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

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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.

CHAPTER 1

INTRODUCTION

This thesis explores and examines shared governance (SG) decision-making. SG is an approach to organising and managing nursing work based on the principles of empowerment, responsibility, authority and accountability. Prior to exploring in detail what SG is (Chapter 2), this chapter begins in Part 1 by outlining the wider context around SG decision-making whilst Part 2 provides material to illuminate the context within which this case study is set.

PART 1 - Policy Context

Quality

In recent years we have seen many changes in the way the National Health Service (NHS) is both governed and delivered, and a growing interest in quality issues. Lack of true multi-disciplinary collaboration, and decisions being made by managers often far removed from the sharp end of patient care, have added to the difficulty of providing quality care with limited resources. This has led to an interest in placing the responsibility for quality of care firmly in the hands of the clinicians as organisations have sought new ways to meet the pressures placed upon them.

Leadership

The need to develop clinical leaders has been highlighted in many recent United Kingdom (UK) health care reforms (Department of Health 1997; Department of Health 1998; Department of Health 2000). As the pre-occupation with the concept of leadership grows, so does the popularity of SG. For SG to succeed, such a framework is dependent on a workforce that is empowered and which demonstrates effective leadership skills, knowledge and attitudes. Hence SG implementation can be expected to coincide with substantive leadership development work.

Involvement

Central to the philosophy of SG is the involvement of staff in decisions concerning practice. Furthermore, there is an expectation that through SG, staff will meaningfully contribute to and so influence their employing organisations' corporate agenda. Such moves have been further fuelled by the notion of consumerism which forms a major theme of NHS-related government policy (Calnan & Gabe 2001).

Seeking consumer and staff opinion influences both service planning and public relations (Bond & Thomas 1992). It is becoming increasingly popular to involve stakeholders in the decision-making process in organisations that have a consumer-provider interface (Waterworth & Luker 1990). *The Patient's Charter* (Department of Health 1991) has been a key document in directing the NHS to be more responsive to patient views and encouraging of their involvement in decisions relevant to them. Similarly, health care professionals are increasingly being involved in decisions concerning the way services are organised and delivered as their perspectives from the practice setting are recognised as being valuable in informing the development of efficient and effective services that meet the patients' needs. However, a tension exists between the growing popularity of consumerist approaches to involvement in decision-making and the reality of how that involvement is realised in practice.

Evidence-Based Practice

The evidence-based practice movement seen in recent years has resulted in a climate where health care professionals are increasingly required to justify their practice. This is because one of the basic assumptions about evidence-based practice is that clinicians directly affect patient outcomes. Clinical governance and the clinical effectiveness movement of recent years have promulgated this relationship between individual practices and impacts on care outcomes. Thus there is growing recognition of the part played by practitioners in the achievement of organisational goals.

Clinical Governance

Clinical governance was unveiled in the late Nineties as the compulsory framework through which health care organisations would fulfil much of the Government's agenda

for quality improvement (Department of Health 1998). Key components include the need for continuous improvement in the quality of patient care, clinical leadership, professional self-regulation and the recognition and replication of good practice (Scally & Donaldson 1998). The general aim of clinical governance is to reduce variability in care received by patients (Donaldson & Muir-Gray 1998). For this to be achieved, individuals will also be held personally responsible for their standards of practice. However, clinical governance will not succeed unless organisations foster a climate of practice development and develop a non-blame culture so that previous mistakes can be learnt from, leading to continual improvement. This is a tall order for many organisations that have previously been dominated by a 'command and control' style of management. Organisations' leaders are therefore intent on attracting, retaining and developing high calibre staff in the hope that this will in turn lead to the achievement of a learning organisation that is needed for clinical governance to thrive (Donaldson & Muir-Gray 1998). SG is commonly viewed as the (optional) supporting framework through which (mandatory) clinical governance objectives will be achieved.

Empowerment

The need to empower health service staff has been expounded within healthcare policy over the last decade in particular. This has stemmed from recognition that staff need to be better positioned and equipped if they are to truly inform decisions and influence standards of care and thus need power to be transferred to them (Department of Health 2001). As a result of being more engaged, staff are expected to impact positively on quality of care (Department of Health 1998) and be better prepared for their roles (Department of Health 1999). With such strong policy drivers it is little wonder that SG has been perceived by some as a panacea.

Yet with such demands for an empowered workforce comes a real risk of tokenism. Empowering staff does not negate the need for some managerial control to be maintained. Systems are required to monitor outcomes and ensure standards are being achieved. The extent to which empowerment is realised may be dependent on a variety of organisational factors including managers' willingness to relinquish control and staff readiness to accept responsibility for their actions. Thus preparation to work in an empowered way, usually through leadership development programmes, is often present when introducing SG into an organisation. It is essential that those who espouse an

empowered way of working demonstrate it in the ways that they act and that its principles become integral to cultural norms. In this way empowerment is perpetuated through organisational measures and senior and junior staff behaviour, which in turn promulgate empowerment.

SG Decision-Making

In embracing SG, practitioners then have the responsibility and authority to implement change through the decisions they make. The structures through which they do this within SG are variable, but models commonly comprise councils of elected or appointed groups of staff representing single or multiple disciplines. Involvement in such structures is believed to harness staff commitment and a sense of ownership of the decisions made. Furthermore, such group working is expected to realise a higher quality of decisions than would otherwise be possible. Thus the current small amount of UK SG evidence developed to date has centred on SG outcomes to see if the expectations of such an approach have been realised. There is even less evidence concerning the processes through which SG achieves its outcomes, if indeed those outcomes are attributable to SG. Thus there has been considerable reliance on the rhetoric and subjective inferences of SG implementers as to how and whether SG works in practice. This is surprising in view of the huge investment that SG implementation demands. It is this lack of understanding of SG decision-making processes that has been the key impetus for this thesis.

Statement of Intent

This study intends to identify factors affecting decision-making within SG as a means of identifying ways to strengthen that decision-making.

Study Aims

The aims of this study are to:

- Identify factors that act as barriers or aids to decision-making.
- Establish the relationships between these factors and the processes by which they impact on decision-making.

- Determine ways to promote more effective decision-making.
- Develop a conceptual model of decision-making within SG.

The remainder of this chapter gives a detailed description of the Rochdale model of SG, which is the locus of this exploratory case study, and outlines the contents of the thesis.

PART 2 - The Case Study

The Rochdale Model of SG

The impetus for the introduction of SG to Rochdale Healthcare NHS Trust was the appointment of a new Executive Nurse Director in September 1997. At this time, the Rochdale Trust was an integrated hospital and community trust situated to the West of the Pennines serving a local community of around 220,000 people. The registered Nursing staff complement at this time was approximately 1,600, whilst qualified Clinical Professional Services (CPS) staff numbered in the region of 160. The annual Trust budget for the period April 2000-March 2001 was £84.8 million. It was the vision of the new Nurse Director to introduce a radically different approach to the way nursing business was managed in the Trust. The idea for SG arose from previous consultation work undertaken by the Nurse Director in Canada and the United States of America (USA). The Nurse Director believed Rochdale Trust to be a fitting setting in which to implement such an approach. Central to this view was her objective to embed SG within an ambitious leadership development strategy for the Trust.

No secret was made of the fact that a large-scale initiative such as Trust-wide SG would require significant investment in terms of finance, time and staff resources. Much of the Nurse Executive's early activity centred on preparing colleagues, including those at Executive and Non-Executive Board level, to support such a venture, not least as a significant element of risk was involved. Indeed, to further secure their backing and to promote understanding, Trust Board members and senior Trust Executives attended a shortened one-day Leading an Empowered Organisation (LEO) leadership development course specifically developed for them. This was to orientate them to the underpinning philosophy and principles of SG and the mechanisms proposed to develop an empowered workforce to ensure its delivery. The potential for SG to deliver the Trust's

clinical governance agenda was a particularly persuasive argument presented at that time. This was because SG and clinical governance share a number of underlying principles. A particular risk was the substantial initial financial outlay needed to release three staff to undertake a visit to the USA in preparation for the initiative. Having undergone the LEO, this request was supported by the Trust Board members on the premise that the money would be repaid within a twelve-month period.

A crucial element of the Nurse Director's vision was to create an environment within the Trust that would support a SG way of working. Essentially, this meant promoting a culture of empowerment through an ambitious programme of leadership development within nursing and the other clinical professions. A central aim was to engage staff as participants in the development of the SG initiative so as to inform it and promote their ownership of it. It was recognised that to do this, managers would have to work differently and relinquish some of their traditional control over the way the organisation operated. Similarly staff were to be actively involved as opposed to being merely consulted about the SG proposals, whereas in a more traditionally functioning organisation, staff may simply have been informed after the event. The first step in this process was to revise existing posts within the corporate nursing team to create two key posts of Senior Nurse (Leadership Systems Development) and Senior Nurse (Practice Development), to lead on the SG project and begin fostering a receptive environment for the introduction of SG.

The main purpose of the USA visit was to train the three Trust staff in the delivery of the LEO programme at Creative Healthcare Management Incorporated headquarters in Minneapolis. These individuals went on to deliver the programme within and outside of the Trust. External delivery of the LEO programme meant that the income generated could be used to pay off the initial financial investment in good time. The programme was at that time little known-about in the UK compared with the high profile it commands today, due to its nation-wide roll-out as part of the NHS leadership development strategy for the NHS in England. Despite this, a commitment was made to deliver the LEO programme extensively in-house through the Trust-employed trainers. LEO courses were targeted at a diagonal slice across the professions encompassing all grades and levels of staff. Delivery of the programme continues to this day at a rate of approximately twenty Rochdale-based staff per month. Additionally, a smaller number of senior staff were supported to undertake the more intensive Leadership Effectiveness

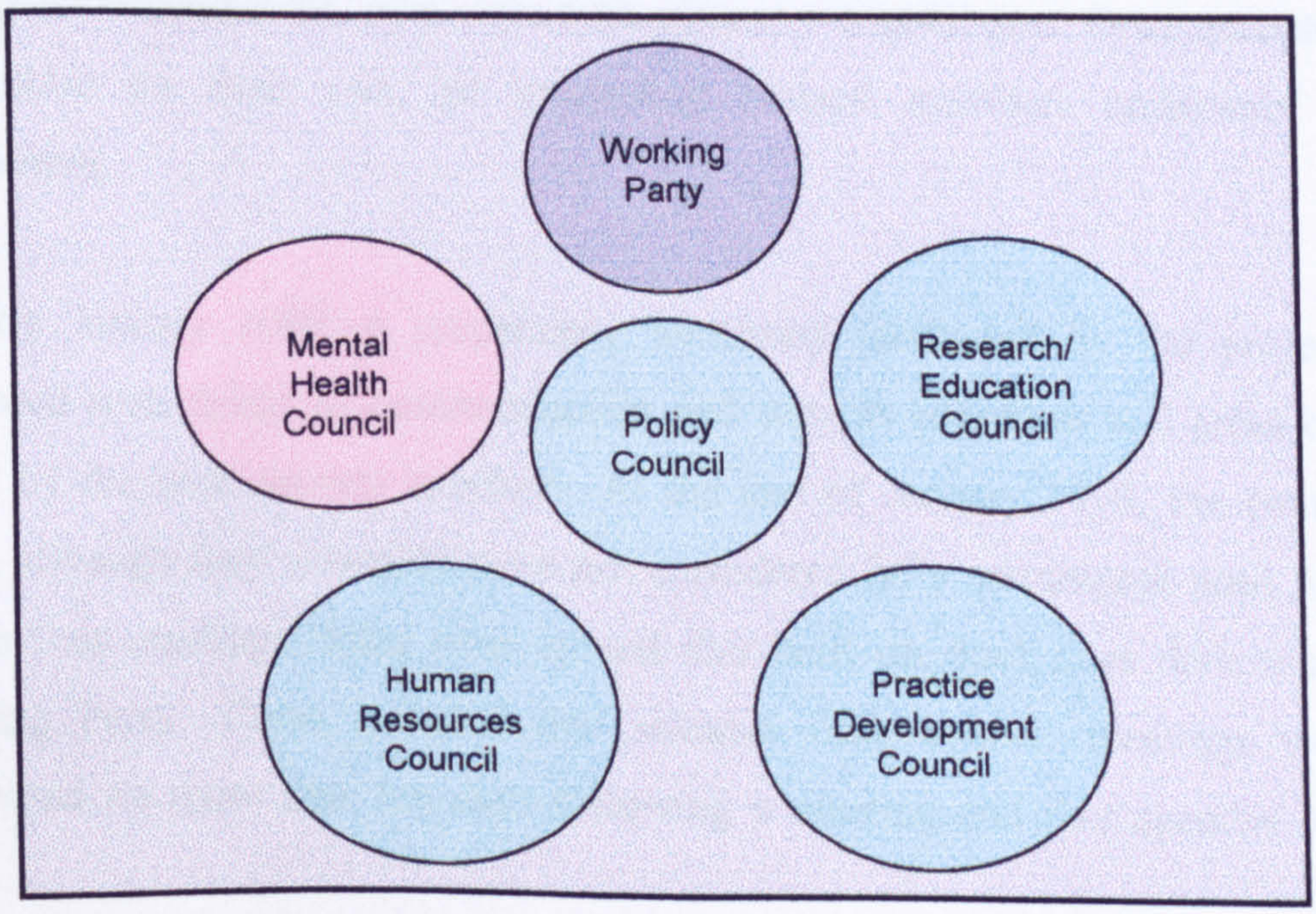
Analysis™ (LEA) course delivered by the University of Leeds. Such commitment to leadership development was considered an important element of the implementation of SG and an ongoing requisite for the continuing development of the Trust workforce.

At this time, the researcher initiated a meeting with the Nurse Director to ask about any evaluation planned for the initiative. It was learned that the project leaders placed great importance on ensuring rigorous evaluation of the Rochdale model of SG to establish its effectiveness. To this end, funding for a NHS Executive Research Training Fellowship was secured for the researcher to undertake a longitudinal evaluation of the SG initiative utilising an action research approach. This fellowship ran from October 1st 1998 until January 31st 2002.

The Council Model

A Working Party was set up and met on a minimum monthly basis throughout 1998 to devise an initial SG model. Following Trust-wide consultation, it was the popular 'council' model that was selected for implementation. Whilst acknowledging its origins in nursing, there was a recognition of the need to adopt a multi-disciplinary approach to SG in the Trust, were a true whole-systems approach to be achieved as was desired. Initially, the model comprised the Human Resources Council (HRC), Research/Education Council and Practice Development Council (Diagram 1, below). Each of these practice-based councils had a Trust-wide remit.

Diagram 1 - Original SG Council Model



Each council had twelve seats to allow for professional representation from Medicine, Surgery, Community, Mental Health, Maternal and Child Health and CPS. At this time, medical representation had not been secured, as this group did not want to participate despite the SG project leaders' attempts to engage them. Members were registered, professional staff and no non-registered (e.g. clerical or support staff) held seats. Each council kept three additional seats vacant for co-option of individuals that may have been needed for their particular expertise to work closely with the council on an issue. Each council had a chair and vice-chair and was supported by a Senior Nurse (one of the project leaders) who acted as a facilitator at council meetings. The councils fed into and were supported by a Policy Council that comprised the Nurse Director, Senior Nurses, Directorate and Service Managers and council chairs. The role of the Policy Council was to give the councils advice and direction, especially in their early developmental stages, and to report on SG activity directly to the Trust Board through the Nurse Director. It was anticipated that a number of outputs from the councils would require ratification at Trust Board level prior to becoming accepted Trust practice or policy. It was considered important that the council structure had this direct link to the Trust Board and that Trust Board members' commitment to the councils was evident.

The Working Party facilitated an extensive range of promotion activities aimed at raising awareness of SG throughout the hospital and community settings. Media used included master-classes and road shows, newsletters, flyers and presentations. Furthermore, the Working Party devised a democratic election process whereby interested practitioners were invited to prepare and submit a personal manifesto that was circulated to colleagues for them to consider. A system of postal voting identified the most popular candidates, who were then offered a council seat. Once accepted, and in preparation for their role, all impending council members underwent the LEO programme.

In early January 1999, a preparatory workshop facilitated by the project leaders addressed such things as communication and support structures and areas of concern raised by the new council members. At the end of January 1999, the councils went 'live', although they generally were not considered fully operational until April 1999. At the first meetings, rules were agreed that built on draft ones determined by the Working Party. These included that minutes from council meetings were to be distributed no more than ten days following a meeting and that agendas were to be

circulated seven days prior to meetings. There were also discussions around roles such as selecting a chair and vice chair and dates and times of meetings for the year. Also ground rules were agreed that commonly included honesty, respect, to hear all views, urgent interruptions only and commitment. General aims for each council were drafted with much input from the project leaders. Philosophies for each council were also determined through group discussion within each council. These comprised the following:

> "The Human Resources Council is founded on the principles of shared governance to help develop Rochdale Healthcare NHS Trust as an empowered organisation."

> "To explore systems and processes around research and education and to encourage and support the development of a research and education culture within the organisation." (Research/Education Council)

> "The Practice Development Council is seen as a resource to identify and establish guidelines for best practice in conjunction with the Professional Codes of Conduct. We recognise and encourage excellence in clinical practice Trust-wide."

All but one council then went on to meet monthly for the next three years. No additional funding was available for the release of staff to participate as council members, although Directorate Managers were aware of the impact on their staffing resources when they originally signed up to SG. Administrative support from a secretary was provided both within and outside of the council meetings.

Over time the Trust-wide councils addressed issues such as:

- The development of a generic support worker job specification.
- Development of evidence-based guidelines.
- Development of a recorded drugs policy.
- Creation of a Trust journals database.

Potential issues were brought to the councils' attention through a suggestion form system whereby any member of staff could forward an idea to a council member whose responsibility it was to ensure the issue or suggestion was raised at the next appropriate council meeting. Suggestion forms had been developed by the Working Party and

distributed to all wards and departments at the time of the councils' formation. This was viewed as a key means of engaging constituents (Trust staff) although a number of issues in fact originated with Policy Council members.

During the Spring of 1999, another practice-based council, this time with a directorate-wide remit only, unexpectedly evolved in the Mental Health Directorate. Staff working in this area were inspired by what they had heard about SG through the promotional events and opted to introduce a council of their own to address small-scale local practice issues, compared with the other councils' Trust-wide remit and sphere of influence. This council comprised thirteen seats occupied by Mental Health nurses from the acute and community settings, an administrator, a psychiatric consultant and non-registered nursing assistants. The council had three seats vacant for co-option of non-council members as required. The council had a chair and vice chair, although it did not have a facilitator. Membership was determined informally, predominantly by one of the Trust SG project leaders who was based in Psychiatry. There was no democratic process of election, with staff members being approached to participate on an individual basis.

Being a directorate-based council, the Mental Health Council (MHC) reported to and linked with the Psychiatric Services Management Team (PSMT) as opposed to the Policy Council. This group comprised Mental Health Directorate service heads, many of whom were incidentally MHC members, the Directorate Manager and psychiatric consultants. The role of the PSMT was to give the council support, advice and direction, although there was no direct link between this group and the Trust Board. No formal link existed between the MHC and the Trust-wide councils, although Mental Health Directorate staff did have an allocation of two seats per Trust-wide council. There was however no cross membership between any of the councils.

The MHC met for the first time in March 1999. One of the Trust SG project leaders was invited to facilitate its first meeting and undertook similar preparatory steps to the other councils, including determination of roles and ground rules. Rather than a philosophy, the MHC agreed a mission statement:

"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 MHC also went on to meet monthly and secured its own secretarial support through a council member's personal clerical assistant.

Over time, this council addressed issues such as:

- A bank nurse training programme.
- Development of a violence and aggression policy.

The MHC had a similar suggestion form system as the Trust–wide councils, with its locally developed suggestion form being available in all Mental Health wards and departments.

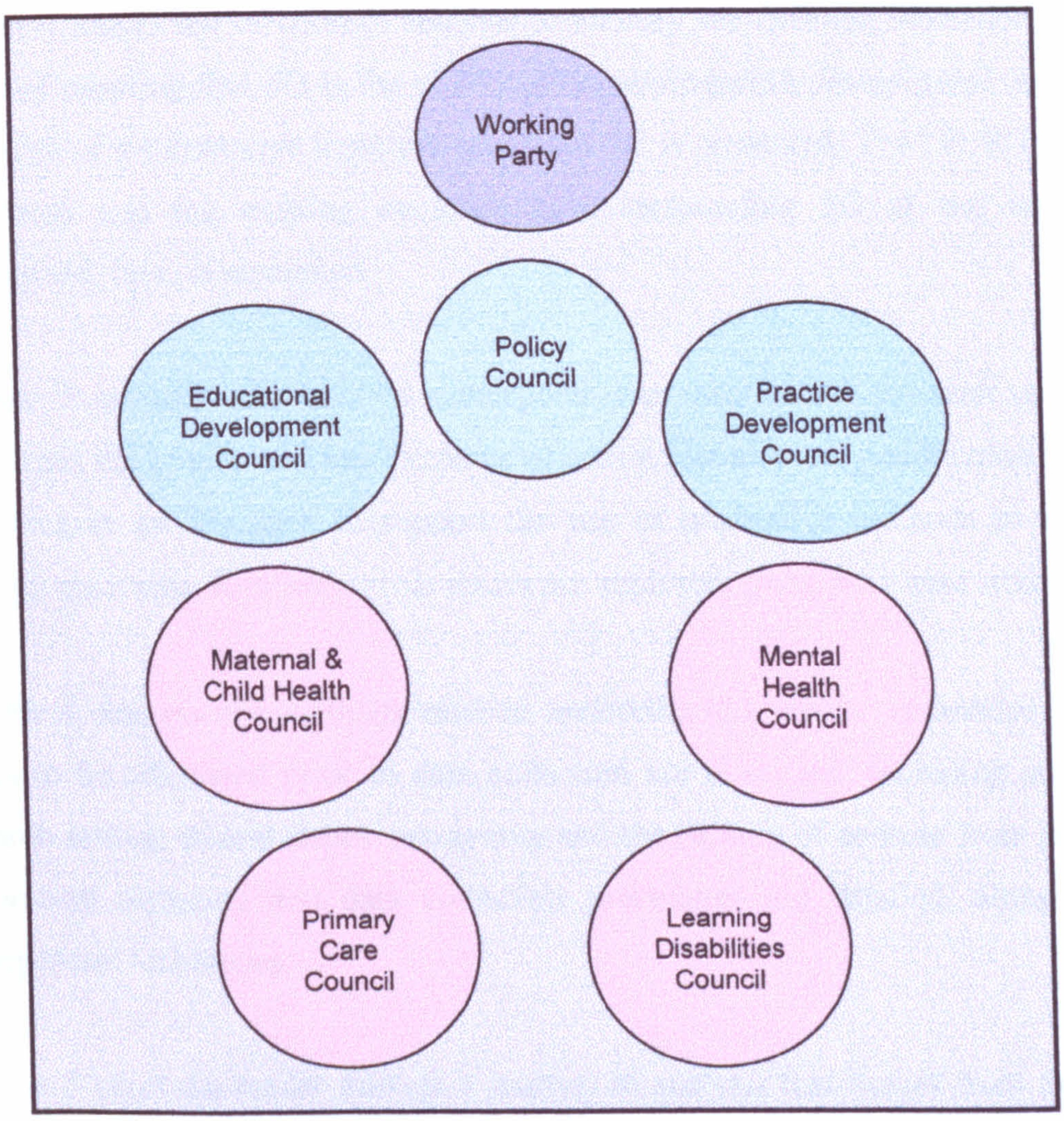
In both types of practice-based councils, it had been originally intended for 50% of council members to step down from their seats after twelve months to be replaced with new ones. The remaining members were to hold their seats for twenty-four months. Staging changes in membership in this way was intended to promote continuity of membership that would not be permitted by a total change of membership at a single point in time. It was further intended that a repeat democratic voting process for appointing new members would be undertaken by the Trust-wide councils. The MHC had no clear plans as to how renewal of membership would occur.

After two years the councils underwent a reconfiguration in response to the changing local need and in part due to this study's formative findings. The Trust was preparing to relinquish its community service provision to two Primary Care Trusts. The HRC and Research Education Council merged to become an Educational Development Council. The perceived success of the MHC at that time in achieving substantial improvements in practice was key in prompting the evolution of other directorate-based councils within the Learning Disabilities Service, Maternal and Child Health Directorate and Primary Care (Diagram 2, overleaf).

As was the original intention of the project leaders, a strategy was developed by senior Trust managers for a whole-systems approach to governance in the Trust. The strategy set out a framework for combining Shared, Clinical and Corporate Governance and was approved by Trust Board in Autumn, 2001 (see Appendix 1 - Whole Systems Governance Strategy). The driving force behind its development was a wish to ensure

continuous improvement of clinical quality that would be achieved through the leadership and teamwork made possible through a SG way of working.

Diagram 2 - Revised SG Council Model



A few months later and all councils were again subject to huge changes afoot in the Trust due to the impending Trust merger with three adjoining trusts that eventually took place in April 2002. Thus Rochdale Healthcare NHS Trust had become part of Pennine Acute Hospitals NHS Trust. However, the Mental Health Directorate joined with other mental health organisations in the region and is no longer part of the new Acute Trust. The size of this new acute care organisation, which provides acute hospital services for a third of the Greater Manchester region, presents logistical and geographical challenges in particular. Just prior to the merger, council activities ceased in anticipation of new Trust structures and key appointments and to await discussions with the new Trust management.

PART 3 - Thesis Overview

The thesis comprises a further seven chapters.

Chapter 2 makes use of concept analysis to identify the defining attributes of SG as a means of ensuring that SG is the phenomenon subsequently investigated in this study. The result of a substantive literature review of SG is presented. The UK SG situation is considered and the existing evidence base surrounding SG at the national and international level is examined.

Chapter 3 presents the study's conceptual framework and research questions. It illuminates the origins and key elements of action research and justification is given for its choice as an approach to support the use of qualitative methods to address the research questions. Researcher role issues are explored, along with case study theory.

Chapter 4 sets out the methods used to undertake this single, embedded case study. Issues to be addressed prior to data collection are discussed, including access to the research setting, ethical issues, anonymity and the gaining of consent from participants. Theoretical sampling and data collection procedures are detailed, along with data management techniques.

Chapter 5 takes the reader through a journey of analysis that ranges from the early use of action research cycles and progresses to use of basic and advanced data displays to aid qualitative data analysis. The evolution in direction from description of SG decision-making to explanation of SG decision-making is illuminated.

Chapter 6 presents findings from all stages of the analyses. The summative study findings are represented in a conceptual model of SG decision-making.

As is commensurate with action research approaches, Chapter 7 provides a significant reflective narrative that details the reflection and learning experienced by the researcher during this study. The theoretical underpinnings of this reflective practice are given and the impact of reflection on the researcher's personal development is outlined.

Finally, Chapter 8 discusses the utility of the action research approach employed and

critically examines the methods used in this study. The strengths, weaknesses and limitations of each method are highlighted. The summative findings and conceptual model of SG decision-making are compared with SG literature and the relevant wider literature. Conclusions are drawn from the study and implications for practice and policy and future research are identified.

Chapter Summary

This chapter has introduced the thesis by outlining the policy drivers behind the adoption of SG by a number of health care organisations in the UK. The approach adopted by one of these organisations, Rochdale Healthcare NHS Trust, has been detailed to set the scene for the remaining chapters. The chapter concluded with an overview of the chapters to follow.

In the next chapter, the theory and application of SG are examined and reviews of the Non-UK and UK SG evidence base are undertaken.

CHAPTER 2

SHARED GOVERNANCE

Introduction

This chapter sets out a review of literature relating to SG and is presented in three parts. Part 1 is set around a concept analysis undertaken to clarify what is meant by the term SG both implicitly and explicitly. The origins and core principles of SG are presented along with the various models. Part 2 illuminates the UK SG situation and considers the international and national evidence surrounding SG. Part 3 identifies decision-making as a gap in existing knowledge around SG and explores this topic as a focus for this study.

PART 1 - The Concept of SG

Introduction

This section presents an overview of concept analysis as a means of clarifying a phenomenon so that it can be investigated appropriately. Various models exist, for example Rodgers (1989), with each commonly seeking to define what are often ambiguous phenomena, and illuminate their composition. The process has proved popular amongst nurses working with complex concepts (Coyne 1996; Rodwell 1996; Wilkinson 1997). Combined with appropriate use of methods, research following concept analysis has the potential to have enhanced validity and measure or investigate what was intended.

