quality assurance in a shared governance setting. *Journal of Nursing Care Quarterly*, Volume 6, Number 2: 15-19
- Titchen, A (1995) Issues of validity in action research. *Nurse Researcher*, Volume 2, Number 3: 38-48
- Titchen, A and Binnie, A (1993a) Research partnerships: collaborative action research in nursing. *Journal of Advanced Nursing*, Volume 18: 858-865
- Titchen, A and Binnie, A (1993b) What am I meant to be doing? Putting practice into theory and back again in new nursing roles. *Journal of Advanced Nursing*, Volume 18: 1054-1065
- Trueman, JA and Turkeltaub, MK (1993) Credentialing and Privileging: Accountability for Professional Practice. *Seminars for Nurse Managers*, Volume 1, Number 2: 91-95

Veeramah, V (1995) A study to identify the attitudes and needs of qualified staff concerning the use of research findings in clinical practice within mental health care settings. *Journal of Advanced Nursing*, Volume 22: 855-861

Vroom, VH and Yetton, PW (1973) *Leadership and Decision-Making*. University of Pittsburgh Press. USA.

Walker, LO and Avant, KC (1988) *Strategies for Theory Construction in Nursing*. Second Edition. Appleton & Lange. USA.

Walker, P (1994) Dollars and Sense in Health Reform: Interdisciplinary Practice and Community Nursing Centers. *Nursing Administration Quarterly*, Volume 19, Number 1: 1-11

Waterman, H (1995) Distinguishing between 'traditional' and action research. *Nurse Researcher*, Volume 2, Number 3: 15-23

Waterman, H (1996) A comparison between quality assurance and action research. *Nurse Researcher*, Volume 3, Number 3: 58-68

Waterman, H; Tillen, D; Dickson, R; and de Koning, K (2001) Action research: a systematic review and guidance for assessment. *Health Technology Assessment*, Volume 5, Number 23.

Waterworth, S and Luker, K (1990) Reluctant collaborators - do patients want to be involved in decisions concerning care? *Journal of Advanced Nursing*, Volume 15, Number 8: 971-976

Watts, B and Jones, S (2000) Inter-professional Practice and Action Research: commonalities and Parallels. *Educational Action Research*, Volume 8, Number 2: 377-382

Webb, C (1989) Action research: philosophy, methods and personal experiences. *Journal of Advanced Nursing*, Volume 14: 403-410

Webb, C and Kevern, K (2001) Focus groups as a research method: a critique of some aspects of their use in nursing research. *Journal of Advanced Nursing*, Volume 33, Number 6: 798-805

Westrope RA; Vaughn L; Bott M; and Taunton RL (1995) Shared Governance from Vision to Reality. *Journal of Nursing Administration*, Volume 25, Number 12: 44-54

Whyte, WF (1984) *Learning from the Field: A Guide from Experience*. Sage Publications. London.

Whyte, WF (1991) (Ed) *Social Theory for Action. How Individuals and Organizations Learn to Change*. Sage Publications, Incorporated. London.

Wilkinson, J (1997) Developing a concept analysis of autonomy in nursing practice. *British Journal of Nursing*, Volume 6, Number 12: 45-54

Williams, A (1995) Ethics and action research. *Nurse Researcher*, Volume 2, Number 3: 49-59

Williamson, G and Prosser, S (2003) Illustrating the ethical dimensions of action research. *Nurse Researcher*, Volume 10, Number 2: 38-49

Williamson, T (2003a) Building the evidence base for Shared Governance: The Rochdale experience. In: Edmonstone, J (Ed). *Shared Governance: Making it Work*. Kingsham Press. UK: 81-89

Williamson, T (2003b) Shared Governance: *Empowering Nurses to Lead on Decision-Making*. Healthcare Events Conference: Developing Nursing Empowerment, Shared Governance and Effective Leadership. February 19 2003, Royal College of Surgeons, London.

Williamson, T and Petts, S (2000) *Shared Governance Survey Report: Evaluation of the Implementation of Shared Governance in an Integrated NHS Trust*. Rochdale Healthcare NHS Trust/University of Salford.

Williamson, T; Taylor, S; and Petts, S (2001) Assessing Leadership Development Training. *Nursing Times*, Volume 97, Number 36: 42-43

Yamauchi, SS (1994) Professional Governance. *Nursing Administration Quarterly*, Volume 19, Number 1: 37-43

Yin, RK (1994) *Case Study Research. Design and Methods*. Second Edition. Sage Publications. London.

Yin, RK (1999) Enhancing the Quality of Case Studies in Health Services Research. *Health Services Research*, Volume 34, Number 5, Part 2: 1209-1224

Zelauskas, B and Howes, DG (1992) The Effects of Implementing a Professional Practice Model. *Journal of Nursing Administration*, Volume 22, Number 7: 18-23

ON-LINE REFERENCES

Catterall, M and Maclaran, P (1997) Focus Group Data and Qualitative Analysis Programs: Coding the Moving Picture as Well as the Snapshot. *Sociological Research* [Online]. Volume 2, Number 1. Paras 2.1, 3.6 Available at <http://www.socresonline.org.uk/socresonline/2/1/6.html> (Accessed December 12 2003)

Dick, B (1997) *Participative processes* [On line]. Available at <http://www.scu.edu.au/schools/gcm/ar/arp/partproc.html> (Accessed December 12 2003)

Dick, B (1999) *Action research and publication* [On line]. Available at <http://www.scu.edu.au/schools/gcm/ar/arp/research.html> (Accessed December 12 2003)

Dick, B (2000) *Data-driven action research* [On line]. Available at <http://www.scu.edu.au/schools/gcm/ar/arp/datadriv.html> (Accessed December 12 2003)

Dick, B and Dalmau, T (1997) *Gaining involvement and participation* [On line]. Available at <http://www.scu.edu.au/schools/gcm/ar/arp/involv.html> (Accessed December 12 2003)