Concept Analysis

The concept analysis model suggested by Walker and Avant (1988) has been selected as a framework to guide this literature review. Elements in the analysis process include defining attributes, identifying example cases, related concepts, antecedents and consequences. A concept can be viewed as a theoretical idea, and the relationships

among concepts as theoretical propositions (Rose 1982). To not define the concept of SG would leave it open to individual interpretation, and any meaning given to it may not be shared (Gibson 1991). Subsequently, examination of SG in relation to other concepts would not be meaningful. Therefore, to undertake a concept analysis was considered a valuable and necessary activity.

Definitions

SG is a relatively new concept that has been described in a number of ways. One suggestion is that SG is a system of management that promotes the empowerment of nurses by moving away from the traditional hierarchical style of nurse management (Geoghegan & Farrington 1995). Having assumed control over their own clinical practice and professional development under a SG framework, the nursing professional then has the responsibility and authority to implement change. Pinkerton and Schroeder (1988) define SG as an organisational structure that creates a climate supportive of autonomous nursing practice. Yet another author, Hess (1998:35) describes SG as:

> "...a multi-dimensional concept that encompasses the structure and process by which organizational participants direct, control, and regulate the many goal-oriented efforts of other members."

And finally, SG has also been purported to be a philosophy of decision-making (Dugger 1998:11):

> "Shared governance is a philosophy that encourages collaborative decision making for nursing practice and is the vehicle by which nursing organizations can be more productive, creative and effective."

This is a view shared by George (1997:17):

> "The basic philosophy of shared governance includes the right for staff nurses to practice in an environment that allows participation in the decision making process."

Collectively viewed, these definitions suggest SG as a combination of structures and processes within organisations that are conducive to staff taking responsibility for their productivity in the achievement of organisational goals. They suggest that as well as

structures and processes, ways of working are needed to support an approach that is unlike traditional hierarchical management structures. There is also the implication that structures and processes are inter-related as 'systems' so that the way they work will depend on the other components within the wider system and the way the system operates. In order to contribute, staff need to be substantively involved in decision-making at all levels.

Defining Attributes

Following review of SG definitions, a number of defining attributes are evident. Porter-O'Grady (1992a) has identified what he considers to be the main attributes that are common to most effective SG approaches, and these are summarised below:

- Staff are ultimately accountable for all matters relating to nursing *practice.*
- Staff are accountable for the *quality* of care given and the quality of the care-givers.
- Education and clinical *development* are also to be clinically driven and involve *peer processes.*
- The *role of managers* must be unambiguous and will focus on co-ordinating, facilitating and integrating as opposed to their previous function of planning, leading, organising and controlling.

Origins & Drivers

No one definitive origin is identified as the source for the concept of SG. However, a number of drivers have created a climate in readiness for SG approaches. Health care is traditionally very management centred and insufficient decisions are made at the point of service (Porter-O'Grady 1991a). SG is said to have arisen as an alternative approach to the traditional power structures typically found in institutional settings that prevent autonomous professional practice (Boeglin 1993). In recent decades, there has been a change in organisations, from being viewed as mechanistic and linear, as is commensurate with the industrial era, to being viewed more as social systems (Rusch 1998). In regarding organisations in this way, staff are seen as components that work together as part of the overall system. Thus for some, SG is considered necessary, as organisations cannot possibly oversee the decision-making activities in all corners of the health care system as dependence on frontline care providers increases (Evan *et al* 1995).

There is also the suggestion that SG has arisen as a result of market forces in health care, including changes in consumer demands and available resources (Minors *et al* 1996). A consumer focus is growing in popularity and new approaches have been witnessed, such as managed care and patient-focused care. Patient-focused care is a movement to deliver as many patient care elements as possible by the bedside in a hospital setting as opposed to numerous inputs by different people and departments fragmenting patient care (Jacoby 1995). It is unlikely that traditional, hierarchical organisational structures would support truly patient-centred care systems (Miller 1997) and so organisations have sought new ways to meet the pressures placed upon them.

Hospitals are caring for a growing population of acutely ill people, yet having to work within financial constraints to ensure care remains of a high quality (LaFoy 1993). Health care organisations are increasingly cost-conscious and constantly have to seek ways of delivering efficient, quality care (Duncan 1997). Essentially, organisations have to work harder with less. What organisations need to have are structures and processes to support the huge amount of change they are facing as a result of the influence of health care reform and global developments (Porter-O'Grady 1994a).

Further drivers have arisen within nursing. DeBaca *et al* (1993) suggest that SG has been developed in response to an American nursing shortage in the 1980s which resulted in recruitment and retention problems. The impetus for SG, as suggested by Porter-O'Grady (1991b), the leading author in the SG field, has been the frustration and contradiction resulting from nurses' lack of influence and control over decision-making which affects their patient care. Additionally, Gavin *et al* (1999) suggest that as career advancement opportunities for nurses diminish, involvement in SG offers an alternative.

Continuous Quality Improvement (CQI) involves the use of data to inform cost-effective improvements through involvement of the people closest to the area of work in need of enhancement (Jacoby 1995). There is a growing concern with quality issues in health care, yet inadequacies exist in accepted quality improvement approaches. For example, failure of quality circles that acted as a bureaucratic design for monitoring performance (Minors *et al* 1996) and presented difficulties around perceived loss of control by managers (Gavin *et al* 1999) have added to the need for work redesign. SG is concerned with the human dimension to facilitate teamwork, integrity and decision-

making, whereas CQI is about structures, processes and work characteristics (Porter-O'Grady 1992b).

Various approaches have been adopted to meet these varied demands, including decentralised management, participative decision-making and SG.

Principles

Core Characteristics

Whilst various models of SG exist, they reflect several common characteristics. The five main tenets identified by Porter-O'Grady (1991b) are personal responsibility for professional development, autonomy for practice which is controlled by nurses, staff ownership of quality control issues, support for the transitional roles of managers and integration of organisational components. Yet in further writings, other principles are highlighted that give shape to SG, including partnership, equity, accountability and ownership (Porter-O'Grady 1995a). Evan *et al* (1995) also selected these latter four principles as the main ones underpinning SG structures. Naish (1995) identifies equality, partnership and openness as necessities. Furthermore, Porter-O'Grady (1995a) suggests seamlessness between governance, operations and service as being a structural characteristic of SG. Of all these, it is accountability that has been described as the foundation of SG (Porter-O'Grady 1992a). A selection of the more frequently highlighted characteristics is given here.

Partnership

Partnership is about staff working together to meet nursing and organisational goals (Porter-O'Grady 1991b). It is believed that once structures have been put in place that exemplify core SG principles, then stakeholders will be forced together for dialogue, collective problem-solving and for arriving at important decisions (Porter-O'Grady 1995a). In this way, they become partners working towards a collective goal. This close working is said to foster development of mutual trust, which is a further concept frequently mentioned as being key between colleagues, and especially between managers and clinical staff (McDonagh *et al* 1989).

Responsibility

Within SG, nurses have full responsibility and accountability for clinical nursing activity (Porter-O'Grady 1991b). There must be a transfer of responsibility, accountability and authority from the manager to the staff member, empowering staff and as a means of facilitating action (Morris & Smith 1993). By conferring authority onto staff, managers make them responsible for attaining the work objectives. This may include peer review to evaluate individual practice and validate wider nursing practice (Porter-O'Grady 1991c).

Accountability

To be accountable, staff must have the requisite autonomy to make decisions and then see them through (Porter-O'Grady 1991b). To express clinical accountability, a framework such as SG is needed to situate decision-making with the staff and prevent location of decisions within a hierarchical structure (Porter-O'Grady 1994b). Accountability, unlike responsibility, cannot be delegated (Naish 1995); it is embedded in the roles people adopt and is concerned with the end product of their actions, as opposed to the processes that lead up to those outcomes (Porter-O'Grady 1997). Therefore, staff must have clear objectives if they are to be accountable for the outcomes achieved (Porter-O'Grady 1998).

Ownership

Porter-O'Grady (1992a) suggests that the structure of nursing services comprises a mixture of management and medical constructs. What is meant is that services are organised to facilitate the work of doctors, whilst nurses and managers are similarly poles apart, reducing the nurses' sense of ownership of the system they are part of (Porter-O'Grady 1992a). Within SG, all members of an organisation must be clear about the part they play in achieving their own work objectives and those of the wider organisation (Porter-O'Grady 1998). As all staff contribute to organisational goals, each should be valued and have their contribution recognised (Porter-O'Grady 1998).

Seamlessness

The notion of a whole systems framework supporting SG assumes some foundational concepts (Porter-O'Grady 1995a:23) that give meaning to work and organisations:

1. The organisation is greater than the sum of its parts; there is an active relationship between all its components.
2. The point of all structures is to support the work operating out of its core.
3. All functions must serve the purposes of the organisation.

Services cannot be delivered in isolation from each other. Any change impacts throughout integrated health care systems, as change in one part impacts on others (Porter-O'Grady 1994a). In the absence of whole-systems working, individual departments have tended to work in isolation and in competition with each other; hence, collaborative problem-solving was not valued (Jenkins 1993). A key tension is the difficulty presented when the nursing part of the organisation functions in an autonomous way, yet other parts are comparably powerless due to being controlled by traditional hierarchies (O'Malley 1992). Therefore, to be an effective framework for clinical accountability SG models must link throughout the organisation which will then support it (Porter-O'Grady 1994b). To promote seamlessness, SG models attempt to integrate disciplines across the continuum of services and connect the patients directly to the people and services they need (Walker 1994). Everybody has a part to play in a SG system which renders them accountable yet gives them opportunity to influence that very system (Naish 1995).

SG Climate

Leadership

As health care becomes more service-focused, managers' roles as controllers, directors and agents of information need to change becoming suppliers of support and information to those making point-of-service decisions (Porter-O'Grady 1997). To support such role changes, the climate that SG operates within is clearly important. A pervasive view is that a strong leadership culture is crucial to the success of SG (Evan *et al* 1995).

DeBaca *et al* (1993) comment that implementation of SG requires transformational leadership; hence, organisations often invest in leadership development programmes for their staff so that they are empowered and equipped to function in their new roles. Porter-O'Grady (1991a) concurs that leadership development is essential when adopting a SG approach. He argues that there exists a positive relationship between the number of learning leaders in a change process and its success and speed of impact (Porter-

O'Grady 1994a). A further view is that leadership role development strengthens those leaders' ability to delegate decision-making responsibilities and so reinforces a culture of empowerment (Davis 1992). Yet Naish (1997) recalls a conversation with a management consultant who suggested that leadership development training for managers was flawed:

> " Managers manage risk while leaders take risks; managers react to the current context while leaders create new contexts; managers are concerned with the present while leaders are concerned with the future."

This suggests there is a need for managers and leaders and that the two are not necessarily the same thing.

Empowerment

Meade (1995:1) defines empowerment as:

> "...the process of thinking and behaving as if one has power in the sense of autonomy, authority, and control – over significant aspects of one's life and work."

One of the key assumptions of SG is that staff welcome empowerment, yet some doubt this to be the case in reality (Doherty & Hope 2000). SG will not succeed where staff feel powerless and believe they have limited ability to excel (Matta 1998). Staff may be reluctant to risk making mistakes, yet a climate capable of supporting SG is one that will recognise the value of risk-taking. Risk-taking can lead to creative solutions, whilst mistakes are to be reflected upon and not punished (Jenkins 1993).

Whilst many organisations purportedly practice SG, what they have are the SG structures and not many of the behaviours (Porter-O'Grady 1996a). For empowerment to be in-built in restructuring of organisations through SG, certain conditions must be met (Porter-O'Grady 1992a):

- There must be commitment to nursing governance and substantive involvement of nurses in decision-making affecting practice.
- The managers' role must change accordingly.
- Accountability-based governance systems, not participation-based systems must be

developed with clear delineation of accountability.

- There must be commitment to a long-term transformation process.

Additional precipitating factors for the successful implementation of SG include a high percentage of degree-trained nurses, primary nursing and a participative leadership style (Edwards *et al* 1994).

SG Models

Types

It has been said that SG is a systems concept, not a model, although structural models are often the visible definers of SG concepts (Porter O'Grady 1995a). Within SG, these staff-driven models are viewed as vehicles for change which should positively affect the outcomes of the work of the organisation (Porter-O'Grady & Tornabeni 1993). Several SG models exist, including the *congressional*, *administrative* and *councillor* models (Porter-O'Grady & Finnegan 1984). Congressional committees are led by a president and chaired by cabinet officers comprising a mix of clinical staff and managers (Minors *et al* 1996). Administrative models comprise elected staff to advise existing management on specific issues and are the least accountability-based models (Porter-O'Grady 1987). No one model of SG is advocated in the literature, and so emphasis is placed on individual organisations to determine the approach that best suits their specific needs.

Composition

The councillor model is by far the most popular model identified and will be discussed here. Whilst primarily uni-disciplinary (nursing), some models are multi-disciplinary, incorporating a range of professionals, whilst a small number have integrated non-registered staff including care assistants and unit clerks (Edwards *et al* 1994). Duncan (1997) considers this to be important, as a whole-systems SG philosophy encompasses all disciplines in decision-making and so models should move away from any early nursing boundaries. Yet it is advised that models begin with nurses, due to their number and location in the patient care system, and then develop into other areas once established (Porter-O'Grady 1994b).

Within councillor models, it is usual for membership to be representative of all levels of

practising nurses. Members tend to number 12 to 15 with each having equal voting rights (Ashbridge 2001). These appointees are generally elected (Beck *et al* 1994), although some may self-nominate (Geoghegan & Farrington 1995), and have clearly defined clinical and managerial accountability (Porter-O'Grady 1987). A chair drawn from the practitioner membership undertakes duties including agenda setting, chairing meetings, and development of the council (Thrasher *et al* 1992). Managers' presence amongst council seats is variable (Bernreuter 1993). However there is usually an administrative (management) representative to advise members of constraints and resources in the delivery system and an individual at executive level to have a co-ordinating function and a strategic overview of the SG process (Porter-O'Grady 1991a). Without an administrative representative, council members may make ill-informed, unrealistic decisions due to lack of knowledge about the resources available to them. The nurse executive role is an important one within SG, not least because they link with the Board of Trustees and so ensure decisions are upheld at every level of the organisation (McDonagh *et al* 1989). This is often done through a separate Policy Council that aims to direct and integrate decisions rather than support function and service and its cross membership with organisational leaders reflects this (Porter-O'Grady 1994b). Some councils have a facility for co-opted seats for advisors (Geoghegan & Farrington 1995), to complement the skills and knowledge of members. Tenure of membership varies from setting to setting, yet it is suggested that membership of councils should be rotational so that all staff become involved in decisions (Porter-O'Grady 1998).

Once appointed, there needs to be substantial education of involved personnel to prepare them for the new way of working (Davis 1992). Roles within SG structures need to be clear and unambiguous, hence clarifying where accountability lies (Porter-O'Grady 1995a). Preparation for membership has included seminars on learning styles, team building, empowerment, leading effective meetings (Westrope *et al* 1995), communication, conflict resolution, problem-solving, change management (Yamauchi 1994), professional development, performance improvement (Prince 1997), coaching, audit, assertiveness (Doherty & Hope 2000), managing the budget (Edwards *et al* 1994), and goal and objective setting (Jacoby & Terpstra 1990). Not usually undertaken but recommended is education about how to make decisions prior to SG implementation (Jones 1995). Skills relating to participation, delegation and creating expectations are needed, and failure to invest in such preparation can result in frustration and apathy

(Porter-O'Grady & Hess 1996).

Preparation does not just come at the outset. SG initiatives commonly set aside substantive time in the form of 'away-days' or 'retreats' to review progress and practices during implementation (Horstman & Zlokas 1995). This dedicated time out can be hugely beneficial in identifying problems and initiating solutions to strengthen the model. For example, failure to develop an appreciation of accountability as well as leadership impacted badly on one model, as many committee members chose not to attend without giving their apologies (Guidi 1995). Measures had to be taken to promote accountability and to hold staff to their decisions through a programme of development.

Whatever model is chosen, it can take 3 to 5 years for it to be implemented fully, and during that time, it will likely evolve from its original design (Porter-O'Grady 1992a) in the light of experiences of implementation.

Function

Councils of various functions are evident, although there are a number of commonalties. For example, there are a raft of council structures addressing combinations of practice (Thrasher *et al* 1992), education (Westrope *et al* 1995), management (Beck *et al* 1994), nursing (Evan *et al* 1995), professional development (Doherty & Hope 2000), quality (Ashbridge 2001), customer care (Prince 1997), and research (Doherty & Hope 2000). To support the work of these primarily practice-based councils, there are often executive councils (Thrasher *et al* 1992) and co-ordinating councils (Yamauchi 1994). Specific council activities depend on the remit of each council and the requirements of the organisation. Typical examples include a practice council making decisions on chemotherapy administration (Westrope *et al* 1995), a management council with influence over areas such as personnel and finances (Minors *et al* 1996), an education council developing training needs analysis (Westrope *et al* 1995), and a professional development council addressing implementation of clinical supervision (Geoghegan & Farrington 1995).

Support for councils during their development has been gained through a number of approaches. For Westrope *et al* (1995) it was through a Steering Committee for the initial 18 months of their SG implementation, whereas a senior nurse management presence on some councils provided more direct support and advice (Geoghegan &

Farrington 1995). A common approach is appointment of a council facilitator of some description. Groups of people working as teams tend to benefit from a facilitator whose role is to facilitate tasks and processes initially and gradually withdraw, as teams become self-sustaining (Collins 1996). This requires skill and sensitivity on behalf of the facilitator to ensure that sufficient support and guidance is given without being overly directing. As Collins (1996) warns, people can be inadvertently disempowered by another's wish to be helpful.

Advantages & Disadvantages

The success of SG is purportedly promoted when the above characteristics are reflected in the chosen SG approach. The literature is replete with suggestions as to the merits of SG. Advantages include improved communication between individuals and departments (Maurer 1995). Hibberd *et al* (1992) suggest that SG implementation has led to nurses having a better grasp of the wider organisational picture plus increased skills and knowledge, enabling them to better articulate their ideas. In a similar vein, staff consider the implications of issues for the whole organisation rather than merely the local situation (Seaquist 1998).

Whilst the evidence of outcomes of SG is scant, Hess (1995) notes commonly listed effects as:

- Staff retention.
- Career progression.
- Increased job satisfaction.
- Positive effect on patient care.
- Increased multi-disciplinary collaboration.
- Increased commitment to the organisation.

However, whatever model is used, there are still problems. Some disadvantages associated with SG include:

- Seen as a threat to jobs by current managers.
- Seen as a threat by hospital boards and medical staff.
- Difficulty getting off-shift and weekend staff fully involved.

- Lack of clarity about parameters over which staff have control.
- Can be interpreted as an illegal effort to forestall any imminent union activity.
- Few staff members remain actively involved or committed to the process long term.
- The same few people take on unit council responsibilities over time and can get 'burned out'.

(Miller 1997:6)

Hibberd *et al* (1992) report on a number of managers who could not adapt to the participative way of working within SG. Similarly a number of clinical staff did not want to take responsibility for decision-making as they regarded SG with suspicion (Hibberd *et al* 1992). Following a unit-based pilot of SG, disadvantages were identified as including 'responsibility overload' and difficulty rolling out the SG structure from the unit to the wider department, which was not familiar with a decentralised way of working (Caramanica & Rosenbecker 1991). Staff can be apprehensive about having responsibility and accountability for decisions that previously rested with managers (Shadley & Gossett 1997).

SG places a strain on certain resources, in particular clinical staff's time. Ensuring adequate preparation of people can be quite time consuming and potentially problematic. Time is also a particular factor in terms of the release time of staff from the clinical area (Joiner 1996) to attend meetings. Involvement in extensive communication activities is acknowledged as a key to the success of SG initiatives (Fagan 1991; Geoghegan & Farrington 1995), especially with non-council members (Beck *et al* 1994). Consensus decision-making is usual in SG and often results in quite lengthy processes that may also lead to frustration (Frusti 1996). The time lag between an issue being received by a council and resolution has been highlighted as a disadvantage made worse when more than one council's input is required (Frenn & Schuh 1995). To conserve time and build confidence, it is suggested that tasks should be small and manageable to begin with, before progressing on to more complex tasks (Collins 1996).

The espoused advantages of SG may or not be persuasive to onlookers. Some may think it is not worth the large-scale commitment and there is no intention to enforce engagement in it. Yet Porter-O'Grady (1998a) asserts that there is no room for staff who do not eventually agree to participate in decisions, support their colleagues and show commitment to the organisation.

Example Cases

A further dimension of undertaking a concept analysis involves the identification of cases to serve as examples of model cases, borderline cases, and related cases.

Model Case

Once exemplar is the Sierra Hospital SG approach described by Evan *et al* (1995). Their approach was inter-disciplinary as opposed to being confined to a single discipline or unit. Staff involvement in decision-making was evident at every opportunity. Value was placed on the principles of partnership, equity, ownership and accountability. A representative, multi-disciplinary councillor structure and processes were successfully devised and operationalised.

Borderline Case

An example of a borderline case is found within the Huntsville Hospital System, Alabama. Here a unit-based shared-governance model was implemented in the Mother/Baby-Gynaecology Unit. The author describing this model had noted from their own literature review that few organisations had aimed for true system-wide implementation of SG, and so confined their approach to a single unit (Prince 1997). A councillor model was used which comprised 10 to 15 members of staff, grouped by the shift patterns they worked. This made attendance of council meetings easier and enabled all staff to participate in one of the eight councils. Whilst most of the defining attributes are evident, there is no mention of plans to develop an organisation-wide, or whole-system approach which would necessarily involve other disciplines and departments. Porter-O'Grady (1995a:22) stresses that:

> "Shared Governance doesn't work if it remains in only one segment, department, or compartment of any organization."

Related Case

Collaborative governance is a unit-based management model adopted by Roseville Hospital, California (Jacoby & Terpstra 1990). Decision-making is tailored to individual unit requirements by having a separate governing council for each speciality unit. In addition, there are central committees to ensure consistency with clinical standards, quality assurance and personnel issues.

This approach does not embrace the desire for seamlessness, as each unit functions separately and merely communicate their work to other areas of the organisation as opposed to working together in the first instance. SG is not to be mistaken for a management model.

Related Concepts

As a result of the varied interpretations of SG, some confusion is still possible between what it is and is not. The situation is made difficult by a range of terms being used for approaches closely aligned to SG (Jacoby & Terpstra 1990). Hess (1995:14) states that:

> "Nurse administrators have used labels, such as shared, collaborative, professional, and participatory governance to describe, what are in fact, dissimilar programs that share just one common thread - an intention to augment nurses' sphere of influence within the organization."

Professional governance (Yamauchi 1994) was introduced as a philosophy comprising collaboration, collegiality and professional accountability, whilst professional practice models (Zelauskas & Howes 1992) decentralise decision-making to committees at unit level. More recently, 'Beyond Hierarchy' is the term attributed to a clinical staff empowerment model at North Staffordshire Hospitals (Buchan *et al* 1998) drawn from SG principles.

Importantly, SG is not synonymous with other participation-based systems. For example, participative management is about allowing someone to be involved in decisions although the overall control remains with someone else (Porter-O'Grady 1987). SG is more than mere contributing to decisions or being consulted.

Antecedents & Consequences

These pertain to the characteristics present before and after the concept of SG occurs in practice.

Antecedents

According to Porter-O'Grady (1991b), the key characteristics of the nurse's role within SG are *responsibility, accountability* and *commitment*. SG cannot be implemented

where staff are not committed to the process and the additional responsibility and accountability they will incur.

Consequences

Measurement of the effects of SG is difficult without defining the concepts that it embraces, and therefore the variables which are present. There has been a failure amongst nurse researchers to ascertain the outcomes of SG and to provide evidence that any findings are transferable to other health care settings (Hess 1995).

Empirical Referents

A number of requisites must be met if the SG concept is to be operationalised:

- Structures which support shared decision-making must be in place.
- Processes that enable shared decision-making must be evident.
- Staff must be empowered to have authority, responsibility and accountability for decision-making.
- Training and development for staff to adapt to their new roles must be evident.

Summary

Use of a conceptual analysis framework has been advantageous in making sense of the concept of SG. The SG literature is highly descriptive and frequently repetitive. Walker and Avant's (1988) model has helped to achieve clarity from a body of literature where rhetoric predominates. The end product has been to develop an understanding of SG, its core characteristics, variations, exemplar models and assumptions. This is a useful prelude to considering the evidence base for SG both within the UK and internationally.

PART 2 - SG Evidence Base

Introduction

This section examines the current status of research and other evidence pertaining to SG. The non-UK picture is considered first, followed by exploration of the UK SG situation and evidence base. The section begins with an overview of the strategy adopted for retrieval of evidence for inclusion.

Retrieving the Evidence

Early on in the study, a broad preliminary literature review was undertaken to inform the SG concept analysis. Whilst some of the identified documents pertained to SG research, most comprised a selection of descriptive articles detailing SG implementation, models, anticipated outcomes and pitfalls. Throughout the course of the study, this body of evidence was added to as new lines of emergent enquiry were explored.

In line with an action research approach, a substantive literature review was undertaken in the late stages of the study to build upon the initial review. This provided a range of material for comparison with the summative study findings and to inform the synthesis of final conclusions. A structured key-word search of a range of databases was undertaken to identify published articles and reports of SG research and SG decision-making in particular. In addition, the National Research Register was searched and findings from the one SG study were requested. Where available, research reports have been obtained direct from those authors, although not all were willing to share these. Thus, many of the summaries of research that follow were limited by the availability of data situated in the public domain.

In the absence of any SG decision-making theory, key management texts were skim read for relevance and relevant items extracted from bibliographies. Reference lists were also followed up to identify other sources of evidence and general decision-making theory to draw upon.

Non-UK & UK Evidence Base

Non-UK Evidence Base

There exists much commentary in the American and Canadian literature as to the benefits of SG within the contexts of those countries' health care systems. Despite a plethora of non-UK papers on SG, the evidence base remains limited. Most of the literature comprises authors' experiences of the implementation process. Whilst the need for evaluation of process and outcomes is recognised, there is little of it (Martin 1995). Measurement of benefits due to SG is a challenge made worse by a lack of research into the assumptions of SG (Minors *et al* 1996). A particular concern noted is the need to be clear about the concept of SG. Once clarified, outcomes can be defined and attempts made to measure them (Porter-O'Grady & Hess 1996). Evaluation of SG initiatives would be advantageous in promotion of success through monitoring and adjustment whilst also providing evidence to deflect the concerns of doubters (Martin 1995). Yet evaluation of SG is difficult, as it impacts upon the organisation in a myriad of ways (Belcher 1998). Perhaps in part response to these difficulties, there remains a paucity of sound research into the outcomes of SG.

Despite the challenges, some research findings and evidence have been reported, although publications frequently make reference to findings rather than present them in any detail. Attempts at evaluation have tended to note subjective inferences of positive work outcomes attributable to SG. For example, Porter-O'Grady and Tornabeni (1993) highlight data collected over a five year period of SG implementation at Mercy Hospital, San Diego, and whilst acknowledging there is no direct relationship between these positive data and SG, believe SG to be the impetus. Positive outcomes purported to have occurred include dramatic changes in patient satisfaction, productivity, new graduate turnover, nurse turnover expense and vacancy rates (Porter-O'Grady & Tornabeni 1993).

A number of authors have highlighted shortfalls in research concerning SG implementation. For example, Beck *et al* (1994) note that many efforts have attempted to establish effects on nurses' working lives as opposed to outcomes affecting patient care. Duncan (1997) highlights the huge financial commitment of implementing and maintaining a SG approach and notes how few studies have addressed this issue. There is also the issue of trying to establish outcomes of SG initiatives when, realistically any impact will take several years to become sufficiently apparent to measure (Porter-

O'Grady 1996b). It is however acknowledged that it is useful to have formative findings along the way and not just at the end of an evaluation study (Kennerly 1996).

In response to his view of the shortcomings of SG research, Hess (1994) created the Index of Professional Nursing Governance (IPNG) tool, an instrument for measuring distribution of governance. Use of this tool to survey staff across ten USA hospitals identified that staff viewed control over their professional practice as less important than control over resources as indicators of SG, a view that contrasted starkly with that of nursing managers (Hess 1995). This work is important as it attempts to establish the degree to which SG is present.

There has been further criticism of the lack of a valid measure of the SG concept in terms of staff understanding and individual and organisational commitment to its implementation (Minors *et al* 1996). In response, these authors developed a nine-item Shared Governance Survey (SGS) instrument as a means of assessing the construct of SG with several hundred nurses across three hospitals. Yet it is the merits of the tool that are discussed, and not the survey findings.

Questionnaire survey research has been a popular choice amongst non-UK SG investigators. Westrope *et al* (1995) undertook a longitudinal survey of nurses at St Luke's Hospital, Kansas, built on a conceptual framework that proposed a relationship between SG and job satisfaction, commitment to the organisation and retention. Whilst acknowledging the possible effects of other factors, the survey results showed a positive change in satisfaction, commitment and turnover attributable to councillor SG. Involvement in decisions was more apparent at unit level than at organisational level.

A pre- and post-implementation survey was undertaken by Prince (1997) to measure staff satisfaction. Whilst general claims were made about positive results believed to have resulted from SG, there were a number of pertinent findings. These included a third of council members feeling that they did not contribute at meetings, a perceived lack of information needed to do the council work, and reduced job satisfaction attributed to the additional workload in particular (Prince 1997).

Edwards *et al* (1994) report on a survey undertaken before and after a one-year pilot councillor SG model in the St Joseph Mercy Hospital, Michigan. Findings suggested

positive indicators around job autonomy and quality, with input into administrative decision-making. Several key difficulties were highlighted during the council's first year of operation. A Peer Relations Council floundered due to an unclear remit and loss of leadership direction, which was added to by the resignation of one of the project's leading figures. A further council recognised its decisions to be reactive as opposed to proactive, which was compounded by lack of reflection.

Few studies have investigated the impact of SG on patients. One exception was a study by Ireson and McGillis (1998) who surveyed staff and patients at baseline, six months on and a year after implementation of unit-based SG. Reportedly, after one year, staff felt an increase in co-operation amongst their colleagues and better understood what was happening in the wider organisation. Patient findings showed improved satisfaction levels in terms of privacy, staff availability, timely care, and knowledge of what was happening to them, yet fewer knew staff names or felt that teamwork had improved (Ireson & McGillis 1998).

Attention to the costs of implementing and sustaining SG is important in view of the large investment required (DeBaca *et al* 1993). Whilst there have been attempts at economic analyses of governance approaches (Jenkins 1988), studies have tended to be flawed, as they did not clearly define SG, so making attribution of outcomes difficult (Hess 1995). However, insights of some value have been gained through cost calculations of staff time spent attending meetings and work undertaken outside of committees, and comparing data with previous decision-making arrangements (Jenkins 1988). What is difficult to establish is the knock-on economic effect of these staff being absent from other duties, other less apparent costs, and impact on quality. In a number of studies, financial claims made are not substantiated by statistics (DeBaca *et al* 1993) unlike their own study of Mercy Hospital, San Diego which, based on the data provided, demonstrated cost savings following SG implementation.

Commonly, reports of the impact of SG are not based on research evidence. A year after implementing SG, Beck *et al* (1994) recognised the need for formal evaluation, yet had thus far relied upon anecdotal evidence of nurses' perceptions of their experiences. Reis and Sturis (1995), in their councillor model at Toledo Hospital, Ohio, identified production of an annual report of council outcomes as a key evaluation activity and expressed aspirations for a satisfaction survey.

Summary

Limited evidence has been identified from outside the UK concerning the impact of SG. Where it exists, evidence is mostly based on the subjective views of those who have been involved in SG implementation. The only substantial research evidence located pertains to measurement of the distribution of SG. Commonly, survey techniques have been used to determine the before and after effects of SG implementation. Scant evidence has been identified that has established any impact of SG on the quality of patient care. No research into SG decision-making has been located. Notwithstanding, it would seem that the rhetoric and research evidence from outside of the UK has been sufficient to compel UK health care workers to seek an alternative approach to health care delivery in the shape of SG.

UK Shared Governance

SG is a relatively new concept in British health care organisations. Over the last decade, SG has been adopted in a few acute care hospital trusts across the UK and is becoming an increasingly popular option.

The impetus for SG being introduced in the UK is a multi-faceted one. In addition to national drivers (see Chapter 1 - Introduction) there have been a number of local influences:

- *Patient care.* Certain organisations have referred to a desire to improve patient care as the driving force behind adopting SG. This is the case in St George's Trust, where it is suggested that the advent of primary nursing has shifted accountability for patient care to nurses, with similar reasons being claimed for the development of SG (Legg & Hennessey 1996).

- *Empowerment.* In Leicester NHS Trust, there was a desire to create a culture of empowerment conducive to the engagement of staff in Trust decision-making, which led to SG being introduced (Geoghegan 1995).

- *Advanced practice.* SG was introduced at Dumfries and Galloway NHS Trust following the appointment of a new Chief Executive who had previously worked in a SG organisation. The expectation was that SG would advance practice through the leadership and professional development of staff and their engagement in patient

care decision-making (Edgar *et al* 2003).

- *Business of nursing.* SG implementation at Kettering General Hospital NHS Trust followed a management restructuring process that highlighted a need for nurses to manage the business of nursing (Goode 2003).

- *Change.* In 1999 the former Edinburgh Sick Children's Trust merged with two other trusts to become Lothian University Hospitals NHS Trust. The former trust then rolled out its established SG approach within the new organisation in 2000. The intention was to empower staff to implement changes that would lead to improved patient care (Conrad 2003).

- *Evidence-based practice.* In Central Manchester Health Care NHS Trust, SG was a nursing response to the need for evidence-based practice and flux induced by constant change. Following consultation, nurses expressed dissatisfaction with communication, involvement in decisions and levels of morale (Burnhope & Edmonstone 2003).

UK Evidence Base

Some UK organisations have instigated research to determine whether expectations from SG implementation were indeed realised (Table 1, overleaf).

Most research identified was undertaken with varying degrees of university collaboration, the remainder being undertaken 'in-house'. A landmark study is the two-year ethnographic evaluation conducted by a research team at the University of Luton, of the introduction of SG at Kettering General Hospital NHS Trust. This study stands as a major contribution to current UK evidence relating to SG. Research team members subsequently went on to work with Leicester General Hospital. Other important studies include a longitudinal action research study undertaken at Central Manchester Healthcare NHS Trust in its evaluation of a councillor SG model and the current action research investigation in Rochdale Healthcare NHS Trust. In the published reports on these studies, most comprised survey methodology with some drawing on interview and observation methods, and varying levels of high to low response rates were observed. The reporting of findings beyond the study sites ranges through being substantive to

Table 1 – Summary of UK Shared Governance Research Evidence

Source	Study Site	SG Start Date	Method	Key Findings
Legg & Hennessy (1996)	St George's Trust	1994	Trust-wide survey of clinical professions and general managers one year on	• most staff nurses welcoming of SG • staff nurse concerns about having their needs for support met, time to attend council meetings and continuing attendance • apprehension at making autonomous decisions about patient care and that senior colleagues should support them more with this regard
Doherty & Hope (2000)	Leicester General Hospital	1995	Survey of Medical Directorate staff 3 years on	• problems around staff being expected to contribute to strategic decisions when unaware of local strategic plans • lack of knowledge of the strategic planning process
Burnhope & Edmonstone (2003)	Central Manchester Healthcare NHS Trust	1996	Longitudinal evaluation using an action research approach aimed at eliciting any impact on nurses in terms such as job satisfaction, morale and career development: • postal questionnaire survey of 250 randomly selected nurses and midwives at baseline and yearly for five years • random council observations • small number of individual interviews • interviews with yearly sample of directorate managers • general implementation costs	Difficulties noted around: • poor council attendance • changes in the senior nursing team including loss of the project leader • the complexities presented by a model that incorporates a wide range of clinical specialities and sites each with their own challenges e.g. communication • frustration caused by low outputs in the early years of implementation • uncertain limits to council remits • intermittent support e.g. facilitation and co-ordination, training for council members
Buchan *et al* (1998); Buchan (1999)	North Staffordshire Hospital NHS Trust	1997	Case study assessment to provide demographic data and attitude indicators for later comparison • questionnaire survey of 500 nurses and midwives one year on • focus groups	A 60% response rate • barriers to involvement including time out from clinical work to participate and a lack of information • the model was well received by most trust staff • awareness raising and involvement of staff not already engaged was under-developed
Brooks *et al* (1998); Mitchell *et al* (1999); Goode (2003)	Kettering General Hospital NHS	1997	Two-year ethnographic evaluation aimed at identifying any impact of SG on nurses, midwives and patient care quality:	Baseline survey response rate 81% (n=200) of staff on shift: • less positive responses from non-council members around SG such as

	Trust		• 63 council meeting observations • a baseline and exit questionnaire survey • 20 focus groups • 120 interviews • mapping of issues addressed by councils	understanding of the concept, its structures, processes, outcomes and the degree that decision-making was associated with it • later evaluation findings indicated that staff felt more empowered and valued, more able to instigate change and that inter-directorate communication had improved • a negative finding pertained to staff difficulties around release time to be involved in council work
Williamson & Petts (2000); Williamson *et al* (2001)	Rochdale Healthcare NHS Trust	1999	Baseline postal questionnaire survey of all clinical professions staff, repeated one year on as part of an action research study	Response rates of 34% were elicited from 1200 staff in both years: • statistically significant differences between staff groups concerning freedom to make decisions, patient care, inclusion in decisions in the ward/team and inclusion in Trust decisions • Senior G and H grade nurses more likely to have freedom to make decisions over patient care & medical staff much more likely to be included in decisions concerning the ward/team and wider Trust • SG had affected a small number (27) of individuals to remain in the Trust's employment • substantial but varied understanding of the shared governance process • 33% perceived one or more positive outcomes attributable to SG including greater empowerment, improved communication, involvement in Trust decisions and ability to influence change. • negative effects of frustration and difficulty finding time to be involved in SG activities • highly statistically significant variations in staff who had undergone leadership development training or not with the former reporting more positive views around the impact of SG on themselves and the wider Trust including involvement in decision making
Conrad (2003)	Lothian University Hospitals Trust	2000	Annual postal questionnaire surveys of all nursing staff concerning their perceptions of empowerment and job satisfaction	Not reported on due to 15% response rates
Ash *et al* (1998)	Montagu Hospital NHS Trust	1997	Twelve-month study to evaluate the introduction of SG. Methods included questionnaire survey 8 months on of a stratified staff sample to identify expectations, focus group interviews with council members and ward managers and observations of 2 councils	Survey response rate 40% (n=72): 47% wanted more councils, 21% felt SG would increase bureaucracy, 13% believed SG would take too much time, 74% expected SG to increase empowerment, 72% thought SG would support clinical governance. Council members reported feeling inexperienced concerning Trust management processes and concerned about not knowing who key Trust contacts were. Time was identified as the most important resource.

scant or completely absent. For example, despite having undertaken several annual staff surveys, Lothian University Hospitals NHS Trust chose not to publish any findings due to low response rates and a belief that the findings had little value (Conrad 2003).

Looking at the key findings from these eight studies, findings are both positive and negative. In five [(Ash *et al* (1998); Kettering Trust (Brooks *et al* 1998); North Staffordshire Trust (Buchan *et al* 1998); St George's Trust (Legg & Hennessy 1996); Rochdale Trust (Williamson & Petts 2000)] out of the eight studies, SG was welcomed. Benefits included feelings of empowerment, being valued and ability to catalyse change (Kettering General Hospital), and improved communication and increased freedom to make patient care and ward/team decisions (Rochdale Trust). In all studies, difficulties and/or barriers were noted. These ranged from apprehension at increased autonomy (St George's Trust), loss of the project leader (Central Manchester Trust) to time constraints limiting involvement in SG (North Staffordshire Trust, Kettering Trust and Rochdale Trust).

In addition to the available research findings summarised in Table 1, a range of views have been expressed by SG commentators about their experiences. These include some outcomes attributed to SG implementation and problems encountered. For example, achievements at Central Manchester Trust include improved communication through provision of a framework for discussion of nursing issues, advancement of the nursing agenda in areas such as clinical governance and a significant contribution to leadership development (Burnhope & Edmonstone 2003). At the Dumfries and Galloway Trust, nurses were viewed as having a voice concerning organisational issues and patient care and increased opportunities for promoting morale and professional development (Edgar *et al* 2003). A huge increase in interest and calibre of applicants for senior clinical nursing vacancies has been suggested to result from SG implementation at Leicester (Doherty & Hope 2000).

In the Lothian Trust, problems were experienced arising from variable attendance at council meetings, reluctance of managers to devolve decision-making control, and council members' ability to address the issues being referred to them (Conrad 2003). Edgar *et al* (2003) highlight difficulties encountered as a result of the huge effort required to promote understanding of the SG concept, gaps in council membership that impeded progress, and a merger of two councils to cope with the large number of

referrals to one of them, at the Dumfries and Galloway Trust. At Kettering Trust some challenges were presented by changes in Trust nursing leadership, slow progression of council issues, and staff finding it difficult to attend council meetings due to clinical pressures (Goode 2003).

As a result of findings being fed back to trusts, a number of improvements to the SG models have been made possible. For example, in Kettering Trust, findings prompted the appointment of a council secretary and co-ordinator, monthly away-days for chairs, a leadership development programme for chairs and deputies, development of a Management Council and directorate-based councils to foster trust-wide involvement (Goode 2003). Leicester Trust appointed a SG development nurse to address council members' training and development needs, and ward time-out days were extended to prompt dialogue and action around culture change (Doherty & Hope 2000). In Central Manchester Trust, workshops were held in response to some difficulties identified and managers adopted a more empowering stance than previously (Burnhope & Edmonstone 2003). Finally, Rochdale Trust was able to improve Trust-wide communication concerning SG through a range of media, further inform plans to develop the council model to include more directorate-based councils and reinforce further investment in leadership training (Williamson & Petts 2000; Williamson *et al* 2001; Williamson 2003a).

Summary

This section has considered the existing evidence pertaining to SG within the UK. This review of evidence indicates a lack of SG research and variable reporting of research activity. The connections between SG and the research findings reported were sometimes loose in nature. Numerous aspects of SG have been identified as being in need of further research:

1. More evaluation approaches are needed to complement the quantitative approaches that predominate SG research (Brooks *et al* 1998).
2. The rigour of studies needs to be improved upon and their design altered to promote greater generalisability of findings.
3. To do this, there needs to be clear definition of SG and the variables present and research beyond single context-specific sites.

Gaps in the evidence base include the impact of SG on practice and patient care (McDonagh *et al* 1989; Mitchell *et al* 1999) as most research to date relates to impact on staff. Greater focus on longitudinal as opposed to short-term evaluations is needed (Motz & Lewis 1994). In particular, evaluations may consider processes to determine how a system operates, and appraisal of decision-making is suggested as an example of such process evaluation (Smith 1990).

Conclusion

Where revealed, the expectations of UK health care organisations implementing SG have been highlighted. There are neither vast amounts of research nor detailed accounts of organisations' experiences of SG in the UK. This is understandable, as only a small number of organisations have adopted SG to date. Survey methodology predominates, yet rarely are detailed findings published and made accessible to the academic and health care communities.

A number of gaps have been noted within the SG evidence base. Further enquiry is needed around the impact of SG on patients and quality of care. Economic analyses to compare the outcomes of SG with the costs are needed. Longitudinal evaluation of SG processes as well as outcomes would also be valuable. Considering decision-making is the core function of SG models, it is surprising that the topic of SG decision-making processes is also little researched. Researchers should make clear their interpretation of the concept of SG prior to any research endeavour by use of definitions, highlighting what they believe are the core characteristics, and giving a sufficiently detailed description of the SG models in question. This would help enhance validity as well as aid generalising of findings as appropriate to sufficiently similar contexts. In this way, a clearer picture of UK SG could be gained which would be of particular use for future implementers.

Despite a limited evidence base, more and more organisations are exploring the idea of introducing SG, as indicated by attendance at a range of national SG and empowerment conferences (Williamson 2003b). Fortunately, much learning can be gained through informal sharing of experiences of SG implementation, which is a considerably more prevalent activity than research into this subject area.

PART 3 - Decision-Making Within SG

Introduction

Initial review of the SG literature reveals scant mention of decision-making evidence. Where it does exist, the focus is on the outcomes of decision-making processes. There is little or no insight into the processes leading up to and throughout the decision-making trajectory. The following review of this evidence examines perceptions and views of SG decision-making.

Decision-Making

Locus of Decision-Making

Decision-making in organisations has been described as a series of sequential stages that lead up to and include a commitment to action to solve a problem (Mintzberg *et al* 1976). The formalised leadership approach of SG structures provides staff with an accountability-based framework for their involvement in decision-making (Porter-O'Grady 1994a). Through nomination to councils, staff become stakeholders in the decisions the councils make (Naish 1995). In this position, they actually take responsibility for decisions and have the authority to make them rather than advising other decision-makers (Bernreuter 1993). In this way, decisions are prevented from moving away from the point-of-service where they should be made (Porter-O'Grady 1995b).

Each decision-making structure should have a clearly defined remit (Frusti 1996) making it explicit as to what issues are, and importantly are not, under its control (Miller 1997). The type of decisions each structure may make include command, consultative or consensus decisions (Jones 1995). Clear delineation of roles is a key requirement and to ensure members appreciate what contribution is expected of them, a focus on desired outcomes is suggested (Evan *et al* 1995). Hess (1995) suggests that in practice, most SG decision-making concerns patient care issues rather than management concerns such as duty rostering.

Expected Outcomes

A number of authors refer specifically to the decision-making element of SG and in

particular its outcomes. Thrasher *et al* (1992) suggest that clinical nurses' involvement in decision-making has led to their increased awareness of professionalism, autonomy, authority and accountability. Decisions made by those who deliver health care services are believed to result in them having increased responsibility and accountability for their actions (Trueman & Turkeltaub 1993; Westrope *et al* 1995). As a result of that accountability, individuals are made to gather needed information and analyse problems as opposed to reacting to difficulties emotionally (Fitzsimons 1995). Others believe that involvement in decision-making promotes commitment to the decisions made (Trueman & Turkeltaub 1993). Whilst various authors note improvement in decision-making during the course of their SG models, most do not specify in what ways (Edwards *et al* 1994).

Prerequisites

It is generally accepted that devolvement of decision-making can be somewhat of a risk (Doherty & Hope 2000). Evan *et al* (1995) suggest that broad, multi-disciplinary decision-making is preferable to uni-disciplinary approaches as it is more effective. Awareness of the many factors affecting decision-making is raised by Paden (1998:13):

> "...where we focus our attention, how we take in information about a situation, how we analyze the information, how we draw conclusions, our previous experiences, and the decision making skills we have learned."

As SG models become established so processes of decision-making informed by SG will evolve. O'Malley (1992:4) illuminates that as SG models develop:

> "...the degree of empowerment, mode of communication, and decision-making mechanisms shift from hierarchical bureaucratic models to socio-technical models characterized by a high degree of collaboration, integration, and cross-functional partnerships."

Evan *et al* (1995) advocate accountable individuals being led through effective governance processes if successful outcomes are to be assured. Thus the role of the nurse administrator can be key. As SG becomes established, decision-making becomes both administrative and professional, so strengthening the case for having the nurse administrator as an integral link to ensure that practice and corporate goals are similarly met (McDonagh *et al* 1989).

Decision-Making Models

Only one SG publication was identified that focused on a decision-making model (Caramanica & Rosenbecker 1991). These authors present a decision tree developed by staff whilst piloting SG in a single unit at Mount Sinai Hospital, Connecticut. This concerns the receipt of issues for their council structure to address and the channels to which they are directed, depending on the urgency. For example, a clinical practice issue in need of resolving in less than three days can be dealt with by the clinical practice council chair, whilst a management decision would need to be made by a nurse manager. This model offers further guidance to staff by making explicit what the remit is for each council (see Appendix 2 - Decision Tree).

Optimising Decision-Making

A number of suggestions have been made for optimising decision-making. Advice centres on the reduction of factors that inhibit decision-making and the promotion of others that are believed to aid decision-making processes.

Key difficulties centre on the time and effort required for thinking, data collection and gaining others' input and the setting of appropriate timeframes (Reis & Sturis 1995). Trying to reach agreement over decisions can be particularly time-consuming if a consensus decision is sought. This may be a preferred option if agreement cannot be arrived at and a win-win situation is sought whereby everyone involved can sign up to the conclusion (Frusti 1996) even though it may not have been their preferred option.

In order to make decisions, it is important that staff know which type of decision-making is expected of them from the outset and that there is sufficient time, information and opportunity to gain ownership (Jones 1995). Adequate planning, implementation and evaluation of decision-making is advocated and these processes cannot be hurried (Frusti 1996). Difficult decisions can be dealt with more quickly and with a greater degree of consensus as individuals and groups work together in partnership within the organisation (Jenkins 1993).

McDonagh *et al* (1989) suggest that involvement in decision-making is beneficial to individuals because they will own and address problems rather than merely identify with them. Evan *et al* (1995) stress that decisions are best made by those who own or are committed to them and have a stake in their outcome, although simply having the

right people present does not ensure that a good job will get done. Decisions can be informed by the advice and fresh perspectives brought by co-opted members (Geoghegan & Farrington 1995). Involvement of numerous people will lead to generation of more options to solve the problems faced and increase resolve to ensure that they are implemented (McDonagh *et al* 1989). Yet they warn that group decision-making is also more cumbersome (McDonagh *et al* 1989). This point is corroborated by Porter-O'Grady (1994a) who advises that organisational work commitments will be better achieved with as few people as needed to focus on the achievement of specific outcomes. Whilst problem-solving by teams with similar approaches can be beneficial as they work comfortably together, such familiarity can also lessen productivity (O'Brien-King & Pettigrew 1996).

Few SG authors define the kind of decision-making that the various SG models embrace. One exception is Evan *et al* (1995) whose SG model was aimed at all levels including governance, operations and service. Interestingly, these authors point out that with adequate support and information, they believe councils made high quality decisions, although the kinds of support or information are not elucidated. Whilst discussions concerning how decisions are to be made are alluded to, no detail is given.

Other measures to support decision-making include use of a level of authority framework (Yamauchi 1994) although Hess (1994) warns that with such a framework, managers may still retain control over who is involved in decisions and to what extent. This is partly due to managers often maintaining control of the resources that support practitioners to deliver care (Naish 1995).

Summary

The decision-making literature on SG has pointed to a number of things. These include the locus of decision-making as being through an accountability-based SG framework, often in the shape of SG councils. Appointed staff take ownership of decisions made within the SG framework and are thus responsible for any outcomes. To do this, frameworks should comprise clearly-defined roles and remits. Involvement in decision-making is expected to promote professionalism and accountability and commitment to decisions made. This can only be achieved by adequate leadership through the decision-making process.

Only one decision-making model has been identified, although this does have some practical utility, as it is focused on the decision-making process itself. Instead, a range of advice for improving decision-making has been offered, including adequate time, involvement of others and a level of authority framework.

Chapter Summary & Concluding Comments

In Part 1, a concept analysis has identified a number of definitions for SG and elicited its core drivers, principles and defining attributes. If SG is present then a framework for decision-making that exemplifies partnership, ownership, responsibility, accountability and seamlessness can be expected. In Part 2 SG research issues have been identified including the need for qualitative evaluation, process evaluation such as appraisal of decision-making, heightened rigour and generalisable findings as well as further research being needed around patient outcomes. Part 3 has presented the available SG decision-making theory and highlighted factors espoused as promoting or inhibiting improved decision-making within a SG framework.

The overall message from the concept analysis is that there is a range of interpretations of SG with no single definition or model. Developing a sound understanding of the concept of SG enables subsequent attempts to access evidence that truly pertains to SG and not other related concepts or management models.

Following review of the evidence, SG has been shown to offer a range of speculative benefits to organisations adopting it. Whilst research evidence is lacking, the consensus opinion expressed by those involved in its implementation and evaluation is that it holds much promise. Researching a complex phenomenon such as SG presents a number of challenges, no more so than in defining the concept. The evidence reviewed suggests there is a need for continued research into all dimensions of SG to build a substantive and much needed evidence base, not least because its popularity in the UK looks set to continue.

Decision-making is the least researched aspect of SG and an area in which a better understanding is needed. If all the rhetoric is to be believed and assuming appropriate structures, culture and conditions are created, then SG success should follow. If the core activity of SG structures is decision-making, then these processes are what need

particular research attention. Failure to do so is leaving much to chance. Having the pre-requisites for SG decision-making does not mean that effective decision-making will occur.

CHAPTER 3

METHODOLOGY

Introduction

This chapter is divided into six parts and explores the methodological considerations made for this study. Part 1 sets out the conceptual framework and research questions. In Part 2, the relevant theory is considered prior to selecting an overall methodological approach. In Part 3, action research theory is explored in detail. Part 4 considers general researcher role issues and the nuances of the action researcher role. Part 5 explores the use of mixed methods, case study methodology. Part 6 concludes the chapter with a rationale for the methodological approach chosen.

PART 1 - Conceptual Framework & Research Questions

Introduction

This section presents the conceptual framework that has informed the development of the research questions and subsequent study design. A conceptual framework diagram is presented that makes clear the variables of concern and their possible relationships, as viewed at the study outset.

Conceptual Framework

It is generally accepted that each of us has a worldview that frames our approach to the world. Its identification is common practice at an early point in the development of a study. Robson (2002) suggests that we all have 'personal theories' about what is going on and why in a research setting. Miles and Huberman (1994) have written extensively on the subject and advise the following. They recommend development of a conceptual framework in diagrammatic form to make explicit, as best we can, what our orienting ideas are in a study. Building a framework comprises several general constructs that

force the investigator to identify the variables and relationships of most concern. Once established, these can then be made explicit by depicting them within a diagram. They add that frameworks can be "rudimentary or elaborate, theory-driven or commonsensical, descriptive or causal" (Miles and Huberman 1994:18). The purpose is to establish factors that inhibit or promote the operation of mechanisms within a particular context (Robson 2002). These can then be drawn upon in the development and refinement of research questions.

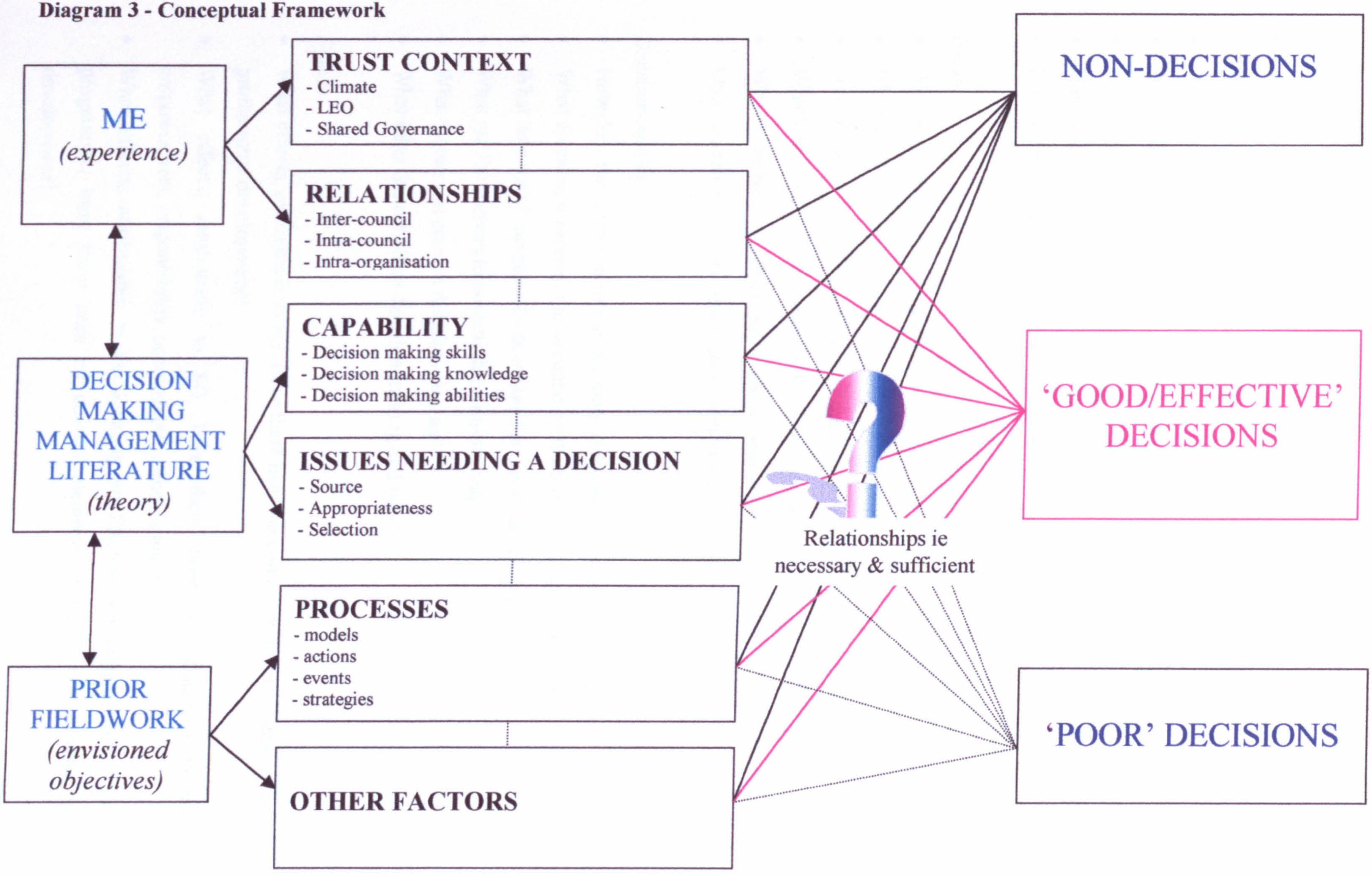
The conceptual framework for this study requires explanation and is to be read from left to right (Diagram 3, overleaf). Firstly, this diagram illuminates three major influences on the study focus. Firstly, there was the researcher in terms of previous experiences, worldview, interests and so on. Secondly, there was the basic decision-making theory, located or known already from previous study. Thirdly, earlier exploratory fieldwork and participation in the research setting leading up to selection of the focus for the study will have informed it and led to the development of some loose expectations. Arrows indicate that, singly or in combination, these three influences were considered likely to have some impact on the next set of variables. It was surmised that any one of these five variables could impact positively or negatively on decision-making so that decisions were either not made, considered good or effective, or considered poor decisions. Inclusion of a further variable labelled 'other factors' acknowledged that there may well be a range of unknown factors other than those presented here, which may be significant but were not included at this time. Indicators of the three possible decision outcomes were not proposed at this stage and were expected to be emergent from the study. The expectation was thus to uncover the actual variables at play and their relationships within decision-making through the research.

Research Questions

Preliminary review of the SG and decision-making literature, early fieldwork, the building of a conceptual framework and consultation with stakeholders in the study led to the development of two research questions:

1. What factors affect decision-making within SG?
2. What steps can be taken to strengthen decision-making within SG?

Diagram 3 - Conceptual Framework



From these main questions, a list of sub-research questions was developed:

Councils

- What is the composition of the SG system being studied - the Rochdale model?
- How does the SG system operate?
- What effect does the setting/context have on councils' decision-making?
- How do council members relate to each other?
- How do the councils relate to each other?
- How do the councils relate to the rest of the organisation?

Issues

- What is the remit of the councils?
- What decision-making duties come with that remit?
- How are issues requiring a decision brought to the council's attention?
- Which of these issues requiring a decision are selected?
- What is the basis on which issues are accepted or rejected?
- Once accepted, how are issues dealt with by the councils?

Decision-making

- How does the council arrive at decisions (activities, processes, strategies)?
- What do council members understand by the term 'decision-making'?
- What do council members think makes for 'good' decisions?
- What are the barriers to council decision-making?
- What factors aid council decision-making?
- What other factors affect decision-making and how?

Effects

- What effects, attributable to SG, have there been on council members' personal and professional development?
- What effects, attributable to SG, have there been on council members' empowerment, responsibility, accountability and authority?
- What effects, attributable to the Leading an Empowered Organisation (LEO) programme, have there been on council members' personal and professional development?

- What effects, attributable to LEO, have there been on council members' empowerment, responsibility, accountability and authority?
- What other factors have affected council members' personal and professional development, empowerment, responsibility, accountability and authority?

Aids

- What preparation, formal or informal, have council members had for their decision-making role?
- What are council members' development needs around decision-making?
- Having gained insights from the above, how can the Trust model of SG be refined to strengthen its contribution to developing members' decision-making abilities?

Summary

Development of the conceptual framework presented here aided the refinement of the research questions and identification of a range of sub-questions considered during the research. Possible variables for investigation were explored and a selection made of those deemed to be of most importance. Assumptions concerning the possible relationships amongst these variables were made and represented diagrammatically. The possibility of unknown variables influencing decision-making was acknowledged.

PART 2 - Methodological Approach

Introduction

To address the research questions and study aims, consideration was given to both quantitative and qualitative methodological approaches. Each approach and issue relating to methodological choices were explored in detail prior to final selection.

Methodological Approaches

Quantitative Approaches

According to Reason (2000), a positivist worldview has generally been accepted by the Western research world. Natural science and frequently positivist social science could

be described as an attempt to reduce everything in existence to a string of variables, each representing an aspect of the phenomenon being studied. These variables can then be related to one another in a statistical equation. Positivists are concerned with demonstrating causal relationships between social phenomena and explain events with reference to law-like generalisations. Quantitative approaches therefore seek understanding of the world through measurement and quantification of observable data (Carter 1996) and attempt to establish probability and generalisation of findings to other settings. Endeavours within this stance are said to begin with a theory which comprises a proposed relationship between phenomena, and to be predictive (Robson 1993). Objectivity is the goal, and to this end, investigators seek detachment from the research setting (May 1997) to prevent contamination.

Qualitative Approaches

In contrast, qualitative enquiry is concerned with the collating and interpretation of non-numeric, narrative data (Polit & Hungler 1993). Phenomena are generally studied in their natural settings with the investigator's aim being one of interpreting the meanings people ascribe to them (Denzin & Lincoln 1994). In particular, they address a key weakness within quantitative approaches, whereby the research takes place in an artificial context (Gill & Johnson 1997). Through their endeavours, qualitative researchers seek to develop rich descriptions and generate theory. The intention is to develop theoretical, rather than statistical, generalisations (Yin 1994). This approach is particularly appropriate when investigating a topic where knowledge is presently underdeveloped or possibly biased (Morse & Field 1996). Finally, subjectivity is intrinsic to the qualitative research process. Rather than striving for detachment, the researcher forms part of the instrument of data collection, data interpretation and analysis (Parahoo 1997).

Methodological Choices

All research designs have their merits and weaknesses. Decisions need to be made as to which approach is preferable and which method/s would be most suited to achieving the goals of the enquiry. For example, generating and testing hypotheses to try and explain social phenomena is an acceptable pursuit, only if such activities fit with the investigator's own 'conception of reality' (Harré 1979). Thus the worldview of the investigator or research team members will influence choices made.

As a result of their stance, researchers with a quantitative leaning may, purposefully or inadvertently, not test rival hypotheses that may refute their own, and so a truthful explanation may be no nearer to being arrived at. A crucial characteristic of positivism is the dualism between being able to separate subject (observer, researcher) and object (the known, observed). Others argue that this in itself is mere assumption, thus illuminating the contradictory nature of positivism (Gill & Johnson 1997).

Gill and Johnson (1997) explore some of the issues around making methodological choices. They argue that the inadequacies of positivism, including prescriptive approaches and aims to explain human actions as being directly and mechanistically influenced by external stimuli, have promoted adoption of more interpretative approaches. Research with humans needs to focus on understanding how sense is made of their surrounding world through their purposeful actions, as opposed to being subject to stimuli within their external environment.

Rather than being confined to seeking statistical generalisations, the value of developing theoretical generalisations has been identified through qualitative approaches. In this sense, qualitative research has been labelled 'hypothesis generating' (Robson 1993), meaning that its end point may be new theory that others may then test out in other settings. What is not being suggested is that qualitative research approaches serve to primarily supplement quantitative ones, although some have argued this. It is rather that they are appropriate for certain kinds of inquiry.

Three key components of interpretative approaches are the integration of data collection and analysis (Robson 1993), involvement of the research subjects as participants in the research process (Heron 1996), and purposeful influence arising from the researcher's involvement (Morse & Field 1996). Integration of data gathering with analyses is beneficial, as the research design can evolve in the light of insights emerging through earlier analyses. Flaws identified in the design can be corrected and new avenues of enquiry initiated. Involvement of participants can be advantageous, as they are often 'experts' within the setting under study. There is potential for them to contribute to the design (and other stages) of a study and make it more meaningful and suited to the research setting with which they are often familiar. Furthermore, involvement can promote the ownership and uptake of findings and lead to desired changes being made either directly in practice or indirectly by perhaps informing policy under development.

Influence by the researcher can be particularly appropriate, so long as this involvement is executed in a rigorous and responsible way. That is, they must remain critically self-aware of their own views and biases, influences (such as relationship to participants), goals and limitations and ensure that professional research conduct is maintained.

Yet critics of qualitative approaches would suggest that objectivity has been lost by these measures. However, objectivity is not the goal of enquiries that seek to understand the meanings people attribute to phenomena, as these are unique, context-related and not replicable (Parahoo 1997). Again, one can counter-argue that achievement of complete objectivity is not possible even within quantitative approaches. A simple example relates to the choice of items to include in a questionnaire.

A further issue concerns beliefs about 'knowledge' within each approach. This has been illustrated by Everitt *et al* (1992). They comment that within positivism, the 'knower' and 'reality' exist independently. Furthermore, conclusions may be arrived at without consideration of beliefs about their meaning held by the 'knower' or the context in which they have been derived. Interpretivists have regard for subjectivity, values, beliefs and the opinions of the 'knower' about that which is considered to be known. Understanding, as opposed to explanation, is the goal. Critical approaches have beliefs about social context, including processes and structures, and how they shape subjective understanding of the world. That is, reality is socially constructed as opposed to being individually constructed. Ultimately, a researcher's philosophical view of human action and explanation colours methodological choices.

Selection of a Methodological Approach

The continuous debate around quantitative versus qualitative approaches looks set to continue *ad infinitum*. Having considered the principles of each approach, a qualitative methodology was chosen as it gave the best fit. The rationale for its choice is as follows:

1. A qualitative approach is appropriate to the study aims and research questions. That is, the study sought not only to identify factors affecting decision-making within SG, but also to understand the processes between these factors that led to effective decision-making.
2. Qualitative research may present a number of practical issues. Examples include, the availability of resources, ease of access to the setting and ethical concerns (Parahoo

1997). Qualitative methods have a tendency to be quite time-consuming (Morse & Field 1996). These issues were considered manageable in view of study costs being allowed for in the study's funding schedule, personal skills developed at Masters level, time available to undertake the study and commitment to addressing access and ethical issues fully.

3. The SG project leaders expressed commitment to releasing participants to engage in extensive fieldwork and maintaining access to the research setting.
4. The vast majority of participants were anticipated to be professional health care workers. These were not expected to present difficulties regarding factors such as language, culture, age, comprehension and so on (Morse & Field 1996).
5. Researchers' practice orientation is a factor, as some people are more suited to certain types of research and may be influenced by their disciplines (Strauss & Corbin 1998). My own orientation is that of nursing practice which, as a mode of social organisation of care delivery, lends itself more to qualitative enquiry (Johnson 1999).
6. The nature of the topic under investigation is a more valid reason for choosing a qualitative approach (Strauss & Corbin 1998). The maturity of the concept being investigated is also important as, when much is known about a topic, it is probably sufficiently developed to be researched with quantitative methods (Morse & Field 1996). Little is known about decision-making within SG, which lends itself to an exploratory, qualitative design with the aim of gaining a better understanding of the concept.

Summary

The merits and challenges of quantitative and qualitative approaches have been examined. Justification has been given for the selection of a qualitative approach as a framework for this study. Reasons for this choice, including appropriateness of the topic, practical issues, researcher orientation and the dynamic nature of SG decision-making have been presented.

PART 3 - Action Research Approach

Introduction

The choice of a qualitative approach was, however, not sufficient. What was needed was an approach that was responsive to the fluid and unfolding nature of SG implementation and would complement the Trust's wish to learn from the project as it was formatively evaluated. This led to examination of action research as a framework. Meyer and Batehup (1997) comment that approaches such as action research have developed within practice disciplines in part due to a rejection of traditional positivist and interpretative approaches.

Within this section action research is closely considered to establish its appropriateness for meeting the needs of this practice-based enquiry. A rationale is given as to why this approach was finally selected for use in this study.

Action Research

Origins of Action Research

It is widely accepted that action research has its roots in action science. Advocates of social action suggest that mainstream science is inadequate in integrating theory and practice, as it does not lend itself well to practical application. The variables concerned may be many and constantly changing (Argyris *et al* 1985). As Carr and Kemmis (1986:180) note, social research occurs:

> "...in social situations which typically involve competing values and complex interactions between different people who are acting on different understandings of their own common situation and on the basis of different values about how the interactions should be conducted."

Thus, theory for practice cannot be applied to a specific set of controlled circumstances (variables) and should instead have practical application in a variety of situations. To this end, 'action science' was developed as a means of bridging the traditional separation of knowledge and action as expounded by John Dewey and Kurt Lewin (Argyris *et al* 1985). In doing this, the integration of theory and practice are promoted with the expectation of some kind of change as a result.

Lewin (1946) suggests that the two main concerns of social research are general laws of group life and diagnosis of a specific situation. Rather than natural science laws, these social research laws guide the achievement of objectives under specific conditions (Lewin 1946). Yet more orthodox social researchers may be uncomfortable as they view that multidisciplinary, eclectic research drawing on multiple philosophical stances is inappropriate and lacking in simplicity (Greenwood *et al* 1993). Others have attempted to legitimise action research by allying it with philosophical viewpoints such as praxis, hermeneutics, existentialism, pragmatism, process philosophies and phenomenology (Susman & Evered 1978). Another response has been to label action research 'new paradigm' research and to associate it with critical social science, which itself adopts a self-reflective mode of theory development that is heavily influenced by participant interpretations (Meyer 1993).

Action Research Schools

Rapoport (1970) describes four main streams of current action research development: the Tavistock, operational, group dynamics and applied anthropology streams. Each represents a group of researchers sharing a common perspective and focus to their work. For example, the latter group values the importance of culture, whereas the group dynamics stream is concerned primarily with issues around leadership, power and group dynamics (Rapoport 1970). A key shared driver for action research development is a desire to promote social action and change.

Defining Action Research

Rapoport (1970:499) gives the following definition of action research:

> "Action research aims to contribute *both* to the practical concerns of people in an immediate problematic situation and to the goals of social science by joint collaboration within a mutually acceptable ethical framework."

In their description, Hart and Bond (1995:35) allude to the wide applicability of action research to a range of settings:

> "Drawing on the social and natural sciences, and being applied to a range of different problem situations, action research has a hybrid genealogy, and this is expressed in the variety of approaches which it has generated."

More recently, a clear and comprehensive definition of action research was developed by Waterman *et al* (2001:11), as part of a systematic review of UK action research studies in health care. Whilst lengthy, it succeeds in encompassing the key elements and variations of action research replete within the literature:

> "Action research is a period of enquiry, which describes, interprets and explains social situations while executing a change intervention aimed at improvement and involvement. It is problem-focused, context-specific and future-oriented. Action research is a group activity with an explicit critical value basis and is founded on a partnership between action researchers and participants, all of whom are involved in the change process. The participatory process is educative and empowering, involving a dynamic approach in which problem identification, planning, action and evaluation are interlinked. Knowledge may be advanced through reflection and research, and qualitative and quantitative research methods may be employed to collect data. Different types of knowledge may be produced by action research, including practical and propositional. Theory may be generated and refined, and its general application explored through the cycles of the action research process."

It is because of the broad applicability of action research that such a complex definition is required, rather than it being an indication of action research lacking in clarity or substance.

Action Research Typologies

A small number of action research typologies has been identified, and Hart and Bond (1995) distinguish four types of action research:

- *Experimental,* drawn from early action research influences, including Lewin's change experiments and work around developing general laws of social life to inform policy development.
- *Organisational,* concerned with problem-solving in organisations aimed at improving work relations and productivity.
- *Professionalising,* with an emphasis on raising the status of new professions such as nursing and promotion of research-based practice.
- *Empowering,* with its origins in anti-oppressive community development work.

In contrast, Holter and Schwartz-Barcott (1993) have proposed a tripartite typology:

- *Technical collaborative,* whereby a pre-determined intervention is implemented in practice through the involvement of practitioners.
- *Mutual collaboration,* whereby practitioners are full participants in all stages of the endeavour aimed at jointly identifying the problem and solutions.
- *Enhancement approach,* concerned with the collective consciousness-raising of participants as well as linking theory and practice to address local problems.

The choice of which typology to use is one of personal preference. None are meant to be prescriptive and movement within each typology is acceptable at different stages in the research process.

Elements of Action Research

Action research may have multiple purposes (Chisholm & Elden 1993). For example, there is the more traditional aim to improve organisational performance and create social science theory. Alternatively, it may be more radical, intending to raise levels of consciousness, explore social problems and empower the oppressed. Rapaport (1970) suggests that there is a spectrum with action at one end that is not theoretically informed and research at the other that is lacking in relevance. The goal of action research is to strike a balance.

Whatever the intentions, action research approaches share several commonalities. Extensive work by Hart and Bond (1995:37) identified seven key elements of action research and suggest that it:

1. Is educative.
2. Deals with individuals as members of social groups.
3. Is problem-focused, context-specific and future-orientated.
4. Involves a change intervention.
5. Aims at improvement and involvement.
6. Involves a cyclic process in which research, action and evaluation are inter-linked.
7. Is founded on a research relationship in which those involved are participants in the change process.

Each is element is now discussed in turn.

1. Educative

The educative element of action research is multi-dimensional, incorporating learning arising from reflection on such things as participants' actions, values, the research topic itself and change management (Waterman *et al* 2001). This view is shared by Schön (1991) who says that it is through systematic reflection that learning takes place. Thus action research is purported as having considerable potential to increase the amount of conscious learning from experience.

Much of the learning, for researcher and participants alike, may involve identification of conditions for developing and disseminating the very changes prompted by the research (Karlsen 1991). That is, learning through discovery of what worked, what did not work, reasons for these and ways of refining or improving the approaches taken in the future. Thus learning is promoted within the study itself and may provide general educative insights for others in similar situations and settings beyond the immediate situation. Learning can be at an organisation-wide level or focused in the group collaborating within the study; 'a community of inquiry', as Reason (1999) describes it. In the latter forum, iteration occurs through the cyclical stages of the action research process, supplemented by peer support and critical review. This leads to reflection that ends with a shift from attention on the anticipated outcome to the learning process itself.

As participants work together, they can develop their relationship as a learning network which permits opportunities such as the sharing of experiences, benchmarking of activities, testing out of ideas with peers, opportunities for feedback and reflection (Levy & Brady 1996). Action within practice and learning is therefore integrated and not separate.

2. Individuals in social groups

Researching social settings is somewhat complicated, yet the benefits can be many. Greenwood *et al* (1993) point out that involvement of research participants within their own organisations has the potential to yield results that are socially meaningful as well as scientifically meaningful. Watts and Jones (2000:378) suggest a number of similarities between action research and inter-professional practice:

> "...promoting and implementing inter-professional practice is inherently challenging and problematic, since it seeks to draw together professionals from different backgrounds with unique identities, ideologies, values, knowledge, culture and power base."

There may, though, be a tension between identifying the individual view and the collective view. There is also the issue of more than one 'insider' having different interpretations of the same actions and events. In these situations, complete explanation is unachievable not least due to incompleteness of data and numerous impacting variables. As Argyris *et al* (1985:27) argue:

> "Hence a proffered interpretation can be valid, in the sense of possessing causal explanatory power, only if it was a reason for the agent in question".

Lewin (1946) expresses the view that inter-group relations depend on cultural standards rather than individual character traits. Their stability and change are as a result of occurrences within groups as groups. However, their 'permanence' may be doubtful. For example, while leadership training workshops motivate individuals, when they return to the work place, their impact is often diluted (Lewin 1946).

Shared interpretations and common understandings may often be the goal, but an individual interpretation is not necessarily a less adequate one. Action research can be effective at an individual professional level and organisation-wide (Hart & Bond 1995) and as such may be particularly attractive to health care researchers. Indeed, it has some similarities to the nursing process, that is, enquiry, intervention and evaluation (Hart & Bond 1995). Involving practitioners also coheres with current health care policy drivers and the need for responsive practitioners to implement research findings in practice.

3. Context-specific, problem-focused, and future-orientated

How action research progresses is dependent on the structure, conditions and issues within an organisation at a given time (Greenwood *et al* 1993). Kitson *et al* (1998) identify the components of 'context' as comprising culture, the nature of human relationships and monitoring of systems. The organisational context can affect the readiness of an organisation for change, impact on the type and degree of collaboration possible, and thus influence how the researcher's role is defined (Chisholm & Elden

1993). In some contexts, use of a more participatory action research approach will not be feasible. The organisation has to be receptive to this approach and have a willingness to instigate change as a result of the process (Greenwood *et al* 1993). Furthermore, the impetus for an action research endeavour can be critical. Whether as a result of a crisis situation or an individual's concern from practice, the context may provide opportunities as well as constraints.

Hart and Bond (1995) describe action research as problem-sensing and problem-focused with direct researcher involvement to purposefully impact on the issue concerned. In terms of its application, Waterman *et al* (2001:22) suggest that action research may comprise:

> "...small-scale interventions, often as part of a larger project, that are reflected on, planned and implemented, reflected on and adapted, and not necessarily formally evaluated."

The process of collaboration is one of jointly establishing the problem focus, identifying the change required and an associated action plan to achieve it (Holter & Schwartz-Barcott 1993). Hence action research is concerned with improving the future of participants (Susman & Evered 1978).

4. Change intervention

Action research seeks to improve practice by reducing the disparity between theory and practice. In nursing, it is well documented that a gap exists between evidence about what is known and what occurs in practice (Mulhall 1997; Thomson 1998). Whilst some practice is based on research, much of it is based on experiences, tradition, intuition, common sense and untested theory (Burrows & McLeish 1995). Traditional research approaches have been criticised as not reducing the practice-theory gap in health care, largely due to the limited utility of the knowledge derived from them (Nolan & Grant 1993). Issues around the limited relevance of published research findings and a failure by researchers to address problems relevant to practitioners have also been highlighted (Susman & Evered 1978). Where findings have been relevant, there has still been reluctance to utilise them in practice, and numerous studies have been undertaken to understand why (Bostrom & Suter 1993; Hicks 1995; Hundley *et al* 2000; Le May *et al* 1998; Parahoo 2000; Rodgers 1994).

Organisational context and supportive climate for change feature highly as requirements for research implementation (Le May *et al* 1998; Parahoo 2000; Veeramah 1995) Kitson *et al* (1998) advocate involving staff in the development of action plans for change. Moreover, organisational changes will be more effective if they fit in with existing beliefs and ways of working (Sibbald & Roland 1997).

Unlike mainstream research, the emphasis in action research is more concerned with effecting change than theory development (Holter & Schwartz-Barcott 1993; Waterman *et al* 2001). This may lead sceptics to suggest that action research approaches are mere practice development (McNiff 1988) and not research at all (Meyer 1993). Yet it is this combination of research and practice outcomes that give it strength as a catalyst for change (Waterman *et al* 2001). Hence action research has proved popular in health care practice settings as a means of introducing change (Webb 1989).

To be successful, Nolan and Grant (1993:307) suggest that action research necessitates:

- A shared and explicit set of values acting as a guide for practice.
- Recognition that a problem area exists.
- A common understanding of the problem.
- A perceived need for change.
- A situation that is viewed as amenable to change.
- A focus on involvement and team building.

Having realised a desirable change, the difficulty can be in maintaining it, particularly after the lead researcher/s withdraw their presence. A common problem with more collaborative approaches is that change is less likely to be sustained as participants themselves leave the setting (Holter & Schwartz-Barcott 1993) so taking their shared understandings of the problem with them. How change is effected and maintained is a key concern for action researchers.

Whilst several models of change management exist, there is no one best way identified for promoting change within an action research endeavour. Whilst popular and influential, Kurt Lewin's three-stage model of change has been criticised. It involves *unfreezing* (preparing the organisation for change), *change* (planning and implementing the change), and *refreezing* (consolidating the organisation in its new way of working).

Yet Dick and Dalmau (1997) suggest that this assumes change is a discrete and pre-planned activity. They suggest that modern day organisations are shifting responsibility for change and improvement to employees, and so their involvement in change processes is increasingly viewed as advantageous.

5. Improvement and involvement

Action research is about involvement and improvement both of personnel and the systems they form part of (McNiff 1988). It is important to remember that the change process can be directed at concerns other than practice (Holter & Schwartz-Barcott 1993). Yet it is practical issues that are usually focused on, with little regard for theoretical concerns. In their review of health care action research studies, Waterman *et al* (2001) draw attention to the poor attempts at defining theory generated within the studies reviewed. They explain that emphasis was placed on the development of practical knowledge, individual practitioner understandings, and the actions themselves, rather than the reasons for them. Furthermore, whilst change processes were examined there was an absence of theoretical insight into the actual topic under investigation. Thus a great advantage may have been lost, as action research has much more to contribute if utilised fully. For example, the cycles of action research allow participants to explore practical and theoretical understandings from a variety of perspectives, across settings, so promoting the general application of findings (Waterman *et al* 2001). Whilst generalisation in terms of quantification, duplication, replication and prediction is not the goal (McNiff 1988), generalisation at a theoretical level is a real possibility. Thus action research has utility in developing theory to inform improvement within and beyond the study setting.

Responsibility for improvement lies with those who appraise action research findings, as they must decide upon their applicability to their own situation rather than accepting the prescriptive generalisations of positivist approaches (Meyer 1993). Yet with freedom to decide and act comes the risk of groups losing their sense of direction in the achievement of the overall objective. To illustrate this, reference can be made to Lewin's (1946) boat analogy. A captain is correcting the steering of his boat and all appears fine. Yet the boat is going around in circles and not achieving its destination. The course taken will depend on many factors including the researcher's role and relationship with participants, the context, individuals' motives and concerns and so on.

Lewin (1946) uses the term 'social planning of action' which usually involves a number of processes. Starting off with a general idea to meet an objective, the first step is usually further examination that leads to further fact-finding which, if successful prompts an overall action plan. By this stage, the original idea may have been refined. Once the first action within the overall plan is executed, more fact-finding results and this is then used to review the first action. This fact-finding is used to evaluate the action and identify whether objectives have been achieved or not. It offers an opportunity to learn from what has occurred and informs the next step. Lastly, fact-finding supports a review of the overall plan. This process has the clear underpinnings for what has commonly become termed 'action research cycles'.

McNiff (1988) presents action research as a systematic enquiry comprising a self-reflective spiral of planning, acting, observing, reflecting and re-planning. Hence, action research is a process of critical thinking and development of theories and rationales, giving "reasoned justification to claims to professional knowledge" (McNiff 1988:3). An action research project does not therefore take place in discrete stages. The various elements and phases overlap and influence each other so that discovery is integrated with action. As might be expected, this blend of stages can realise something of far greater utility to practice than the generation of theory alone.

Actions are revised or affirmed as a result of their consequences being evaluated; thus, theory generated is grounded in practice (Susman & Evered 1978). However, action research spirals may risk a lack of explanation about what is observed and described (McNiff 1988). For example, interventions within an empowering approach, such as the building of alliances, opening up lines of communication and re-framing issues, may not be easy to identify (Hart & Bond 1995). Hence the important issue is raised that interventions may be less than discrete and more accurately described as contributory factors. This makes the establishment of 'causes', and thus prediction and appraisal of outcomes, that much more difficult (Waterman *et al* 2001).

Identification of success and improvement arising from interventions poses problems, not least as views may differ between researcher, participants and managers as to what constitutes 'success'. Thus the value placed on the outcomes may well be a judgement

of those that commissioned or participated in the study. Yet positive outcomes can be achieved throughout the action research process and are not just goals to be achieved at its end. Neither is action research merely concerned with positive end outputs, as action research is still an appropriate label where an intervention has failed yet something has been learned and evaluation of the processes has taken place along the way.

7. Participation

Practitioners provide insider knowledge and expertise pertaining to the setting being studied (Holter & Schwartz-Barcott 1993) and their participation is intrinsic to action research. Participation is expected to generate ownership by participants of the problem and actions aimed at reaching solutions to the problem (Whyte 1991). The alternative may be the imposition of 'top-down' change that is possibly not the most appropriate or sustainable change to instigate.

Gill and Johnson (1997) suggest a number of ways in which participation can occur. Examples include identification of the problem to be researched, diagnosing of the problem, joint development of a tool such as a questionnaire, jointly agreed action plans and joint review of progress. Dick (1997) lists a range of participant's roles including that of informant, interpreter, planner, implementer, facilitator, researcher and recipient.

The extent to which participants perceive ownership may depend on the source and relevancy of the problems. However, full participation of group members is not usual from the outset, but evolves gradually during the project's lifetime (Greenwood *et al* 1993). Furthermore, Hart and Bond (1995) warn that participation can only be encouraged and facilitated and is very much dependent on the setting, circumstances and attributes of those involved, and as such can not be imposed. This view is echoed by Waterman *et al* (2001) who describe a wide range of participation dependent on the aim of the study, stage of the study, experience of the researcher, philosophical approach, personal factors, and financial and human resources available. Whilst an element of participation can be an objective of a study, it cannot be made to happen, only worked towards.

Greenwood *et al* (1993) comment that the participatory intent of the research is an important issue, but is often less focused on within the literature. Much is dependent on

the research design and whether the researcher wishes to retain control over the research processes or utilise participants' local knowledge and contributions (Chisholm & Elden 1993). Meyer (1993) questions whether true collaboration can actually be achieved when a power relationship exists between the researcher and participants, however noble the intentions. She even suggests that the scope for exploitation is greater in such new paradigm research compared with positivistic approaches where relationships are more prescriptive. It is therefore up to the researcher to constantly reflect on the participatory elements in a given situation as a means of refining their approach to its promotion (Greenwood *et al* 1993).

Summary

This section has illuminated the origins of action research and defined it as an approach that may generate practical knowledge as well as develop theory. Core characteristics common to all action research types have been identified and examined. Action research is concerned with the rigorous examination of practice and meaningful participation of stakeholders to arrive at solutions to a problem or concern. It seeks to generate knowledge and understanding that may have utility beyond the research setting. A number of factors have been highlighted that promote the success of an action research endeavour, including the degree of ownership experienced by participants, the context within which it takes place, and the approach undertaken by the researcher.

PART 4 - Researcher Role Issues

Introduction

There are a number of issues and considerations around the role undertaken by researchers, dependent on whether they are viewed as external, internal, or practitioner-researchers. Action research roles also have their own peculiarities. These issues are considered in this section.

External Researcher

The nature of the researcher relationships with the participants can vary from an 'outsider' academic researcher to an 'insider' practitioner-researcher. Chisholm and Elden (1993) suggest that the external researcher brings general knowledge of systems, social science and research, whilst participants understand the local situation better.

Working within an organisation as an 'outsider' researcher can present difficulties. For example, it may require incorporation of some managers' wishes into the research brief in order to gain the required access. The commissioning brief may specify or allude to a preferred approach and this can be a tension for the researcher wanting to determine the best approach that fits the problem being investigated. However, the researcher also needs access and support through the commissioners, and so negotiation of these requirements can be tricky. Tensions may also arise around the kind of data preferred by the different stakeholders and their intended outcomes, for example changed practice or policy, ways of working and so on.

Difficulty can also arise as health care organisations provide practice-oriented services whilst researchers come from a discipline-oriented university and may hold differing values and beliefs (Mulhall 1997). The change may not be sustainable once the researcher has left the setting (Titchen & Binnie 1993a). To offset this, partnership working between an internal facilitator and an external researcher may present a solution (Titchen & Binnie 1993a). This model presents advantages in terms of access, psychological, emotional and intellectual support and sharing of responsibilities.

Internal Researcher

Argyris *et al* (1985) suggest that understanding of action is akin to understanding a language, as this too only makes sense in the particular community of practice where it occurs. Practice-based studies are not uncommon and undertaking research in the workplace can have its advantages. Rather than being given 'sanitised' explanations for occurrences as in the case of outside researchers, Cole (1991) commented that he received more open and honest representations from participants as an insider researcher. Insider researchers generally have insight into the context and politics, know who to approach for easier access and may anticipate problems better than an outsider

researcher (Robson 2002). Trust and rapport are likely to exist already between participants and researcher (Morse & Field 1996). Unlike external researchers, they do not have to cultivate and rely on informants to ensure sufficient insider understanding (Lofland & Lofland 1995).

As regards disadvantages, there are several. Whilst insider researchers are likely to endure fewer difficulties with implementation, they may lack expertise and confidence (Robson 1993). Insider qualitative researchers could be criticised for failing to achieve sufficient objectivity due to being too close to the data (Coghlan & Casey 2001). At worst, this could lead to biased assumptions about what is happening (McNiff *et al* 1996). Yet achievement of true objectivity in social research is a myth (Rolfe 1996). What is needed is a balance between sensitivity and objectivity (Strauss & Corbin 1998). Maintenance of pre-existing work relationships is difficult and due regard is needed to prevent the researcher being construed as patronising. Williams (1995) argues that this is offset by the fact that the internal researcher generally shares the same occupation as the participants. Regardless, exploitation of participants must be avoided.

Practitioner-Researcher

An increasingly popular practice is research being undertaken by nurses in their own workplace (Coghlan & Casey 2001). A practitioner as researcher, as described by Robson (1993), is someone who undertakes systematic enquiry in relation to his/her employed work. The dual role of colleague and researcher can be challenging to relationships, especially in a hierarchical setting (Robson 2002).

Yet having authority in the workplace can be both beneficial and a hindrance to the researcher. For example, burnout may arise from the emotional investment in one's own setting (Titchen & Binnie 1993a). Coghlan and Casey (2001) stress the value of pre-understanding that action researchers bring to studies in their own workplace. Furthermore, practitioner-researchers may be viewed as having less status than external academic researchers (Elliot 1991).

Action Researcher

An action researcher needs to embrace the range of researcher roles described above. Whatever role is adopted, action researchers face a number of issues that are pertinent if not exclusive to their discipline. There can often be a complex relationship between the

researcher and participants. Susman and Evered (1978) suggest that both the action researcher and participants contribute expertise to the research relationship in the form of theoretical knowledge and experience and local knowledge and experience respectively. Holter and Schwartz-Barcott (1993:300) elaborate by saying that practitioners from within the action research setting are viewed as having:

> "...a historical perspective of the organization's development, knowledge of how members expect things to be done and personal knowledge, experience and practice of how things are done, although this later base of knowledge is not always well documented or systematized."

Susman and Evered (1978) point out that the interdependence between researcher and the client system, and the ethics and values that each have are intrinsic to the action research process. They go on to say:

> "The success of action research hinges on understanding of the values of the relevant actors since such values guide the selection of means and ends for solving problems and develop the commitment of the actors to a particular solution."
>
> (Susman & Evered 1978:598)

Democracy is often referred to in writings about action research and is a concept manifested by group decision-making (Waterman 1995). Elden and Levin (1991) suggest that people have a 'right' to quality jobs. What it does not mean is that researcher and participants can take part equally throughout a project (Karlsen 1991). There are practical and ethical issues around the decision to act, the positive and negative impacts resulting from action and where the responsibility for these lies (Argyris *et al* 1985). Being an agent of change is not straightforward and success very much depends on the climate of the change setting and degree of participants' resistance to change (Titchen & Binnie 1993a).

The empowering element of action research arises from the intention to address current inadequacies or inequalities in the setting (Waterman *et al* 2001). Importantly, empowerment of participants means that decisions about the nature of the researcher's involvement are not simply the choice of the researcher. Marrow (1998) advocates that the researcher and participant roles should be negotiated early on, and did this in her own work through workshop-type events. Karlsen (1991) also made use of voting,

conferences, and representative staff meetings to clarify issues around what problems to address, what measures to take in response and the roles of participants and researchers within these processes.

Participants empowered to act may do so in a different way to the researcher and indeed exclude the researcher from the group altogether (Hart & Bond 1995). A real risk with empowering action research is the loss of control over the situation by the researcher, although in many ways this is what is desired if true empowerment is to be realised. Misuse of participation approaches can result in manipulative techniques being employed as opposed to a genuine attempt at joint working (Hart & Bond 1995). Then again, ensuring the involvement of people with organisational authority, such as those with responsibility for allocation of resources, can affect the outcomes of any actions or decisions by participants and could be seen as a legitimate move.

Nisbet and Watt (1984) describe the researcher within case study research as the 'chief instrument' and it is suggested this is also the case in most action research. In terms of contribution, participants are not expected to have the same expertise as the researcher, hence the need for negotiated roles and discussions around aspirations for the research study. Yet it is primarily the researcher's responsibility to ensure that research outputs are shared with the research community (Karlsen 1991).

A key focus within action research is a concern with researcher and client relationships. To effect their role, it is crucial that the researcher develops the best possible social relationships, not least to help with issues around accessing the data (Nisbet & Watt 1984) and to promote utilisation of the study findings (Gill & Johnson 1997). Development of relationships with stakeholders is dependent on intuition, personality and the research context (Nisbet & Watt 1984). To be able to communicate effectively across settings and agendas means that action researchers need to have excellent communication skills (Meyer 2000).

Researchers have a responsibility to deal appropriately with pressures they may encounter. For example, research funders may have time expectations around the availability of findings or not be welcoming of 'negative' findings (Lathlean 1994). Thus political awareness is required of action researchers to fulfil their role, as their presence and actions can be viewed as threatening by the organisation they are involved

with (Coghlan & Casey 2001). Continued development of the action researcher role itself is important within a study and necessitates personal development and learning through a process of reflection (Karlsen 1991).

Summary

This section has identified a range of possible researcher roles that may be adopted within a study. Action researchers may undertake endeavours within their own workplace as insider researchers or act as external researchers in other settings. Action researchers have particular issues to address around their role including the fostering of meaningful participation, involvement of participants in the research design decisions and maintenance of appropriate relationships.

PART 5 - Case Study

Introduction

This section draws on a Case Study Protocol developed for the study as advocated by Yin (1994). The purpose of its use has been to provide a tool to guide the case study design element of the doctorate. Such a protocol is also desirable as a means of promoting reliability in case study research (Yin 1994). The section begins with a review of case study literature.

Case Study Method

Case studies are particularly appropriate when contextual conditions are pertinent to the phenomenon being studied (Yin 1994). Perhaps unsurprisingly, the main criticism of the case study concerns generalisability of findings, yet Sharp (1998) points out that valid theoretical generalisation, as opposed to statistical generalisation, is what is being sought. Robson (1993) describes exploratory case studies as ones which aim to get a feel for what is going on in a novel situation, and as such this type of study may be more emergent than tightly pre-planned, although most case studies tend to be somewhere along the continuum between exploratory and confirmatory.

In this study, the SG model cannot be separated from the Trust and wider NHS context within which it is situated, and so to understand the model it is necessary to appreciate the setting it operates within (see Chapter 1 - Introduction). The study is not entirely emergent as a substantive body of knowledge around professionals' decision-making is already in existence, particularly in the management literature from which considerable SG literature has evolved. Yet no one model of decision-making is advocated in the SG literature. What is novel, so meriting further investigation, is decision-making within SG and in particular this model of SG.

It is essential to ensure that the focus of the case study, known as the case or unit of analysis, is clearly related to the original research question (Yin 1994). The unit of analysis in this study is the overall model of SG in Rochdale Healthcare NHS Trust, for which a single case design was developed. One rationale for the use of a single case design is when the case being investigated is unique (Yin 1994). This SG model is considered somewhat unique compared with the handful of others established in the UK at the outset of this study. As discussed earlier, the Rochdale model of SG adopted a multi-disciplinary, councillor approach from the outset. It comprised three practice-based councils supported by a Policy Council, and a directorate-based council. Evaluation was in-built within the implementation process, to commence prior to the councils becoming fully operational.

Mixed Methods

Case study is an approach that supports the use of multiple research methods most suited to answering the research questions and enabling discoveries within and interpretation of the social world (Coffey & Atkinson 1996). A number of arguments have been presented for the use of multiple methods to study subjective phenomena, including criticism of positivism (Webb 1989).

Johnson *et al* (2001) advocate for multiple methods so long as those adopting them fully comprehend the associated strengths, weaknesses and fit. Multiple perspectives may give researchers a fuller, more holistic picture than can be gained from a singular perspective (Morse 1994; Webb 1989). Yet no force of fit between methods and approaches is suggested and previous proponents of such a suggestion have been likened to 'armchair theorists' (Bryman 1988). Bromley (1986) points to triangulation

as enabling greater confirmation of the conclusions. However it is not just about strengthening conclusions but drawing on different tools as appropriate for the different elements of the enquiry, so promoting rigour. This point is developed further by Denzin and Lincoln (1994:2) who argue that "objective reality can never be captured", and so triangulation is not about promoting validity but rigour.

Whilst the lack of representativeness achieved by the case study has been criticised (Hamel *et al* 1993), the purpose of case study research is not to understand other cases but to gain understanding of the one under study (Stake 1995). Case study research and action research go hand in hand to produce evidence for consideration by others as to its applicability beyond the study setting (Webb 1989). Thus the findings of this study are expected to be of relevance and have utility for UK health care settings.

Case Study Selection

The case study method is appropriate where the phenomenon under study is not easily separated from its context and necessitates the use of multiple sources of evidence (Yin 1994). Yin (1994) identifies five particular strategies open to social science researchers, ranging from experiments to case studies, and goes on to suggest that the choice of strategy depends on three conditions: a) the type of research question (who, what, where, why, or how), b) the extent of control of the researcher over behavioural events, and c) the degree of focus on contemporary events. Case studies are appropriate for 'what' and certain 'how' questions.

Whilst the case study method is appropriate for use within this investigation, it would be strengthened by being situated within an action research approach. Ordinarily, case studies answering 'what' questions may seek connections between the data as a means of establishing causality and offering an *explanation* for phenomena. Yin (1994) points out that plans for the analysis of case study evidence are often weak and ill thought out. The case study method combined with an action research approach to analysis thus has great potential to advance this research from mere exploration to the development of some explanation of decision-making phenomena occurring in the SG councils. Action research involves constant comparison of emerging data and a commitment to seeking both supportive and contradictory evidence for theoretical propositions arising from the analyses and ongoing use of results to enhance the achievement of the desired ends.

Whilst this case study is initially exploratory, use of an action research approach would facilitate the identification of variables that can be judged as having a positive and negative effect on council members' decision-making. This would enable identification of which action works when implementing changes to the SG model, in an attempt to strengthen council members' decision-making abilities.

Defining the Case

Following consideration of the above, the case study method to be used is the 'single case embedded' design. The overall *case* is that of the Rochdale SG model, which is suited to being a single case as it is unique (Yin 1994). The main sub-divisions (embedded units of analysis) within the case comprise two SG councils and a selection of individuals from across the councils.

Determination of Sub-Cases

The purpose of the case study is to explore council members' decision-making. Earlier fieldwork with the SG councils indicates that most decision-making occurs as a group. Yet to establish the contribution of SG, it is considered necessary to examine decision-making at an individual level also. Therefore, subdivisions are to be selected within the case, which will best enable the research questions to be answered. Constraints such as time available for fieldwork and the time-scale of the research study also need to be taken into consideration.

The purpose of sub-divisions within a case study is not about representative sampling but about achieving greater insight into the overall case without losing a holistic overview of it (Yin 1994). A maximum diversity sample, as opposed to attempting a representative sample, has been the strategy of choice. Issues around sampling are detailed in Chapter 4 (see page 96 - Sampling).

Summary

Development of a case study protocol document has framed thought about the overall case and sub-cases to be studied. It has promoted the likelihood of maintaining a clear doctoral focus in pursuit of answers to the research questions. Use of mixed methods

has been shown to be appropriate within case studies as a means of strengthening analyses and subsequent conclusions. Combination of case study and action research approaches has been explored and found to give a good fit.

PART 6 - Methodological Rationale

Introduction

The above discussion has emphasised the exploratory, formative and explanatory power of an action research approach in the context of study of an innovative approach to SG. This section provides insight, personal reflection and rationale of the choice of this approach for this study.

Selection of an Action Research Approach

Drawing on Hart and Bond's (1995) typology, an empowering action research approach was selected, and within this I shall be adopting the role of internal practitioner-researcher. Action research fits well with the study aims and is appropriate for use within a qualitative framework. The rationale for its choice is summarised below.

Personal Location

As a developing practitioner-researcher, action research principles 'made sense', perhaps due to its practice orientation and similarities with the nursing process as well as familiar elements around change management. The reflection emphasis with action research acknowledges that the researcher develops his/her abilities and self-awareness throughout the study as they learn from their own situation. Thus action research is very much a developmental exercise for the research practitioner (Kemmis & McTaggart 1988). This was an important issue to me as a research fellowship trainee.

My approach to my nursing work is one of seeking improvement in the way things are done and working together with people (staff, patients, relatives) rather than doing things 'to' or 'on' people as recipients of care. The older persons and rehabilitation settings I have primarily worked in are indicative of this. A considerable amount of nursing work includes assessing situations, setting goals with others, acting and

reflecting on those actions. This is done in a climate of enablement wherever possible, with others acting as participants in the process. At times, it means acting or advocating for people who are unable or unwilling to do so themselves and then stepping away at a time when they are able to regain independence. Nursing care places great emphasis on understanding the experiences of those cared for so that the best can be done for them. This requires sound clinical and professional judgement in addition to a range of qualities and skills including intuition, problem-solving, critical thinking, a sense of duty, accountability and integrity. Much of what is done is informed by what is seen and heard; good communications skills are key. These are all attributes I consider myself to have and that I believe are needed by an action researcher. This is especially so as action researchers may well be in a powerful position as an instrument of change and often work with vulnerable groups.

Accommodates Mixed Methods

Of further relevance is my epistemological position. It is my contention that action research is advantageous, as the design need not be constrained by any one epistemological standpoint. Understandings may be socially or individually constructed or, alternatively, may seek objectivity. Action research accommodates the use of a mixed method, case study approach that is associated with differing epistemologies. This is preferable for a study where the exact detail of methods to be used cannot be pre-determined at the outset. Lines of inquiry and appropriate methods with which to collect data will be determined according to the values, views and concerns of participants and other stakeholders and not merely reflect the standpoint of the researcher. Exact research questions are not necessarily known at the outset to an action research study, unlike standard research approaches (Cole 1991). In order to gain a better understanding of SG as a little-implemented concept in the UK, a range of methods can be tailored to meet the research questions developed through the course of the study.

Inadequacies of Other Qualitative Approaches

Prior to deciding upon a qualitative action research study other qualitative approaches were considered and found to be ill-fitting. The two most closely considered were grounded theory and ethnography.

Grounded theory is a primarily inductive approach to theory development whereby emergent hypotheses are tested deductively and subsequent theory and data collection modified until the optimal fit between the data and theory is achieved (Morse & Field 1996). Notwithstanding an emphasis on developing theory of social processes and appreciating individuals' experiences it did not offer as good a fit as action research geared at substantive participant involvement and facilitation of change. Some of the key characteristics were evident in descriptions of the action research process, in particular the constant comparison of data and theoretical sampling. Therefore the strengths of grounded theory could be drawn upon despite the approach not being adopted fully.

Ethnography is more concerned with cultural beliefs and values explored by participating in people's daily lives (Hammersley & Atkinson 1995). It seeks to gain an insider's view in order to understand human behaviours (Morse & Field 1996). Ethnography was at first an attractive approach in view of SG being underpinned by a heavy investment in development of a leadership culture in the Trust. Like grounded theory, it is suited to the use of a variety of research methods, yet again it lacked an emphasis on participation and catalysing of change.

Desire to Improve Research Methods

Within action research, there is scope to generate improved understanding of research methods themselves and the ways in which they are applied. As a new paradigm research approach (Meyer & Batehup 1997), action research is not yet fully understood and is continually being developed and applied to different situations. Part of its attractiveness is the need to further develop the approach (methods, research design) drawing on an eclecticism of existing theory (Karlsen 1991), so exploring its potential application in health care (Meyer & Batehup 1997). Whilst benefiting from the learning of earlier researchers and welcoming the opportunity to use guiding theoretical frameworks, I would not want to be constrained by them.

Action research appears to offer a greater degree of flexibility in methods used in all aspects of the research process. It encourages reflective cycles of seeing what works in practice, and this creativity can be applied to the methods themselves. It is my view that researchers are responsible for gaining new insights into the approaches and methods

they use and not simply the phenomena which form the focus of their studies. I believe action research to be less prescriptive than some other research approaches.

Novel Situation/Problem

Decision-making within SG is little researched, although there is much rhetoric on the subject. It was desirable to be able to learn and create new knowledge about what works so that it can be strengthened locally and inform others in similar situations. This fits well with all seven key principles of action research as described above. For the findings from a study of a novel, context-specific situation to be relevant in other settings, it is important to build in an evaluative element. Whilst SG is relatively novel to the UK, the Trust approach is also somewhat different to other UK organisations. In view of this and the large-scale investment made in it, I felt that it was doubly important to evaluate whether the approach worked and indeed help it to work. Action research has evaluative elements within it.

Utilisation of Research Findings

Other personal bearings on the choice of action research were its potential for creating findings of immediate relevance (McGarvey 1993) and likely uptake. Having made a large personal commitment to undertake the study there was no desire for findings to be irrelevant to practitioner colleagues or not utilised at all as has often been the case with nursing research. I did not want a lengthy study with findings being presented too late for impact, as had been the experience of other nurse researchers (Lathlean 1994). Action research was viewed as being more likely to lead to findings with utility and application, thus prompting changes (Karlsen 1991). Key to this is the opportunity within action research to share and act upon emergent findings at various points throughout the study and not just at its end. At the same time, it would contribute to theory, thus addressing one of Waterman *et al*'s (2001), concerns over action research.

Fit with SG Principles

Many key tenets of SG are mirrored in the action research methodologies reviewed. Principles of action research resounding with those underpinning SG include participation, empowerment and involvement. The empowering type of action research proposed within Hart and Bond's typology is particularly complementary, as it reflects the essence of SG in advocating the engagement and empowerment of practitioners in developing their own professional practice.

View of SG Project Leaders

The leaders of the SG initiative advocated the use of an action research approach, which has proved fortunate as it matched my own judgement as to what was the most appropriate approach. If this had not been the case, then negotiation and assertion of action research as the preferred approach would have been vigorously undertaken. It is the researcher's responsibility to appraise the available research strategies, as consequences will ensue from choosing one over another, not least in terms of application and usefulness of findings (Morse 1994). The commissioners expressed commitment to empowering Trust staff and action research was a way of ensuring that staff were indeed instrumental in the development of the SG initiative. As an insider action researcher, I would be in a position to paint an accurate picture of the progress of SG implementation and ensure a fair representation of the views of all stakeholders.

Insider Researcher Status

The SG initiative was being implemented in my employing organisation. That in itself was a tension that I was happy to manage, but it is important to note that I had a vested interest in the success of the initiative as a committed employee and a senior nurse with clinical leadership responsibilities. Rather than adopt a research approach that determined whether or not SG was successfully implemented or not, I preferred an approach that meant I could personally influence its success. Success for me would be the effective establishment and operation of the SG councils with systems to engage all Trust staff in identifying issues to address and positive outcomes achieved for these as defined by all stakeholders. This I was more able to do with an action research approach that overtly aims at improvement of a situation with the role of the researcher being key to that improvement. With other research approaches, I would probably have had to present the findings and hope that they would 'speak for themselves' and be sufficient to promote improvement. The uptake of these findings would then be dependent on a number of factors including what I presented, when and to whom. The researcher role and how it is conducted is clearly an important issue with a number of ethical considerations. Within action research, much attention is rightly paid to critical examination of the researcher role to ensure transparency in the way it is managed.

Chapter Summary

This chapter has illuminated the choice of a qualitative methodological approach to frame an action research enquiry. This gives the best fit for meeting the study's aims regarding the strengthening of decision-making within SG. It supports a mixed method, case study approach that is appropriate for use when investigating an evolving and complex initiative such as SG. An empowering typology has been selected which will complement the key tenets of SG. Crucial to the success of an action research endeavour is the role undertaken by the researcher. Advantages and disadvantages of insider and outsider research roles have been explored prior to adopting the position of insider practitioner-researcher. The next stage is to consider the methods utilised to collect the data that will answer the research questions.

CHAPTER 4

METHODS

Introduction

This chapter is divided into three parts. Part 1 presents the methods considered for use within the study and the final selection made. Part 2 explores issues around establishing the study and accessing the field, ethics, anonymity and the gaining of consent. Part 3 details the sampling strategy adopted, data collection and data management procedures.

PART 1 - Methods

Introduction

This section sets out the methods chosen for the study. The methods critiqued for use to explore individual and council decision-making are participant-observation, one-to-one interviews and focus group interviews.

Participant-Observations

Observation is a method that requires entry into a setting to observe phenomena directly so as to gain an understanding of them (May 1993). This activity can either be undertaken in a covert or overt manner (Atkinson *et al* 1987). What to observe would be dependent on a researcher's personal and academic interests (Delamont 1992) yet Merriam (1988) suggests that systematic observations could be made of the setting, participants, activities and interactions. Robson (2002) counters that systematised observations tend to be used by those in 'pure observer' roles and comments that unstructured observation is also possible. However, observation can only identify facts which are directly and empirically observable (Graziano & Raulin 1993) and is not appropriate for eliciting views and opinions, which would have to be gained by some means of follow-up after the observation period.

A key challenge with observation is the degree to which the researcher is a participant or an observer. May (1997), proposes a trajectory from complete participant, participant as observer, observer as participant to complete observer. It is unlikely to be able to adopt a complete observer role without inadvertently exerting some influence on what is being studied. Instead, participant-observation is a mode through which influence is expected and may be purposefully applied rather than being unintentional. Classic participant-observation comprises looking, listening, watching and asking (Lofland & Lofland 1995).

Observation work is very time-consuming (Robson 2002) which does present difficulties when working within time constraints. However, it is valuable for reaching an understanding of the context in which participants operate (Patton 1990). The method risks lack of external validity, as the researcher may inadvertently display selective observation of phenomena which support their existing beliefs (May 1993) and so much depends on the abilities of the investigator. The way the researcher is perceived by participants, who may be suspicious of their motives, presents a further challenge (Parahoo 1997). However Morse and Field (1996) assure that changes in participants' behaviour due to the presence of the researcher reduce over time. These authors highlight a number of other challenges, including the power-relations between the researcher and participants, unethical behaviours observed during observations and difficulties around accessing and leaving the observation setting when desired (Morse & Field 1996).

A further ethical issue is when to gain the consent of participants. This may be an ongoing process as opposed to a one-off event (Merrell & Williams 1994) and is a particular concern when observing groups with a fluctuating membership. Difficulty would also present itself if a previously consenting participant withdrew that consent, yet remained in the field (Moore & Savage 2002). Despite the difficulties, participant-observation offers the rare advantage of being able to question participants as events occur rather than gaining their recollections at a later date (Cole 1991). Furthermore, a number of these problems can be successfully countered by use of an insider researcher as participant observer (Bonner & Tolhurst 2002).

Interviews

The second main method to be considered was interviews. A range of interview types exist, the most commonly used being individual unstructured, semi-structured or structured interviews and focus group interviews. Telephone surveys and self-administered questionnaires can also be viewed as interviews (Fontana & Frey 1998).

Individual

Interviews are a method of discovery about things that cannot be directly observed (Patton 1990). They can elicit useful data concerning people's experiences, opinions, hopes and feelings (May 1993). Unstructured and semi-structured self-report methods utilise general questions in no specific order and encourage participants to converse (Polit & Hungler 1993). This means that the participants can raise the issues that are important to them and so divulge their own terms of reference. Additionally, a semi-structured interview guide permits prompting and probing during the actual interview to check meaning and encourage elaboration of participants' views (May 1993). May (2002) adds that non-verbal cues noted during the interview can aid understanding of the meaning of the actual words people use. The nature of qualitative enquiry is that it evolves as data are collected and simultaneously analysed, thus providing opportunities for revision of any initial interview guide as the study progresses.

Whilst unstructured methods would permit participants to express their views with less influence from the researcher, the participants could also answer at length about an irrelevant topic. Yet they are useful when investigating a new area of research and may elicit more spontaneous responses than carefully thought out written responses. It is questionable whether many participants would answer open questions at length in writing; hence the interview technique appears to have distinct advantages over self-completed questionnaires. Furthermore, with interviews, participants are prevented from feeling forced to select from given alternative responses, as is the case with questionnaires. With structured interviews and questionnaires, there is little scope to adapt the questions schedule once the study is underway, and so exploration of emerging issues is limited.

Interviewees may find it more conducive to be interviewed singly as opposed to the group interview. Individual interviews avoid the steering of the conversation by group

dynamics (Kidd & Parshall 2000) and people may feel more comfortable and prepared to divulge sensitive or confidential issues in a one-to-one situation without an audience (Smith 1995).

Focus Group

The focus group is a type of group interview that provides a convenient means of generating data from the communication between participants (Kitzinger 1995). Unlike individual interviews, focus groups engage participants to converse amongst a group of presumed peers with a probable shared frame of reference (Kidd & Parshall 2000). In a similar vein, Frey and Fontana (1997:21) assert that group interviews:

> "...provide data on group interaction, on realities as defined in a group context, and on interpretations of events that reflect group input."

Group sizes are recommended as being between four and twelve participants (Morrison & Peoples 1999).

Focus groups may be advantageous as they often enable spurring of recall of experiences and allow participants to rethink and amend their comments as they listen to others (Lofland & Lofland 1995). Catterall and Maclaran (1997) speak of the focus group interview as being a social event as opposed to a 'natural' conversation, as it takes place over a period of time and under the direction of a facilitator around a key topic area. Use of a focused interview guide can lead to discussions that are somewhat constrained (Kidd & Parshall 2000), yet action research supports a flexible approach and careful use of probing to explore issues for discussion raised by participants.

Organising such events is fraught with difficulties, such as people not turning up or having difficulty making time to participate during working hours. Whilst it has been argued that focus groups are quick and cheap to undertake, Morgan and Krueger (1997) suggest that this is a myth and explain that the recruitment and analysis processes in particular can be very lengthy. An ethical issue of note is the risk of over-disclosure of personal information through the synergistic processes of this type of interview (Smith 1995). Successful focus groups depend on members being interested in contributing to the focus topic, the group's composition and a skilled facilitator (Anderson 1990). In some studies, outside facilitators are employed. However, it can be desirable to have a

facilitator who is familiar with the project goals (Morgan & Krueger 1997) so it is acceptable for researchers to facilitate their own focus groups in many circumstances. Other problems can occur, for example, how to control group interactions, especially if certain members of the group are much more vocal than others (Kvale 1996).

Analyses of interactions between participants are rarely detailed in articles of nursing research that report use of the method (Webb & Kevern 2001) nor in social science and market research literature (Catterall & Maclaran 1997). The way the data are analysed is very much dependent on the aims of the study (Kidd & Parshall 2000). Yet the analytical rigour that happens in practice may well be down to the conscientiousness of the investigator. For effective research presentation, enabling research appraisal, the researcher needs to make plain the processes of analysis and interpretation and their interaction.

Secondary Data

Secondary or supplementary data can be generated from a setting or be relevant to research questions about it (Lofland & Lofland 1995). They are commonly used to describe the research setting in terms of individual, group, organisational and environmental factors (Rousseau & Fried 2001), thus giving shape to the issues being studied. Use of secondary data does not suggest that the primary methods selected are inadequate in any way. Archives can be a useful source of supplementary information to provide facts and contextual data that cannot accurately be recalled from memory (Robson 1993), whereas documents may allow corroboration of certain factual aspects of participant's accounts and historical information that is unavailable from other sources (Bailey 1997). In certain circumstances physical artefacts can be key components of the overall case being studied (Yin 1994).

Selection of Methods

The complexities of decision-making add weight to the preference for the case study as the preferred approach. Observation and interview (individual and focus group) techniques were adopted as the primary methods within this framework, supplemented with secondary data.

Whilst the role of participant observer is a complex one to manage, it seemed most appropriate for this study for a number of reasons:

- Some kind of observation was needed to see the decision-making processes for myself rather than rely on interviews alone, which would only gain other people's perspectives. Issues raised at interview could be observed or sought in the decision-making setting.
- The role of the researcher as participant observer fitted with my philosophical stance, having reviewed the methodological literature and that around research role issues within action research (see page 69 - Researcher Role).
- The range of observation roles was discussed with potential participants during the design phase of the study. Both they and the SG project leaders were unanimously in favour of this approach.
- I wanted to promote a collaborative approach to the research design, to reinforce the principle of empowerment and undertake the research 'with' and not 'on' participants so that they had a meaningful say in how it should be conducted. A participant observer role would build up the good relationships necessary to permit this to happen.
- Participant-observation was a tried and tested method within action research approaches.
- As an action researcher, I would be acknowledging a role in facilitating change, which did not fit with a purely observational approach.
- With participant-observation, I could follow up lines of enquiry at the time, whilst they were fresh in participants' minds. I expected that it would be difficult to contact participants away from the fieldwork setting of council meetings, should I have issues to follow up.
- It was considered inappropriate to be a researcher in a full participant role. I believed this to be ethically unsound. I would be less able to be aware of and monitor my own interactions and impact on decision-making encounters.

The individual, semi-structured interview was preferred to unstructured interviews. The former would provide some structure to encourage focus on the research topic whilst permitting scope for exploration of new insights. An approach that enabled refinements to the interview guide was also preferable so that new ideas or contradictions could be

explored with subsequent participants. As an insider researcher, it was anticipated that by the time the interviews were undertaken, a good rapport would have been built with potential interviewees. This would make people more comfortable with expressing their true views, as trust would have had opportunity to develop. I also believed that people would be more inclined to share views concerning their individual experiences, both positive and negative, of decision-making within SG on a one-to-one basis. Interviewing was also an approach with which I was familiar and adept both in the research and nursing contexts.

Focus groups were also selected to enable discussion of any shared views amongst participants concerning their decision-making as a group. I believed that interaction would be promoted, resulting in a more free-flowing discussion of issues amongst participants. This method had the potential to be less influenced and directed by me as an interviewer compared with the individual interview situation.

The combination of interviews and participant-observation is recognised as a valuable strategy, as data generated from one method can serve to illuminate the other (Hammersley & Atkinson 1995). As well as attempting to follow up and clarify issues after a period of observation, I expected interviews to be a more substantive approach in seeking further clarification of issues and the reasons behind any actions that were seen to occur in the field. Similarly, issues raised at interview could then be verified during subsequent observation periods.

Secondary data, mostly in the form of documents, were recognised as valuable in providing a historical and contextual dimension to the research. Thus, examination of secondary data would support contextualising of the SG initiative within the organisation at a time of great change.

Summary

This section has illuminated the choice of adopting participant-observation and interviews as the core methods. These are acceptable in line with the research questions, intended action research approach, study stakeholders and myself. It has been shown that these two methods will complement each other and be supported further with secondary data.

PART 2 - Initiating the Action Research Process

Introduction

Before data collection could begin, a number of steps needed to be taken to ensure access to the research setting, to obtain ethical approval and to gain consent from participants. This section considers these issues in turn and elaborates the actual steps taken within the study.

Gaining Access to Site & Data

Literature Overview

When gaining access to an established group or setting, it may be useful to gain an understanding of it beforehand (Whyte 1984). Having the backing of a well-regarded academic institution can be beneficial to gaining access, or could indeed be detrimental (Punch 1994). The institution may be favoured or otherwise by stakeholders of the study. In a discussion about access and gatekeepers, May (1997:86) makes the interesting point that researchers can be viewed as "extensions of their political sponsors" despite attempts to refute this. This view is shared by Cole (1991), who suggests that there is a real tension between the relationship of the researcher and sponsor and how participants might interpret this. Participants' reactions to the researcher's presence are in themselves valuable data, indicating things such as relations and people's concerns (May 1997). May (1997) goes on to point out that gatekeeping can also be about funding, even at the level of resources such as typing and travel costs. Ultimately, gaining access into an organisation can present a number of difficulties and success can often depend on how the researcher or the proposed study are perceived by those who can facilitate access (Bryman 1988).

Buchanan *et al* (1988) have identified a number of access issues, summarised here. When accessing an organisation, it is unlikely that the researcher will be able to access all that is intended, and instead opportunities may have to be taken as they arise. Problems encountered include movement of personnel out of the setting, individuals blocking access and loss of research materials. Common restrictions to access to organisations can be caused by time issues and the presence of sensitive data. Solutions suggested to minimise access problems include ensuring minimal interruptions to

working patterns and the promise of a preview of the study report. Lastly, Buchanan *et al* (1988) warn that having gained access, maintenance of it can be a particular challenge, with its success resting largely on the personality of the researcher, although it can equally rest on 'goodwill'.

Gaining Access in Practice

Despite being an existing employee of the Trust with a wide range of access to sites and staff, there was a need to redefine this access in view of my new position as a researcher. Formal agreement to access the Trust site and its staff was assured by the development of an Access to Site and Data Agreement (see Appendix 3 - Access to Site & Data Agreement) endorsed by the Chief Executive and Nurse Director of the Trust. The agreement was further secured by establishing and maintaining an informal yet close working relationship with a small team of senior nurses that comprised the SG project leaders.

One formal element of the agreement was related to communication. It was agreed that one project leader in particular would keep me informed about the project implementation plans and communicate with me directly, so acting as my key Trust contact. Examples might include changes in council membership, dates and times of relevant meetings and circulation of minutes and newsletters. The main communication opportunity was through my attendance at the Shared Governance Working Party. This was a regular meeting every few weeks, which was an ideal forum for two-way communication of what each of us was doing. It was anticipated that once the study was underway, these meetings would present a key opportunity for sharing emerging findings and so inform the project leaders' decision-making around further implementation of SG.

Additionally, key stakeholders were informed and involved through the setting up of a multi-disciplinary Trust Research Advisory Group. This comprised an invited membership including two of the project leaders, namely the Nurse Director and Senior Nurse Leadership Systems Development, and the Medical Director, Trust Research and Development lead (later replaced by an Associate Dean), and my academic supervisor.

It was agreed that the purpose of the group was to:

- Review the progress of the research study and offer feedback.
- Advise on how the study might be strengthened and any weaknesses addressed.
- Comment on relevant reports produced during the study.
- Be a forum to share the emerging findings from the research along with the Trust-wide practice-based councils, Working Party and Policy Council.
- Suggest ways the emerging findings could be acted upon.
- Be approachable for advice on an individual basis as needed.

It was expected that keeping in such close contact with the project leaders would help to maintain access and be a forum to address any potential or actual problems that arose. Furthermore, working as a researcher in my own organisation and communicating closely with the SG project leaders was expected to be helpful in preventing me from being viewed as an outsider. As the research topic was negotiated with the Trust, the project leaders viewed the study as a key component of the SG project implementation that could add significantly to its success. Being part of the process in this way was further likely to secure my position and access to the site.

A second area addressed in the Access to Site & Data Agreement concerned the specifics of what I could access. This was agreed to include any documents, such as papers and minutes, related to SG. I also requested and was provided with a letter signed by the Nurse Director that clarified issues around ownership of the research data and its publication in line with intellectual property rights guidance (NHS Executive 1998). Full permission was granted to access all SG meetings and to maintain field notes. This was later extended by the Advisory Group to permit interviewing of Trust staff. Finally, assurances concerning the gaining of ethical approval were given.

Ethical Approval

Management approval to undertake the study was gained direct from the Nurse Director and Trust Research and Development lead. A Local Research Ethics Committee application form was submitted and an interview attended. Approval for the study was received in due course (see Appendix 4 - Study Approval) with conditions attached pertaining to the storage of data and a request for a copy of the final report once available.

Consent of Participants

With any research study there is a need to ensure that informed consent is gained from participants. For this to take place, participants need to be free to decide following receipt of sufficient information about all that is expected to occur, in a suitable form that they are capable of understanding, and be able to competently make a judgement.

Within this study, individual and focus group interview consent was to be gained in a fairly traditional way, having first spoken with likely participants to gain their approval in principle. Individuals were sent a letter with information about the study and a request for them to participate in an interview. A reply was requested by telephone or email, or a follow up contact was made by me to ascertain their wish to participate. Any queries were answered and a date and venue set for the interview that suited them. Reiteration of study information took place immediately prior to the interview, followed by their signing a consent form. Information given in writing detailed who I was and why the interview was required, what was expected of participants, that they could withdraw at any time, when findings would be made available and so on (see Appendix 5 - Individual Interview Letter).

Consent for participant-observations within the various groups that comprised the SG model was less straightforward. Approximately sixty-four individuals who were members of the various SG councils needed to give consent at the study outset. It was anticipated that there would be movement of members as some left and new ones joined over time. Verbal as opposed to written consent was deemed preferable, primarily because this was more manageable from a practical viewpoint. I wanted to give comprehensive information and respond fully to what I expected would be number of shared concerns and repetitive questions.

Prior to actual fieldwork being scheduled to commence, an afternoon preparatory workshop was held for all Trust-wide practice-based council members. This provided a good opportunity for me to give an informal presentation and have discussions with council members about the planned study, their thoughts on how it should be designed, consent and confidentiality issues, and share views around our respective roles. It was agreed with members that unless they told me or one of the project leaders that they did not wish to participate, or communicated this to me by some other means, their consent

would be taken as granted. All of those present were content with this approach. A minority of members were absent on this occasion and so I spoke with them in person at a later date. No-one refused or withdrew their consent. Council members' response at this time was a very positive one, and they expressed belief that the study would help them to make the SG initiative work.

Most of the Policy Council members were similarly informed at their next meeting. Consent was agreed verbally and fieldwork began from the subsequent meeting. The Mental Health Council had not been set up fully at this point, yet members had approached me about it being included in the study. I met with them two months later and underwent the same process of presentation and discussion, and verbal consent was gained from all members.

At following meetings, members of the respective councils had discussions and reached agreement on how and when they preferred emergent study findings to be communicated (see Chapter 8 - Reflection) and so this activity was also underpinned by verbal consent. As membership changed over time in all councils, I repeatedly spoke with new members to ensure that they understood my role and gained their verbal consent.

Minor aspects of the study in need of verbal informed consent pertained to photographing of participants at a workshop and permission to use the responses from verification pro-formas (see Appendix 6 - Network Diagram Verification Form) completed by some participants once they had critically reviewed a set of data displays and narratives.

Confidentiality & Anonymity

Confidentiality and anonymity issues were addressed in consultation with participants at the preparatory workshop prior to the study commencing. Discussion was held around my need to maintain field notes and what these would comprise. In view of plans to store field notes securely, it was considered acceptable to refer to individuals by their initials. It was acknowledged that some occurrences might be of a sensitive nature, such as disagreement between individuals. Participants were assured that these events would be treated with due regard. Where appropriate, I would not note the incident in detail,

identifying individuals, but mark the text with a symbol and maintain a mental note. In practice, this happened very rarely. Guests attending council meetings were referred to loosely to protect their anonymity, for example, as a 'member of academic staff from a local university'.

Interview transcripts were coded to identify each interviewee and kept separately from consent forms. Pseudonyms were used for any persons named during the interview. Tapes were similarly marked and kept separately and securely. These materials were made available only to the research assistant from the wider evaluation study and myself, as had been agreed with participants. Council members were not informed which colleagues had been invited for individual interviews, simply that eight members were participating. Council members not participating in focus group interviews were not allowed access to the transcripts from those who did.

In presentation of findings it was agreed that individual participants would be identified by pseudonyms or referred to as members of a named council. Key individuals were identifiable by their roles, for example chairs, and it was agreed that it was acceptable to refer to individuals in this way. Furthermore, I was entrusted to select appropriate material and presentation approaches that respected their needs for confidentiality. Wherever maintenance of anonymity was difficult, it was agreed that I would request individuals' approval to include specific material. It was further agreed that participants could request to have anything they said or did removed from the field notes during observations or by contacting me at any time. Similarly with interview transcripts, participants were given the opportunity to request amendment of what they had said or cut sensitive text completely. Having given assurances and gained trust in the ways described, no requests to make omissions from my records were received.

Summary

This section has set out the steps taken to secure access to the study setting and increase the likelihood of it being maintained. Smooth access was promoted by development of an Access to Site and Data Agreement in collaboration with SG project leaders and establishment of a Research Advisory Group. Close working relationships were developed with participants and project leaders from the outset. The study design was discussed with participants and assurances given regarding anonymity in data

presentation. Approval was gained from council members for proposed steps to assure confidentiality and sensitive handling of fieldwork material. Considerable care was taken to ensure that verbal and written informed consent was obtained throughout the study.

PART 3 - Data Collection

Introduction

Having determined the methods of choice, this section sets out the sampling choices made, data collection processes and subsequent data management. The sub-cases of the case study are made explicit. Procedures followed for undertaking interviews and observations are described. Steps taken to prepare the data in terms of transcribing, coding, verification and storage are summarised.

Target Case

The overall case, or target group, is the Rochdale Model of Shared Governance. The subdivisions within that case include the Human Resources Council (HRC), Research & Education Council, Practice Development Council, Mental Health Council (MHC), Chairs' Meetings and Policy Council.

Sampling

Strategy

Sampling in qualitative research tends to be guided by the principle of purposing. That is, purposeful identification is made of cases that are information-rich and will inform the questions under study (Patton 1990). Choices about the type of cases to include or exclude are based on a desire to represent a range of cases within a population with which to make contrasts and comparisons, and are not concerned with statistical representation. The type of purposeful sampling adopted here is 'theoretical sampling'. According to Strauss and Corbin (1998:203) the aim of this approach is:

> "... to maximise opportunities to compare events, incidents, or happenings to determine how a category varies in terms of its properties and dimensions."

There are also choices to be made about depth versus breadth. Subsequent selections are informed by previous fieldwork and analyses and become more focused as they are informed by the evolving theory (Strauss & Corbin 1998).

Broad sampling permits focus on extreme cases to illuminate ordinary or typical cases that may elucidate the phenomenon under study (Patton 1990). This sampling strategy has been described as a 'maximum diversity' approach. This aims at identifying shared patterns across cases through their comparison and identifying uniqueness from close examination of each single case (Patton 1990). It is important to note that once sampling has been addressed, further sampling from the data available in the case, during observations for example, is also necessary (Hammersley & Atkinson 1995). Careful consideration must be given to who or what to observe and when. A maximum diversity approach to sampling has been selected for use with this study.

Selection of Sub-Cases - Councils

Sub-cases were chosen from the three practice-based councils that have a Trust-wide remit, and one council that has a directorate-wide remit. Following examination, the characteristics of the Trust-wide councils were found to be fairly similar, yet they differed considerably from the directorate-based council (see Appendix 7 - Council Comparison). To explore only one council would not permit theoretical generalisation to be made across all the councils within the model. However, more than two councils would be too large a task to manage within the study time constraints. Choice was guided by the principle of maximum diversity. Finally, it was considered that the HRC and the MHC would offer the most potential for comparison and contrast.

Following this selection, it was decided that the other Trust-wide councils, Chairs' Meetings and Policy Council would be observed selectively. While these formed more minor subdivisions of the case, observation, albeit selective, would be valuable for comparison and verification of the ensuing data.

Selection of Sub-cases - Individuals

Selection of individuals as key sub-cases was also undertaken. It was decided to draw a sample of council members from across all of the practice-based councils and not just the HRC and the MHC. This was a measure aimed at not losing focus on the whole case due to intense concentration on individual sub-divisions. Non-selected members were still to be observed generally as part of the fieldwork. These were a source of supportive and contradictory evidence for comparison with emerging findings required for any theoretical generalisations to be made across the overall case.

The selection of individuals was theoretically guided. Choice was informed by earlier fieldwork and participants' completion of a pro-forma developed within the study to establish a range of their characteristics. The rationale for the pro-forma was one of minimising bias in the selection procedure, not least as I had greater familiarity with some participants than others. A maximum diversity approach meant that a broad range of individuals was selected, who displayed varied characteristics such as junior and senior staff, short and long council tenure, previous experience of attending meetings and so on. The characteristics of the individuals finally recruited are shown in Appendix 8 - Interview Rationale. These individuals were the focus of the participant-observations of council meetings and were invited for individual interview.

- A maximum diversity sample of 8 practice-based council members was selected for individual interview.

A number of individuals were recruited for focus group interviews. Mostly these participants had not been selected as sub-cases for individual interview. However, a small number of them had. This was partly due to recognition of the value in hearing people's individual views and then seeing them interact with colleagues in a group situation. A second reason was practical, in order to ensure sufficient numbers for a focus group were attained.

- An opportunistic sample of 8 MHC members was identified for a focus group interview by making a verbal request for volunteers at a prior MHC meeting.

- An opportunistic sample of 5 HRC members was identified for a focus group interview by making a verbal request for volunteers at a prior HRC meeting.

- An opportunistic sample of 6 Clinical Professional Services (CPS) staff was identified for a focus group interview by making a verbal request for volunteers at a prior staff meeting.

The focus group of CPS staff was a late stage decision, having concluded that data collected thus far had a nursing bias. To balance this, it was thought necessary to interview this homogenous group to probe for deeper insights into their perspectives.

Fieldwork

Original fieldwork began in January 1999 with participant-observations of all councils taking place from their first meeting that month (March in the case of the MHC). Participant-observation of all councils continued until the phase focusing on decision-making commenced in January 2000. This decision-making phase then continued until June 2001 (see Appendix 9 - Time Frame for Decision-Making Data Collection).

Participant-Observation

At each meeting, I sat around the table with council members for the full duration of the meeting. The setting was almost always the hospital Board Room for the HRC and a less formal small meeting-room for the MHC. Policy Council meetings were always held in the Board Room with Chairs' meetings convening in the Nurse Director's office.

I would generally arrive a few minutes before the scheduled meeting start time. This allowed for a choice of seating that gave a good vantage point amongst members, avoided a seat next to the Chair and permitted some casual pleasantries to be exchanged with individuals as they arrived. Field notes were commenced from this point and written openly throughout the meetings within an atmosphere of general acceptance and welcome for my presence as a researcher. Occasionally I would pointedly put pen and notepad down to non-verbally demonstrate tact to members, such as when they were having a heated disagreement with each other. Detailed field notes recorded such things as who was present, who was not present, who had given apologies and reasons given, (for example, clinical workload), and a general summary of the process and outcomes of the meeting. These notes were interspersed with points of interest and personal prompts to compare occurrences with other fieldwork and tentative assumptions about what was

seen to take place. At no time were any tape recordings made during council meetings. If any points needed clarifying with individual members, this was done at the end of the meeting, during the coffee break, outside afterwards once people had dispersed or, rarely, within a day or two. Meetings lasted just over two hours on average, with the MHC meetings lasting an average of three hours. Council materials such as meeting minutes were obtained at meetings or by post in the same way as members.

Promptly, following each meeting an initial 'Thoughts' section was written that noted impressions from the fieldwork and any points of interest in need of further examination. An example of field notes is given in Appendix 10 - Sample Field Notes.

Interviews

Individual Interviews - Pilot

The first of the 8 potential interviewees were approached informally on a one-to-one basis to see if they agreed in principle to being involved in an interview about SG decision-making. Following a full explanation, if the individual was willing to participate, an appointment was made for the interview. An information letter was sent to provide more details for them to consider before going ahead with the interview. A venue for the interview was identified as a private office within the individual's area of work. The interview room environment was prepared as much as possible to ensure seating was comfortable and appropriately placed with other furniture to encourage conversation. Risk of interruptions was minimised by putting a sign on the door and asking colleagues to interrupt only if necessary. Pagers and telephones were diverted.

Following a welcome, the study information letter was again given to the participant to consider and questions invited. Once satisfied, the participant read and signed the consent form (see Appendix 11 - Individual Interview Consent Form). At this point the tape recorder and microphone were positioned and a sound check performed. The interviewee was encouraged to relax and ignore the equipment as much as possible. Reference was made by me to an interview guide (see Appendix 12 - Individual Interview Guide) that was placed nearby so as not to form a barrier between us. This guide was developed to elicit information that would address the research questions and had been informed by earlier data collection and emerging findings that were in need of further exploration.

The first questions had been designed to encourage the interviewee to ease into the conversation and asked about their recruitment to the council, role within it and activities to-date. No questions were misunderstood and the pilot was deemed a success. No amendments were made to the interview guide prior to use with the remaining interviews. The pilot interview transcript was included in the main study.

Individual Interviews - Main

Similar considerations were made as when undertaking the pilot interview. Council members agreed and so were aware from the study outset that a range of interviews would form part of the data collection. Following informal discussion, individual appointments were made to meet with the remaining seven staff to undertake interviews with them. Suitable office-type venues were found within all interviewees' places of work. Importantly, the environment was suitably prepared to produce a context that was conducive to interviewing (May 1993) including refreshments and careful positioning of seating. All interviews took place within the participant's rostered shift.

By this stage, I was well known to all participants. A friendly but professional manner was adopted and smart casual dress was worn, as had been the norm during earlier fieldwork. I explained that the interview would be informal and offered reassurance that participants should take their time and not worry about pausing to think whilst the tape was running. They were encouraged to elaborate their responses fully and not to be selective because they knew that I had some relevant insight from earlier fieldwork. It was stressed that it was their views and interpretations that were being sought, regardless of how they compared with mine. All participants read the information letter and were happy to have their interviews tape-recorded. Written informed consent was gained. Interviews lasted between the expected range of approximately 30-45 minutes.

The same interview guide and sequence of questions was used as in the pilot interview. A small number of prompts and probes were used to explore issues further or seek clarification and any additional comments were invited. At the end of the interview, participants were thanked and reassurances were given that a copy of the transcript would be sent to them for them to check, amend and keep.

Focus Group Interviews

Agreement in principle to take part in the focus group interviews was obtained from

potential participants prior to scheduling them. Dates and venues were set to suit the participants. Whilst planned for, the HRC focus group did not take place due to dwindling membership and this council unexpectedly disbanding from December 2000. However, three members had already been interviewed individually which was fortuitous.

Numbers of focus group participants were limited to those who expressed that they were able to make the most popular of a choice of dates given (MHC n=8, CPS n=5). All potential participants were English speaking and had no difficulties such as speech or hearing problems. No one exercised his/her right to withdraw from any interview at any point. Arrangements for the interviews were confirmed and venues arranged as suggested by the participants, which were a day room, classroom and seminar room.

As with the individual interviews, I was well known to most participants and a friendly but professional manner was adopted. The interview process was described and assurances reiterated. An information letter was circulated to those present on each occasion and written consent obtained. Each focus group interview lasted between 50 and 90 minutes.

The interview guide was designed to explore decision-making from a group perspective (see Appendix 13 - Focus Group Interview Guide). In addition, my facilitation skills were used to promote discussion amongst participants around the topic area to allow for exploration of ideas without losing the focus on SG and decision-making. At the end of the interview, participants were thanked for their participation and assured that a copy of the transcript would be sent to them for them to check, amend and keep.

Secondary Data

A range of relevant secondary data was accessed. These included SG strategy documents, personal communications, minutes from relevant meetings, presentation slides and data from the earlier, wider evaluation of SG. These were hand-searched for their relevance and stored for later reference. The purpose of the secondary data was to assist in making inferences by attempting to ensure that all rival explanations and possibilities were duly considered.

Data Management

A number of considerations and decisions were made around the management of data that had been collated, including data sources, preparation, coding and retrieval. Data management in this way organises the data and forces decisions around such things as data for inclusion/exclusion to be made, and makes working with copious amounts of raw data more manageable. Each is considered below.

Data Sources

As well as data drawn from the dedicated period of decision-making data collection, other data from the previous, wider evaluation of SG were considered.

The data sources used have been divided into three sections shown in Table 2 - Data Sources.

Table 2 - Data Sources

A.	Human Resource Council - decision-making *field notes* Human Resource Council - decision-making *individual interviews* × 3
B.	Mental Health Council - decision-making *field notes* Mental Health Council - decision-making *individual interviews* × 2 Mental Health Council - decision-making *focus group interview*
C.	Policy Council, Chair's Meetings and Workshop - decision-making *field notes* Other councils - decision-making *individual interviews* ×3 Clinical Professional Services - decision-making *focus group interview*
D.	All other field notes from July 1999 All other shared governance interviews × 23 from the wider evaluation study Survey data Secondary data

Sections A to C relate to data collected since January 2000 that were specifically focused on decision-making. Section D relates to other relevant data from the wider evaluation study. All sources of data analysed within each section are listed in full in Appendix 14 - Data Sets. Secondary data in the form of documents have been reviewed

and a list of key documents considered pertinent is also listed in the Appendices (Appendix 15 - Secondary Data Documents). Only field notes made from July 1999 were coded for inclusion, as the councils were barely operational prior to this point. As there was some overlap of fieldwork from the wider evaluation study and focused decision-making work, field notes from the wider evaluation study were used only where no decision-making field notes existed.

Data Preparation

The purpose of data preparation was to organise the data to facilitate easier retrieval ready for the next stage in their processing.

1. Interviews

Transcribing

Each individual and focus group interview recording was listened to once in its entirety to gain a familiarisation with the data (Morse & Field 1996). I then transcribed each recording personally, which enabled further familiarity. As names arose, they were replaced by indicating that individual's initials. A facility on the computer numbered each line of the transcript in preparation for analysis. This transcribing process was usually done within 24 hours of the interview and maximally by 48 hours. Transcription took between five and eleven hours to complete, depending on the length of each recording.

Memo Writing

Notes arising from the interviews and transcripts were also maintained. These contained ideas, points of interest or importance and possible connections between the data. These are known as 'analytical memos' and aid the process of making sense of the data (Bailey 1997). Importantly these were regularly referred to and compared with emerging data. This is a process that is sometimes forgotten when immersed in the process of data collection (Hammersley & Atkinson 1995). This regular process of review was also noted and enabled a record to be kept of developing ideas and decisions made, and so acted as an *aide memoir*. Memos provided useful discussion points when reviewing progress with the research assistant for the wider evaluation study, who acted as a critical friend.

Data Verification

Copies of transcripts were sent to the participants for them to check, amend any errors, elucidate any of the inaudible words highlighted and to keep. This also served to promote participants' sense of control over the data (McDonnell *et al* 2000). Fortunately, the use of a quality tape recorder and microphone resulted in clear recording.

Data Storage

All interview transcripts were anonymised by coding each one with a number known only to me, and were kept separate from the consent forms. All transcripts were kept on disk and these and the tapes were kept locked up securely in my office on Trust premises in line with the Data Protection Act.

2. Participant-Observation

Transcribing

Field notes were managed similarly, in that they were almost always personally typed up within 48 hours of the fieldwork having taken place. Each line of text was numbered and individuals referred to by their initials. Familiarity was gained from reading through the field notes and reflecting back upon the observation episode. Transcriptions took two to three hours to type depending on meeting length.

Memo Writing

'Thoughts' sections at the end of each set of field notes served as analytical memos. Separate notes were maintained that summarised the status of action research cycles being focused on at any one time. These helped to maintain a focus, to prevent fieldwork being disorganised and aided preparation for the selection and sharing of emerging findings at various points throughout the study. The memos highlighted potential new insights in need of further exploration in subsequent fieldwork.

Data Verification

Field notes were not made available to participants to maintain their confidentiality. Individuals were contacted after observations if any issues needed clarification or their perspective was required. Formative findings were shared with participants on a quarterly basis at their request, which provided an opportunity to verify emerging

interpretations of the fieldwork data.

Data Storage

All field notes were coded for ease of retrieval, kept on disk and hard copy and locked up securely in my office on Trust premises.

Preparation for Analysis

From here on, management of the interview and field note transcripts was the same.

1. The first step was to add to the familiarity gained through the transcription process by re-reading the transcripts and field notes. This immersion process is recognised as valuable in highlighting the persistent themes or phrases within the data (Morse & Field 1996).
2. The next step was to print two hard copies and examine each line of the transcription, picking out any significant phrases. These were highlighted on the first copy as a record of what phrases were picked out. The purpose of the first hard copy was to note what was *not* considered significant as well as to note what was deemed significant. It was acknowledged that when the transcripts were re-read in their entirety at a later date, certain phrases formerly seen as insignificant could appear significant and warrant labelling at this later stage, although in practice this happened minimally.
3. The phrases from the second hard copy were then cut and pasted onto index cards. A decision to use manual sorting was made, primarily due to my lack of computer skills at the time and following advice from peers concerning the number of interviews that would be manageable in this way. Any analytical memos that pertained to the chunks of text were attached to the reverse of the relevant cards to help illuminate their significance. The front of each index card was given a written tracer to identify its data source and the exact location of the segment in the text. The content of each card was then considered and assigned a specific *label.* These were then manually sorted into piles relating to broad *categories*. Particularly in the early stages, some phrases fitted into one or more categories and so duplicate index cards were prepared. In these instances a note was put on the cards to highlight the fact.
4. Continued examination, reflection and sorting enabled more fine-tuned analysis of this condensed data, leading to an end product of major categories, sub-categories

and labels.

It is important to note that data collection and data analysis should not be considered as separate stages in the research process (Coffey & Atkinson 1996). Early and formative analyses took place throughout the fieldwork phase of the study and not when all the data collection was complete.

Coding Scheme

Rather than coding in an inductive manner, an '*a priori* start-list' had in part been drawn from the conceptual framework and research questions (Miles & Huberman 1994). The decision-making fieldwork had been centred on specific research questions as opposed to broader exploratory questions. For example, the study set out to answer questions such as 'What are the barriers to council decision-making?' and not questions like 'What is it like to be a council member?' Importantly, the source sub-research question (see page 51) that each category was derived from was made explicit. Labels were primarily descriptive rather than being clustered into categories using a more inferential approach (Miles & Huberman 1994). These coded data provided the medium for further analysis and inferences through use of data presentation methods.

Draft coding schemes were refined on several occasions as some categories were subsumed into others and other categories were further broken down into smaller groupings. The final coding scheme is presented in Table 4, overleaf, whilst the earlier drafts can be found in Appendix 16 - Draft Coding Schemes.

Data Presentation

The in-depth process of labelling and category development was in itself part of the analysis process and as expected, informed the decisions around data presentation methods. Familiarity with the data and emerging themes resulting from their preparation prompted a review of recognised data presentation methods. For the analysis, the work of Miles and Huberman (1994), *Qualitative Data Analysis*, was drawn upon extensively. The clearly written, comprehensive and detailed text was considered beneficial in aiding the selection and development of data display tools that would best aid deeper analysis. The rationale is explored in the next chapter.

FINAL CODING SCHEME – May 2001		
MAJOR CATEGORIES, SUB-CATEGORIES & *Labels*	**ASSIGNED CODE**	**SOURCE RESEARCH QUESTION**
SHARED GOVERNANCE SYSTEM	**SYST**	
MODEL	SYST-MOD	1, 2
REMIT – *Other's View, Own View, How Deliver Remit*	SYST-REM	7, 8
COUNCIL RELATIONSHIPS	**REL**	
INTRA COUNCIL – *Influential Members, Roles*	REL-INTRA	4
INTER COUNCIL	REL-INTER	5
INTRA ORGANISATION – *Common Language, Engagement, Insular, Other Groups*	REL-ORG	6
DECISIONS	**DEC**	
ISSUE IDENTIFICATION – *Constituents, Managers, Types*	DEC-ID	9
ISSUE SELECTION – *Clarify Problem, Gain Further Info, Fit Remit, Issue Size, Subjective Selection*	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 Issue, Money, Time/scale, Issue Size, Lack of Support, Lack of Info, Other's Input, Other**	DEC-BAR	12, 13, 16
AIDS – *Appropriate Time, Impact of Decision, Monitoring, Options, Gather Info, Informants, Coaching/support, Discuss Opinions, Clear Purpose, Experience, SG Research Findings, Other**	DEC-AID	12, 13, 15, 17
OTHER INFLUENCES – *Venue, Level of Authority, Implications, Personality, EBP, Who Present, Other**	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 ONEMPOWERMENT	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 ONEMPOWERMENT	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

Other* = Factors identified only once and which don't fit into a theme

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

May – further breakdown of themes (italicised). Addition of 'Other' section for factors identified *once* only so not constituting a theme. Merged all Level of Authority themes into one theme under 'Other Influences'. New theme 'Experience' identified. Omit 'Miscellaneous' theme as no 'unexpected' factors were identified that did not fit existing themes.

Summary

This section has detailed data collection processes arising from individual interviews with eight participants, two focus group interviews and extensive participant-observations. Data preparation and management undertaken in preparation for further analyses have been detailed. Data collection for the decision-making phase ceased after eighteen months in June 2001, as sufficient data and analysis were evident by this time to enable the development of summative findings.

Overall, this chapter has explored and justified the adoption of participant-observation and interviews as the main methods. Their fit within an action research framework has been demonstrated. Issues around access to the research setting, confidentiality, anonymity, and gaining of consent were discussed prior to detailing the data collection phase of the study. The next chapter deals with the analysis of those data.

CHAPTER 5

ANALYSIS

Introduction

This chapter is divided into three parts. Part 1 summarises early steps in the analyses of fieldwork data. Part 2 presents an overview of data display theory prior to detailing the displays developed for use in this study. Part 3 illuminates how a wish to contribute to the development of SG decision-making knowledge and theory was addressed through creation of a conceptual model.

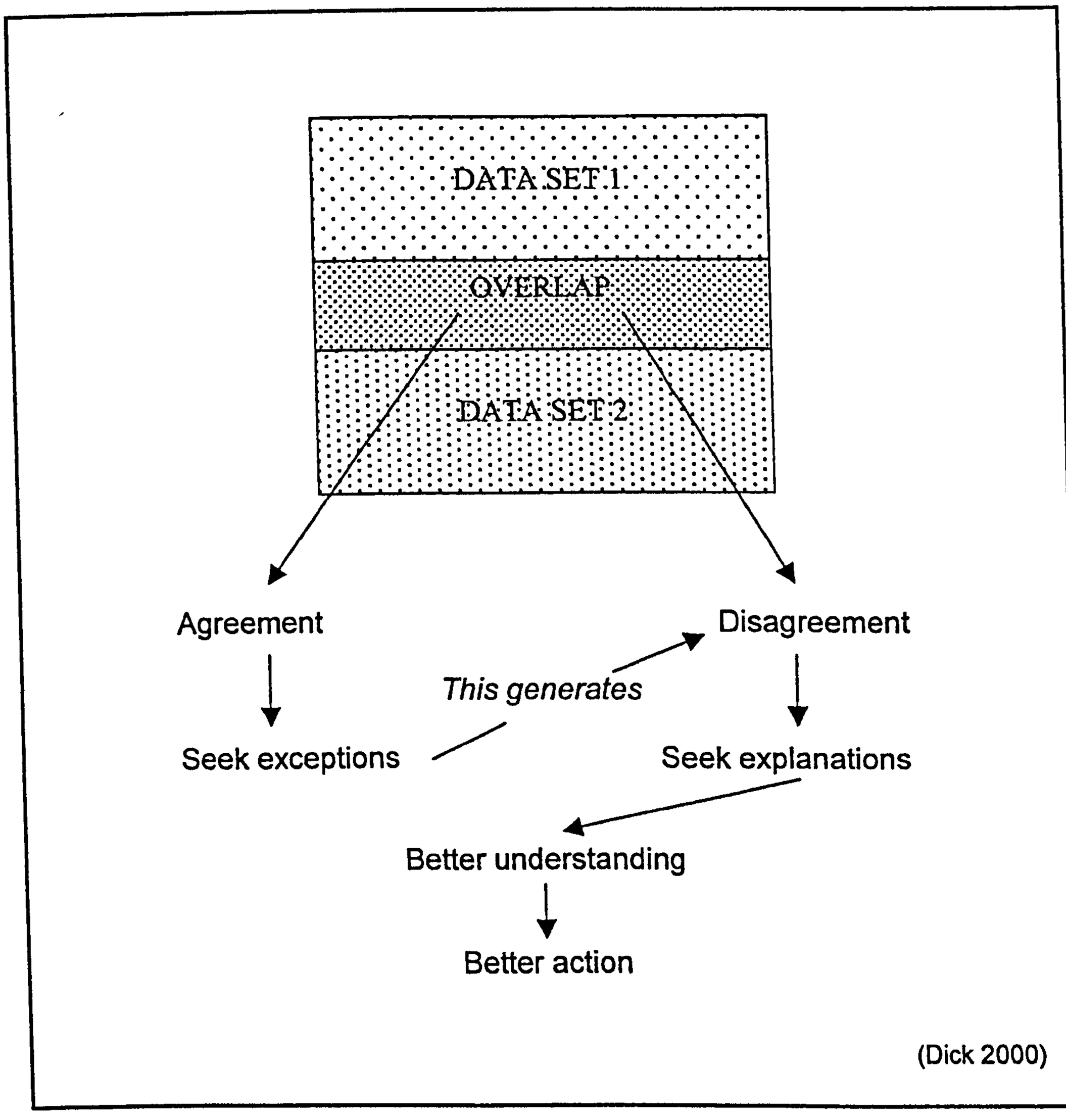
PART 1 - Action Research Cycles

As has been elaborated on in Chapter 3, action research has been the overall approach utilised within this study. Early fieldwork has incorporated the use of the action research strategy of 'observe, plan, act, and reflect' in order to identify early indications of factors affecting SG structures, processes and outcomes. Issues of importance/relevance were identified through fieldwork and subjected to critical examination by way of constant comparison with other data and emergent themes. The goal was to identify corroborative or contradictory evidence in support of a number of provisional assumptions. In this way, data collection and analysis have been necessarily intertwined (Diagram 4, overleaf).

Once identified, foci of interest were recorded, compared within and between all Trust SG councils and data sets to see whether or not they are spurious or recurrent, and applicable to other situations and whether any conditions or other factors appear to be associated with them. An important part of this early analysis stage was to share emerging insights and interpretations with council members for their perspectives and views regarding their relevance. This verification process added to the analysis by challenging and/or corroborating the researcher's interpretations prior to decisions being made by participants as to any action taken in view of these formative findings.

A summary of these early insights into the data arising and issues/areas for development is given in the Findings Chapter Part 1 (page 124).

Diagram 4 - Process of Data-Driven Understanding



PART 2 - Data Displays

To deepen this early and continued analysis, more critical and focused analysis was indicated to identify what specifically affected SG decision-making and why those effects were incurred. To do this, data displays were recognised as useful tools to aid subsequent qualitative data analysis. Initially an overview is given as to the use of data

displays as an approach to analysis, including examination of their merits and disadvantages. Following this is a description of the process of developing a number of basic and advanced displays from previously coded data. These include basic Checklist Matrices and Time-Ordered Matrices, the more advanced Time-Ordered Meta-Matrix and Causal Networks. Consideration is given as to how well each display type worked at aiding analysis and informing subsequent steps in the analysis process.

Data Displays as a Method

Miles and Huberman (1994:11) describe a data display as:

> "... an organized, compressed assembly of information that permits conclusion drawing and action."

Qualitative research can yield great quantities of data in the form of extended text that can be quite cumbersome to manage. Data displays can be utilised as a means of condensing large amounts of data into a more manageable form that can more easily be described. Their purpose does not end with description, as further analysis will lead to comparisons within the coded data and other data sets, looking for verification, contradictory evidence and so on, leading to the development of theoretical propositions. Thus, as well as description, data displays can enable exploration, explanation and in some cases prediction of phenomena. Miles and Huberman (1994) view explanation as being about justifying an action or a belief, giving reasons, supporting a claim or making a causal statement. A particular value of data display use to aid explanation is that they can minimise the risk of jumping to ill-founded, over-simplistic conclusions.

Extended text itself is a data display, and others include matrices, graphs, charts and networks. The type of display chosen and its subsequent design has implications for the analysis. For example, decisions have to be made by the researcher as to what data to include, and that in turn will influence decisions about further data reduction. Used incorrectly, they run the risk of being incomplete or mechanistic. Yet their particular value is as schema to encourage a systematic approach to analysis. Consequently, no single type of display is advocated. Careful selection is required depending on what variables are to be analysed and how. It is advisable to keep early displays loose to see

what works in practice, so permitting a more contextually and empirically grounded version to evolve in later analysis.

Basic data displays of condensed versions of data can be spread out over many pages. It may be advantageous to stack these to form 'meta-matrices' that also respect chronology. Advantages include being easier to make comparisons, to trace backward and forwards, and view displays simultaneously. Whilst meta-matrices have potential to denote points in time of key events, their main limitation is that they do not fully illuminate sequences of events.

During complex analyses, it is acknowledged that many variables exist and may relate to each other. That is, they are 'conjunctural' and affect each other. The effects they have also depend on such things as the situation, their combination and so on. To build on emergent threads of causality, other displays are indicated that incorporate the most important independent and dependent variables and their relationships in a directional manner. To this end, causal networks are indicated. These too permit cross-case analysis and rely largely on the accuracy of preceding analyses and displays that have determined the variables for inclusion within them.

The process of writing narratives to describe what is presented in displays is a necessary part of the analysis. It promotes the examination of the data, the making of comparisons and the identification of any themes or patterns. The completed narratives then serve as a record of what is depicted.

Basic Data Displays

In view of the range of possible data display types, each with a slightly different utility, it was necessary to consider the exact aims of the displays chosen. In this study two objectives needed to be met:

1. To identify the key factors that affect SG decision-making, as identified by the researcher and participants.

2. To display the data in such a way as to show the processes of council decision-making over time.

Checklist Matrices

To meet objective 1, checklist matrices were indicated (Findings Chapter Part 2 - page 139). Matrices were devised to depict factors affecting decision-making within the Human Resources Council (HRC) and Mental Health Council (MHC). Further matrices comprising data pertaining to the remaining councils and related fieldwork were also devised for comparison. Column headings identified the data source as being participant-observations or interviews. Each row was assigned a factor affecting decision-making representing each of the categories set out in the Final Coding Scheme (page 108). For their completion, the previously coded data stored on index cards were used. The identity tag for each coded segment of relevant data was entered into the corresponding cell.

As the main sub-cases of the research, data from the HRC and MHC were presented together. The remaining data sources were much less substantial due to targeted fieldwork with the HRC and MHC. Therefore it was decided that their collective presentation was more likely to reveal any patterns or gaps than many matrices of scant content. Use of identity tags made tracking back to the original data source much simpler. Whilst the complete segments of text could have been inserted along with the identity tags, this was felt to be too visually cumbersome. However use of identity tags alone still meant that the matrices covered several pages and were over-elaborate for presentation purposes.

To aid presentation, all checklist matrices were further condensed into 'summary tables'. The original matrices were used for reference purposes to permit a counting exercise of the frequency with which factors were evident. Evidence of a factor being present on more than one occasion was marked with the following symbol - ✓. For strength of influence as rated by the researcher, the following symbol was used - +.

A process of rating, to give an indication of strength of influence, was achieved by establishing the number of occasions on which a factor was evident during fieldwork:

Up to 5 instances = *no symbol*

Between 6 & 8 instances = moderate +

Between 9 & 11 instances = strong + +

12 or more instances = very strong + + +

Narratives were written for each of the summary tables (Findings Chapter Part 2 - page 140).

Use of summary tables made visual examination of the displays considerably more manageable. Establishing the frequency with which factors occurred and representing this by symbols was useful. It facilitated a considered approach to examining each factor's importance as opposed to a more arbitrary approach on the part of the researcher. It enabled identification of patterns of agreement and disagreement between researcher and participants. Thus more critical examination was promoted as incongruent instances were further explored. The potential for the summary tables to be used with participants for verification purposes was also recognised. Whilst valuable, merely knowing the frequency with which each factor occurred did not necessarily indicate the impact each had on decision-making. Hence some lesser-evidenced factors were considered by the researcher to be particularly influential, although this was not portrayed with use of these particular displays.

Time-Ordered Matrices

To meet objective 2, time-ordered matrices were developed for the HRC and MHC (Findings Chapter Part 2 - page 153). Columns were numbered to show each consecutive month on which the council was addressing each issue. At each monthly point a summary of the council's decision-making processes was noted. Each row was assigned a heading that prompted for evidence of elements that were emerging as significant in early analysis of the decision-making process (e.g. was a lead allocated?). Any council issue lasting in excess of 3 months' duration was included and its progression tracked in this way. Thus 12 issues were tracked in all. Only events and processes that were directly evident through participant-observation, interviews and secondary data were included. Blank boxes indicate that no evidence was identified. Narratives were written for each of the matrices (Findings Chapter Part 2 - page 153).

To consider issues of less than three months' duration was felt to be too limiting when seeking to look at complex processes over time. It was decided that the time sequence within the displays be monthly as this corresponded with the monthly nature of council meetings. It is acknowledged that some events may have occurred away from the

fieldwork setting and so are not indicated. However, decisions had to be made about what data to include and exclude. It was felt that the data collected here were sufficient. Choices were made about which decision-making variables were most key to include as cell labels. Otherwise it would not have been possible to contain each display within a single page, as was the goal in order that they achieve maximum visual utility. A means for indicating absence of evidence was deemed useful. Being aware of gaps in evidence was just as valuable as establishing what was evident. Gaps prompted a double-checking process to ensure that a dearth of evidence was not due to oversights on the researcher's part and promoted further investigation.

Overall, the checklist matrices and time-ordered matrices served to identify key variables around SG decision-making. The latter have also gone some towards showing their chronological order in the decision-making process. These achievements have been valuable in themselves. Yet condensing and displaying data in this way, along with a degree of selectivity over what to include in the time-ordered displays, has meant a risk of over-simplification and a loss of the 'wider picture'. To maintain a sense of the whole, further analysis was considered necessary. This would ensure that no major variables had been overlooked and inadvertently excluded. At the same time, deeper insight could be gained into the relationships amongst variables so as to develop their explanatory power. More advanced data displays had to be developed.

Advanced Data Displays

Time-Ordered Meta-Matrix

Steps in the development process:

1. The first step was to review what was presently depicted in the time-ordered matrices. Key variables are identified as being the main factors/stages/events during the process of councils addressing issues. A matrix was designed that condensed the time-ordered matrices into a single meta-matrix. Column headings prompted for evidence of factors that were emerging as significant. Each council issue was allocated a row of cells into which information was transferred from the time-ordered matrix pertaining to that case. Each council issue had been identity tagged to correspond with the numbering of the associated time-ordered matrix diagram.

2. A system was devised to indicate the stages at which events had taken place. These stages were denoted by use of the '*' symbol and colour codes for easier viewing:

- Events/actions occurring in the *first 2 months* of an issue being addressed by the council were categorised as 'early stage'.
- Events/actions during the *remaining first half* of the lifetime of that issue being with the council were categorised 'intermediate stage'.
- Events/actions during the *latter half* of the lifetime of that issue being with the council were categorised 'late stage'.

3. Once the cell entries were completed, comparisons were made between issues, councils, time periods and so on. In addition to comparisons and contrasts, extreme cases were also examined. Any insights that were 'ill-fitting' led to a return to the coded data and earlier narratives for further deliberation. A narrative was written for the meta-matrix (see Appendix 22 - Time-Ordered Meta-Matrix).

Whilst progress over time was clear within the time-ordered matrices, sequence was not necessarily apparent, not least because many actions/events appeared to occur simultaneously, for example, clarifying the aim of an issue and appointing a lead. Thus, incorporating a means of developing greater insight into the ordering of events was considered useful. This was done in the meta-matrix by grouping events into early, intermediate and late stages, as opposed to specifying the month in which actions took place. This was because the duration of issues varied greatly between 6 and 24 months. To compare issues by how long they took to address in total would therefore not permit meaningful comparison. Issues varied considerably, not least in terms of size and complexity. What is more useful is the stage at which events/actions occurred in an issue's lifetime and their sequence in relation to other events/actions. For example, was a lead allocated promptly in the early stage or did this step come later?

Consideration was given to ordering the issues themselves in some way to aid their comparison in addition to them being time-ordered. Whilst case-ordering is a valuable process (Miles & Huberman 1994), this was not possible, as the most useful ordering would have been to rate the effectiveness of each issue's progress in some way, thus comparing the processes of issues that 'fared well' and those that did not. It was not felt that an objective judgement could be made of this in view of the complexity of

decision-making. If all issues had been resolved during the council's lifetime or by the end of fieldwork, then the outcomes of each could possibly have been rated in some way in order to make a judgement. However, the majority were not completed during this time.

Overall, simply knowing what variables there are is insufficient. It is necessary to establish any relationships between them and to include them in subsequent displays. Hence the need arose to advance the analysis a stage further by developing causal networks for each council issue.

Causal Networks

Steps in the development process:

1. The first step was to be explicit as to which variables were to be included in the network diagrams. Initially it was decided to utilise all variables identified in the HRC and MHC Checklist Matrix Summary Table (Findings Chapter Part 2 - page 145).

2. Refinement of this list of variables for inclusion was necessary, as not all were factors in the decision-making pertaining to the 12 council issues examined here. The more detailed checklist matrices from which the checklist matrix summary table is drawn detailed the original data sources. This made it straightforward to revisit the original chunks of coded data to see if they pertained explicitly to one of these 12 cases. Variables not found to fit these criteria were excluded.

3. Each network diagram was drafted and refined by hand on a flip chart prior to being transferred onto a computer package. Each diagram was developed and is to be read from left to right. Thus, the starting point is when an issue was submitted for a council's attention. Each factor was situated in a box and placed in order of chronology. Some of the diagrams curve downward for ease of presentation as opposed to presenting them linearly. An adjoining arrow indicating direction of influence depicted the relationship between factors. Each boxed factor was colour coded to correspond with the time frame used within the time-ordered meta-matrix, these being early, intermediate and late stage.

4. Once drafted, each diagram was compared with the corresponding time-ordered matrix and meta-matrix to verify its completeness. Frequent visits back to the original data were made to check the ordering of events, investigate any perceived gaps, unexplained occurrences and to keep a sense of the whole decision-making process and not merely its component parts. A small number of inconsistencies/inaccuracies were found and addressed, ensuring that the network diagrams were as accurate as possible. Narratives were written to describe and critically examine what was depicted within the diagrams. This process was very important in drawing attention to additional events and occurrences that, when looked at in context, showed an impact on the decision-making process. These additional factors were also included in the network diagrams.

Decisions around what factors to include in the network diagrams were crucial. Many of those listed in the checklist matrices were mentioned generally as factors that could affect decision-making but that didn't necessarily do so during these 12 issues. For example, 'discussion of opinions' was identified as a very strong factor by council members at interview, but was not evident as a strong influence within observations of these 12 cases. Such factors were not included in the network diagrams.

Some variables identified explicitly within the detailed checklist matrices had been omitted deliberately from the time-ordered matrices. This is because it was, at that time, considered necessary to include only the main or most important variables in later displays. Such decisions about what is sufficient detail to include, and what to exclude without loss of detail, are some of the decisions researchers need to deliberate over. On reflection, to incorporate only the factors identified within the basic displays in the more complex network diagrams effectively over-simplified some of the decision-making processes being investigated. This was not helpful when attempting to move on from description to explanation. Whilst labour-intensive, to address this concern a process of returning to original data sources was necessary to ensure that all key factors were eventually included in the network diagrams. Thus, full and accurate representations of council decision-making were achieved.

Arrows indicate the direction of influence/impact, although it was decided that it would overcomplicate the diagrams if symbols for positive or negative influence/impact were to be added. Instead such judgements are made clear in the accompanying causal

network diagram narratives (Findings Chapter Part 2 - page 153). The criterion for assigning these judgements about impact was that each proposed variable/relationship had not been refuted by any other data. Instead a judgement was made based on considered opinion arising from the preceding rigorous steps and with the knowledge that there was supportive coded data available to substantiate these claims of association/relationship.

Overall, representing each council issue as a separate diagram facilitated cross-case analysis, as a means of developing more powerful explanations than is possible when examining single cases. Logical chains of evidence were built and refined through constant reference back to the coded data, earlier displays and narratives. Attention is now turned to the quest for a single causal model of SG decision-making that would comprise a network of variables with causal connections among them (Miles & Huberman 1994). Development of such a model would be a theory-building exercise aimed at deriving a testable set of propositions about the complete network of variables and interrelationships, so presenting the basis of a theory to strengthen council decision-making.

PART 3 - Theory Development

This final stage of analysis draws the earlier analysis work together and identifies the final findings and conclusions for presentation. To conclude with an original contribution to the field of knowledge and existing theory around SG decision-making has been the ultimate goal. What has been appropriate and achievable through the network diagrams is to identify observable associations, identify mechanisms and establish connections amongst events over time, resulting in a well grounded set of explanations. What remains is to represent and communicate these findings in the form of a general model. To this end, a conceptual model of SG decision-making was developed.

Use of the term 'theory' here is synonymous with the definition of theory as defined by Strauss and Corbin (1998:15):

> "A set of well-developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict phenomena."

Development of knowledge about the little-understood phenomenon of SG decision-making has been achieved through observation, investigation and analysis and as such is considered 'grounded'. Grounded theories drawn from the data, are likely to offer insight, enhance understanding, and provide a meaningful guide to action (Strauss & Corbin 1998). Once developed, theories may be presented in the form of theoretical models.

A symbolic model comprising words, numbers, shapes or symbols may be used to represent the real situation, and may bear no physical resemblance to reality. Neither does a conceptual model resemble reality, yet these are less abstract than symbolic models and depict the connections between concepts as opposed to less concrete ideas (Slevin 1995).

Through comparisons of the causal network diagrams and their narratives, twelve factors were identified for inclusion in the model. The list of factors was then assembled and reassembled until a clear sensible diagram had been created. Each draft model was subject to verification by reference back to the individual causal network diagrams and amended accordingly. The finalised model is presented in the Findings Chapter Part 3 - page 170.

In developing a model, an earlier objective had been to generate a *causal* model of SG council decision-making. However, it was realised during late analysis that the decision-making being researched here was too complex and multi-factorial to be represented within a singular causal model. At any one time, numerous factors could be influencing each other and in ways that cannot be discerned. Therefore, any attempt to arrive at a causal model that could accurately depict and so predict SG decision-making would be problematic, not least because causality is arguably an unworkable concept with regards to the complexities of human behaviour (Lincoln & Guba 1985). As Miles and Huberman (1994:145) assert:

> "Just as there's no clean boundary between description and explanation, there's no precise demarcation between general 'explanation' and 'causality'. It's not fair to say that determining

> causality is necessarily a 'stronger' form of explanation than others."

A conceptual model was considered appropriate and development of the one here was aided by substantive immersion in the earlier analysis. This had led to a deep understanding of the factors at play during council decision-making. Thus it was possible to draw out the more important factors and set aside those of less importance. A model to explain as opposed to predict SG decision-making was achieved. Determination of twelve factors for inclusion was arrived at following the drafting of earlier models with more or less elements than this. The final version comprising twelve factors was chosen because it gave the best fit. That is to say that the model respected individual network diagrams from which it was derived. There was no intention to try and establish a standard set of variables that were present in every case (council issue). Whilst writing the accompanying narrative (Findings Chapter Part 3 - page 170), it was realised that the twelve factors were indeed a combination of elements affecting decision-making and supportive conditions.

The visual appearance of the model was finalised after several drafts and seeks to balance clarity at communicating its component parts with being visually stimulating and memorable. Representing the factors as circles within circles was considered an effective way of conveying that eight elements were encompassed by four decision-making conditions. It was decided not to dictate a specific order to following through the components of the model e.g. by numbering each factor. In practice, the order in which factors occur may vary or indeed overlap. Ultimately, the model achieves a representation of reality, not a prescription of how it should be viewed. Detailed examination and justification of each of the model's components is undertaken in the Findings Chapter Part 3 - page 170.

Chapter Summary

This chapter has shown how early analyses progressed through action research cycles to exploration of data displays as a tool to aid further analysis. A range of tools was developed and the steps in the development processes and characteristics of each are presented. The thinking underpinning the displays has been elucidated to show why analytical choices were made. Analyses were deepened over time until a conceptual

model of SG decision-making was devised. The findings from these analyses are presented next.

CHAPTER 6

FINDINGS

Introduction

This chapter is divided into three parts. Part 1 summarises the findings from the early wider evaluation study. It is these findings in particular that prompted the selection of decision-making as a focus for the doctoral study. Thus they are provided to illuminate these underpinnings. Part 2 presents the findings from the development of basic and advanced data displays used to progress data analysis. Part 3 concludes the chapter with the presentation of a conceptual model of SG decision-making.

Reference is made within this chapter to a number of extracts or sources of evidence. Each of these has a field note tag attached to it, for example, (FG1/678), to identify its exact location within stored data.

PART 1 - Initial Findings Summary

Introduction

This section summarises the early evaluation study findings. An overview of findings at six, eighteen and twenty-four months into the study are given. From twelve months, the decision-making phase commenced and ran concurrently with the wider evaluation. At twenty-four months the wider evaluation ceased whilst the decision-making phase continued for a further six months.

Evaluation Study

During the wider evaluation fieldwork, factors/stages/events of relevance or importance were noted. Upon identification, each was summarised into a diagram (see examples in Appendix 17 - Action Research Cycles). Field notes were made to record details of

how each issue arose, what the causes appeared to be, why it was important and so on. These field notes were continually revised and added to in the light of further fieldwork and ensuing comparisons with other data sets. Summaries of these developing yet fundamental findings are presented here. Included are the observations made at each phase of the evaluation and the researcher's response to these in terms of facilitating/encouraging action. Furthermore, these summaries illuminate how decision-making became a topic of interest and subsequent focus of the doctorate.

Evaluation Findings at 6 Months

Sense of Direction

After the first six months, councils' roles and remits were becoming clearer, although some aspects still remained unclear. For example, members were uncertain as to what levels of authority and responsibility they had and whether their council's role was to ratify the work of others or to undertake the work themselves. Whilst supportive and encouraging, the Policy Council was not communicating as clearly as it might, such as giving vague verbal instructions as opposed to clear written ones that could be referred back to. Whilst the Policy Council guidance received was helpful, according to practice-based council members, further support could perhaps have been gained by attendance of practice-based council members at the Shared Governance Working Party. The Human Resources Council (HRC) and Research Education Council expressed a sense of 'gap filling' and 'information sharing'. Lack of appreciation of the councils' role was further indicated by a continued lack of suggested issues to address from constituents. As a result of these concerns, an away-day was prompted to address these issues.

Constituents' Views

From the outset, obtaining the views of constituents presented difficulty. Despite members' attempts to encourage constituents to suggest ideas for the councils to work on, responses were minimal. However, members expressed that they were not very active with regards to raising awareness of the councils or encouraging involvement and so this was identified jointly as an area in need of improvement. Due to inactivity with regards to this need, members were later encouraged to make use of existing opportunities to raise their profiles, such as networking at a Research and Development half-day event and the running of some workshops for staff. Creation of new opportunities, such as a marketing and promotions strategy, presentations and an

information leaflet, were also brainstormed by members.

Decisions

Decision-making around council issues proved difficult at times, seemingly due to a lack of information on which to base decisions. Following discussion, members were encouraged to consider the use of co-option of informants. This strategy had appeared effective on occasions that it was used. Furthermore, background preparation away from the council meetings and sub-group work were also considered effective, so members were encouraged to build on this.

Council Interface

Another early issue was the councils' interface with other groups. This arose as a potential difficulty, and it was noted that some council members were well informed about the activities of other groups in the Trust, which was helpful. It was questioned whether the councils' roles might be unclear to other groups too. Council members were encouraged to invite people to meetings to see what help they could give the councils. Issues being addressed elsewhere and the risk of the councils duplicating others' work were a real possibility that they were not addressing. With regards to the Mental Health Council (MHC), it is unclear how this council fitted within the Trust in terms of it addressing issues that could have Trust-wide implications, for example the Violence & Aggression Policy (MH1), and members were encouraged to seek clarification. However, clarification was not sought and the relationship of the MHC and Trust-wide councils remained unclear. It was suggested that some benefit might ensue from some means of meeting up with the other councils on an appropriate occasion. Trust-wide council members agreed that they would find an away-day useful. The project leaders announced this event, which clashed with the date of the next MHC meeting. MHC members took offence at this move and expressed that they did not see the benefit in attending. During discussion of emerging findings, it was suggested that MHC members should take care that they did not end up with a 'them and us' situation. In response to the MHC reluctance to participate, MHC member attendance on the day was made mandatory by the SG project leaders.

Communication

A need for improved communication between all councils was indicated. This was especially the case with the MHC to prevent repetition and open a channel for the Trust-

wide councils to be made aware of issues being discussed at the MHC that may have Trust-wide implications, for example, issues relating to development of case notes, violence and aggression management and bank nurse training. All councils were advised to develop mechanisms to continue to promote optimal communication. A few months later, some improvement was evident. Policy Council members had offered to attend/inform council meetings. The HRC planned to approach the MHC with regards to having a Mental Health representative on the HRC. Also a number of measures were planned to attract and engage constituents, such as revamping the Trust SG Bulletin, a one-page information flyer. A few months later further efforts were made around communication with the MHC agreeing to write a column for the Trust SG Bulletin and their own MHC Newsletter being sent to the Trust-wide chairs. Generally, communication around the Mental Health Directorate was substantive, according to members. However, suggestion forms received from constituents indicated a lack of appreciation as to the council's exact role. The suggested issues did not fit the council remit as defined by members.

Organisation

Also in the MHC at this time, a model introduced by council facilitators to frame the organisation of the meetings was proving useful (see Appendix 18 - OARRRS Model). Therefore its continued use was encouraged. Over time, its repeated use appeared to contribute to the efficient, organised, and well-planned approach to MHC meetings. Careful planning, consultation of members, good timing, remembering of all agenda items and tackling of non-attendees by the chair were evident. The MHC members became exemplars in its use and were encouraged to share this good practice with the Trust-wide councils. The model was used in full and supported by the use of posters of ground rules and a display of the model on a flip chart. The chair ensured that the member adopting the Process Facilitator role, which involved co-ordinating the model's use, could take part in meetings but ideally should not be a lead on items. Thus they could concentrate fully on facilitation. A pattern of the MHC being fairly organised was emergent. Members were frequently seen to be thorough at preparation prior to meetings and organising work by way of sub-groups on occasion. These measures coincided with progress being made with the associated issues. The HRC showed little evidence of being organised and at the same time were making little progress.

Evaluation Findings at 18 Months

Progress

A year on, the progress being made by the Trust-wide councils had gathered momentum. Some issues had now come to fruition, for example development of the Recorded Drugs Policy. Council Information sheets produced by members to summarise progress for each issue illustrate and communicate this progress. A number of small measures appeared to be aiding effectiveness of meetings, for example chairs ensuring that agendas and minutes were sent out in plenty of time and papers to read being sent out prior to meetings. The MHC continued to ensure good preparation by members for meetings. For example, flip-charted information was brought to the council from the User Involvement Issue (MH4) sub-group and Motivation Survey Issue (MH6) documents were sent out before the meeting to allow for pre-reading.

Organisation

The OARRRs model was still being used and where it was used fully it paid dividends in terms of keeping to time, agreeing action and so on. Although originally an exemplar in its use, the MHC's use of OARRRs had wavered in recent months. For example, in one meeting it was decided to 'go with the flow' and not set desired outcomes. Across the councils, incomplete use of OARRRs led to impaired time management and lack of clarity around who was doing what and the outcomes of items. A couple of items had even been unclear to their leads, and so progress had been difficult. Built in with this was being clear about what tasks were being taken away to be addressed, such as occurred with the User Involvement Issue (MH4) sub-group of the MHC that became rather muddled. A reluctance to be Process Facilitator was noted, and this was in part due to lack of understanding of the role within the OARRRs model.

Preparation

At times, items were being deferred, as no one member was co-ordinating or driving the issue forward and inadequate preparation meant that, for example, required documents were not brought. Hence items could not be progressed. Members were repeatedly not reading drafts and preparing comments as requested, so slowing progress further.

Roles

Council roles and remits were becoming clearer as time went on. Members' self-

identification of issues to address was more evident. At this stage, they were thinking of things to tackle, for example guidelines for job specifications, national guidelines for National Vocational Qualifications (NVQ) and generic worker roles. Members were noticeably more relaxed and participatory at the Policy Council. Requests for action by the Policy Council tended to be verbal. Sometimes council chairs had to rely heavily on the facilitators to remember what was said at the Policy Council. The MHC appeared to cope satisfactorily without a facilitator in that good progress was being made in the absence of one.

Workload

Topics being tackled and subsequent agenda sizes tended to be quite sizeable, hence workload was proving to be a growing issue. Papers and such like were going out before meetings as appropriate but a number of invitees or speakers had failed to turn up at meetings, resulting in a significant chunk of meeting time being wasted. Across the councils, time was tending to be lost discussing suggestion forms that had been received, often at length, when it was often unclear what the issue was. Of the few suggestions being received by councils, most were unclear, with no attempts being made to clarify them prior to meetings. Yet mostly these unclear suggestions were still discussed at the meetings and on occasion clarification was sought by telephone during the meeting.

Communication

Even at this stage, engagement of constituents remained difficult. The Trust SG Survey (Williamson & Petts 2000) undertaken as part of this early evaluation phase identified that approximately half of Trust staff surveyed did not know of the council suggestion form system. The MHC continued to address communication well locally, for example through the regular MHC Newsletter and posters at a Royal College of Nursing Trust visit. Communication within and between councils was found to be lacking. Letters inviting council members' input or comments were having to be re-sent on occasion and/or chased up, for example those concerning the Orientation Pack Issue (HR5) and a request for vice chair nominations. Similarly feedback to constituents on reports/documents they had submitted was slow. The Council Information sheet that originated with the Practice Development Council was found to be useful and had been adopted across the Trust-wide councils by this stage. The Trust SG Newsletter, proposed as the main medium for Trust-wide councils' communication, was progressing

very slowly with quarterly issues being many months behind in production. The HRC helped itself by clearly dividing up the work for the Trust SG Newsletter but limited action ensued. As shown by member's activity analysis data (Petts 2000), collated following members' completion of activity sheets (see Appendix 19 - Council Activity Sheets), dissemination and engagement of constituents was receiving little attention.

Support

The introduction of a monthly Chairs' meeting (Trust-wide councils and MHC chairs with the Nurse Director) opened the door for communication with the MHC. The meeting was apparently useful when well-attended, although this was frequently not the case. It provided an opportunity for peer support, clarification of issues and guidance. MHC attendance at this forum was particularly poor. It also presented an opportunity to find out existing work and be pointed to useful contacts. For example, the MHC could have sought advice around its Ethnic Minorities (MH7) and User Involvement (MH4) issues from this group.

Co-option

In the HRC, progress had been particularly enhanced by securing a Personnel Department representative in terms of providing information and ideas for members to address. Councils were generally making use of various invitees to inform their discussions. This proved useful, and it was notably less useful when they were not present and there was a lack of insight/information available to inform decision-making. The Trust-wide councils, by way of sub-groups and inter-council work, were making notable progress. Yet councils tended to have sub-groups comprising council members only, rather than engaging constituents.

Council Interface

Council members had not taken up the opportunity to be gained by seeing personally how the MHC operates, as previously advised as a means of sharing good council practice. At this time the interface between all groups was being looked at Trust-wide through clinical governance processes. Whilst unclear council remits were originally quite an issue, the only real difficulty around this at this stage has been with the HRC, due to clarity of its remit still having not been reached. Much discussion was taking place in the Trust around the potential for rolling out a directorate-based council structure in other directorates. This was prompted in part by these findings, highlighting

a need to engage constituents, but also by the success of the MHC. Such local, practice-based councils are increasingly considered as having potential to meet some of the difficulties being experienced around engagement of non-council members in SG.

Profile

To raise its profile, the MHC held a 'Celebration Day' comprising mainly a poster exhibition that was well received and reasonably well attended. Little notice of the event meant that the other councils were unable to plan to attend. The Trust SG Bulletin was proving ineffective, as reported by council members and as demonstrated by the Trust SG Survey findings (Williamson & Petts 2000). The MHC was content with having just its own MHC Newsletter, although other council members had asked it to consider a page in the Trust SG Newsletter too.

Attendance

Short tenure and poor members' attendance were two notable issues. Members identified and addressed these difficulties themselves. Chairs' appointments of 6 months duration, as in the Research Education Council, were proving too short. Terms of office are over just as members are mastering their new roles. Members decided to have a process of chairs becoming the vice chair again after serving, as a model to support new chairs to adapt to their role, as seen with the Practice Development Council. Actual attendance was variable and was also being addressed by chairs in person with members concerned or by letter. The same issues around tenure and attendance existed for the MHC also. The MHC expressed that a key problem with attendance is the lack of release time from the clinical area. A reluctance to accept the vice chair position was identified as being due primarily to the off-putting workload.

Teambuilding

An away-day for council members was delivered in part response to earlier SG research feedback. There was a low response rate to the event evaluation forms, so feedback was elicited through direct discussion with members. Overall, this appeared to be an enjoyable, well-organised day that helped to foster a team spirit amongst people present. General agreement was that it was very valuable. In particular, the monthly Chairs' meetings had been prompted by it as a possible solution to inter-council communication problems. Part of the purpose of the day was to help bridge the gap between the MHC and other councils, but it was not particularly successful at this, primarily as MHC

members had to reluctantly cancel a council meeting to attend.

Action Taken

Where effective organisation and working was noted, its continuance was encouraged. Examples include the production of Council Information sheets, preparation before meetings and pre-circulated documents for reading. The OARRRs model has repeatedly proved beneficial when used in full, and so the researcher advocated its continued use.

What was consistently a significant element of OARRRs was the allocation of leads for issues to drive them, ensure papers are circulated, information is brought and so on. The allocation of leads was actively encouraged. A recommendation that a single lead be assigned to items for continuity as opposed to temporary ones was made, as periods without a lead had been notably unhelpful.

Despite being more at ease at the Policy Council, members were still reluctant to ask for instructions in a written format, and they were repeatedly leaving those meetings with unclear objectives. This was highlighted to members, who agreed to work at articulating their wishes in this forum.

Where council remits were unclear, members were encouraged to seek clarification through the Policy Council or Psychiatric Services Management Team (PSMT) in the case of the MHC.

Council members were advised to pay attention to the size of topics being tackled and subsequent agenda size, which tended to be quite unwieldy. In view of workload being a problem, members were prompted to ensure equity in how the workload was divided up, not least so that certain members (chairs and vice chairs especially), did not get overloaded.

Delays caused by unclear suggestions to councils of issues to address led to discussions with members as to how these could be minimised. It was agreed to seek clarification before the meeting rather than discussing them, taking them away for clarification and then bringing them back again. Having raised the issue of many constituents being unaware of the suggestion form system, members were stimulated to take a number of

steps to improve communication in response. These included refinements to the Trust SG Bulletin (different colours, more eye-catching format), development of an Annual Report summarising achievements, a council-specific newsletter, poster presentations within the Trust, and so on. MHC members were advised to continue to build on their early successes at communicating with their constituents, largely due to the smaller geographic area they cover.

Frustration was being experienced by constituents as a result of delays in receiving feedback from the councils concerning their suggestions and draft documents. This was discussed and members responded by agreeing to feed back to constituents promptly and clearly and in writing where possible.

Often it was seen that if something was a shared responsibility, it never got done. Members were therefore asked to consider how they promoted themselves and review how they could do more of this to raise their profile amongst constituents. The need was recognised for members to look for and create time to promote themselves more, especially with regards to recruiting new members. For example, on the most part there was not a defined lead for the Trust SG Newsletter. The chair cannot do everything and so it was suggested to members that someone from each council take responsibility for publicity and promotion. Thus they could liase with each other, share ideas and plan things together. It was advised that members needed a planned approach, otherwise only one newsletter was on track to be achieved that year. Members were further encouraged to have publicity as an agenda item, to keep it visible.

Practice that had worked well, such as use of informants and invitees, was reinforced. Sub-groups comprising council members only were discouraged, as these did not present opportunities to engage constituents. Trust-wide council members were advised to keep an eye out for opportunities to co-opt, develop sub-groups and so on as these had been effective where used.

Failure to attend the Policy Council resulted in poor communication, and so chairs were asked to consider sending a nominee in their absence.

As Trust-wide council members had not taken up the learning opportunity to be gained by seeing personally how the MHC operates, this suggestion was reinforced.

Following discussion, an OARRRs pro-forma was developed with members and introduced to all councils to encourage its use (see Appendix 20 - OARRRs Pro-Forma). This was piloted, refined and worked well. Its continued use was advocated, not least because it provided a useful record of meeting outcomes, which had been a particular problem in the MHC, remembering who was doing what, what was agreed and so on. The pro-forma was also in part a response to a reluctance to undertake the Process Facilitator role within OARRRs. The pro-forma guided the user through the OARRRs process, so those members became more comfortable with it.

A key medium for communication with Trust staff was the Trust SG Bulletin. This single-sided information flyer was proving ineffective as reported by council members and as demonstrated by the Trust SG Survey findings (Williamson & Petts 2000). Following discussion with members, the Trust SG Bulletin and Trust SG Newsletter were combined.

In the light of feedback about tenure, a tenure of a minimum of 18 months was recommended and agreed for members and chairs. As workload was putting members off the vice chair role, sharing of the workload was advocated. Council members were encouraged that if they had not got enough time, then they should be raising that as a concern that can be addressed with the SG project leaders. To avoid the difficulties that the MHC had experienced with the change-over of lots of new members, it was encouraged to have their orientation pack ready on time for the approaching change-over of members and timely re-election of members, with shadowing where possible.

Evaluation Findings at 24 Months

Progress

Now two years into the SG initiative, a review of experience and learning to-date took place. The Trust-wide councils had benefited from various measures that had positively influenced those councils' progress and decision-making. Examples include the use of invitees, attendance of a Personnel Department representative, Chairs' meetings, having a Research Education Council representative on the Trust Research & Development Committee and having a facilitator present at meetings. However, the HRC remit and place alongside other Trust forums remained unclear. The MHC had similar difficulties, and had done some thorough work into clarifying its mission, remit and purpose.

Communication

In terms of communication, the Council Information sheet had been adopted successfully across the Trust-wide councils. This was produced monthly and disseminated around the Trust. Publicity representatives were agreed across all councils and were leading on the revamped Trust SG Newsletter, which is now back in production.

Council Interface

The Chairs' meetings continued, but were not particularly helpful unless well-attended. Meetings tended to be rushed and focused on a briefing of the Policy Council agenda of late, rather than an opportunity to discuss issues, share best practice and difficulties faced. One of the key original prompts for a Chairs' meeting was the need to improve communication with the MHC, yet MHC members had rarely attended. Whilst minimally attending this forum, the MHC members endeavoured to promote much-needed inter-council liaison by attending two Trust-wide council meetings to see how they operated.

Profile

Engagement of constituents remained a difficulty, not least as there was limited time for council members to disseminate. Newly-appointed publicity representatives were less active than perhaps they could be. The MHC was continuing to produce a regular newsletter. Plans were underway to develop an orientation pack for new members that would also be informative to others.

Workload

Members still did not share responsibilities and workload fairly, and so chairs remained challenged by the extent of their workload. The reluctance amongst members to adopt the vice chair role, leaving this post unfilled in some cases, was not helpful. Time needed for the role was off-putting, yet chairs were still leading on several items at a time, thus adding to their workload. Where no specified lead existed, items generally progressed much slower, for example the Trust SG Newsletter and Orientation Pack issue. Even where a lead had been appointed, information was not always forwarded in their absence from meetings, which tended to result in delays in progress.

Organisation

The OARRRs pro-forma had been found to be a useful guide, as it had helped to clarify actions, target dates, and responsibilities and provide a record of what was agreed, which had in turn assisted the chairs. Within the MHC, meetings of late had not been 'typical' meetings due to the addressing of a number of council difficulties. Consequently the OARRRs model had been little-used. This appeared to be partly due to a continued lack of clarity about the role of the Process Facilitator, a key element of the OARRRs model. When previously used, OARRRs repeatedly helped improve the process of the MHC meetings.

Members had made some improvement around organisation, including preparing as much as possible before meetings, for example, drafts, pre-circulation of documents, bringing comments and so on. It was still not always clear who was doing what, as not all items consistently had leads.

Suggestions

The low number of suggestions received and findings within the Trust SG Survey (Williamson and Petts 2000) indicated the suggestion form system to be failing. The MHC had taken a number of positive steps to review their suggestion form system, including their format and re-launch and also invitation of the suggestion 'proposer' to the meetings.

Attendance

Attendance continued to be a difficulty. Participant-observation suggests this may have been as a result of lack of time, lack of support to be released for meetings and/or lack of motivation to attend.

Orientation

The previously recommended orientation pack for new council members was now approaching completion. The MHC was looking at preparing an orientation pack of its own. The stepping-down process of members was disastrous in the MHC, which at one point had considered disbanding completely. Particular problems were no/insufficient shadowing of retiring members by new members, no proper hand-over of issues when leads stepped down, as well as insufficient notice of stepping down. It was originally agreed to aim for 3 months' shadowing for new members. This was not always possible,

for example when members were leaving the Trust. However, there were several occasions when this has not been the case, yet no notice was given. Council members had originally acknowledged their responsibility to ensure the smooth transition of replacement members. Furthermore, not all new members had attended a LEO programme prior to appointment, and this further hampered their grasp of council working. Similar issues arose with the change-over of chairs. It was not ideal when an appointed chair or vice was newly appointed to the council as well, as has happened on occasion, or that the chair was left unsupported because a replacement could not be agreed.

Action Taken

Despite repeated encouragement, the HRC never sought clarification as to its remit and place alongside other Trust forums. Ultimately, a review of the whole SG model was advocated, as this council was persistently ill-fitting. This took place in February 2001. The MHC was still being encouraged to ensure that its own role and that of the PSMT was agreed and clear to both. The MHC was also advised to negotiate a of level of authority with managers prior to working on an issue and then not knowing what to do with it, for example the Motivation Survey (MH6). It was further advised to utilise sources such as the PSMT, Chairs' meeting and other councils to identify other work, key informants and so on, prior to commencing work on an issue, for example Ethnic Minorities (MH7).

All council members were prompted to review and perhaps redefine the format of Chairs' meetings so that the chairs got out of them what they needed. It was suggested that more of a 'support group' meeting for chairs was needed as opposed to the briefing sessions they had become.

The MHC was continuing to produce a regular newsletter. However, each council's publicity representatives were advised to meet up and address communication together, for example, inclusion of a MHC page in the Trust SG Newsletter, as this was not happening.

Members had made some improvement around organisation of meetings and so were encouraged to build on recent efforts to prepare as much as possible before meetings,

for example, drafts, pre-circulation of documents, bringing comments and so on. Discussion was held regarding members still needing to ensure that clear objectives were set with a level of authority and decision about who was doing what by when.

As chairs were still leading many items, it was reinforced that they should lead fewer items, and that new issues should have a lead agreed at the outset, regardless of who brought the issue.

Members were advised to continue OARRRs pro-forma use.

As the suggestion form system continued to generate little response by constituents, it was suggested that the system be revamped and re-launched to be more user-friendly. It was proposed that publicity representatives could possibly co-ordinate this, building on the successful suggestion form refinements made by the MHC.

Poor attendance continued across all councils. Some reluctance to attend had been identified as being due to lack of time, lack of support to be released for meetings and/or lack of motivation to attend. Again, sharing out council workload amongst council members and involving constituents might have been helpful, and was encouraged. Members were encouraged to raise and address problems with ward/department cover.

Whilst members had acknowledged poor orientation of new members as being a particular hindrance to their progress, the orientation pack was not completed by the end of fieldwork. It was encouraged that adequate provision be made should there be a change in chair or vice chair. That is, that the chair should never be left without the support of a vice chair, even if it is just a temporary one until a permanent replacement is found. The chair's job proved very demanding. Lastly, chairs were advised to ensure that new members attended a LEO course promptly, and preferably prior to taking up a council seat.

Summary

The findings from the wider evaluation work presented in this section informed and catalysed ongoing improvement to council structures and processes throughout the

study period and culminated in the development of a Good Practice Guide (see Appendix 21 - Good Practice Guide). It was during this wider evaluation that an interest in examining council decision-making developed to become the focus of the doctorate. The need to draw specific inferences from these findings around council decision-making prompted the search for a more detailed approach to analysis that would ensure greater transparency and promote further accuracy, so optimising validity and reliability. For these main reasons, the subsequent findings have been developed following further deepening and strengthening of existing analysis by the use of data displays as an aid to qualitative analysis.

PART 2 - Identifying Factors Affecting Decision-Making

Introduction

This section presents findings from the intermediate stages of analysis, which centred on the development of basic and advanced data displays.

In order to preserve a sense of progression or 'flow' through the findings to best illuminate their development, the findings pertaining to the development of the Time-Ordered Meta-Matrix, an advanced data display tool, are presented separately in the appendices (Appendix 22 - Time-Ordered Meta-Matrix Diagram & Narrative).

Checklist Matrix Narratives

In this section, narratives are presented that pertain to a set of basic checklist matrix diagrams that served as tools to extricate what are tentatively viewed at this stage as key factors within SG decision-making. Findings derived from checklist matrix use with the other Trust SG councils are also given, as these were used during this period to permit valuable comparison and contrast of emerging findings. The purpose of these narratives is to draw together the diagrams' contents and begin to make sense of them, thus producing a plausible account of what happened (Miles & Huberman 1994).

The full set of checklist matrix diagrams is presented at the end of these narratives on page 145.

Checklist Matrix Summary Table A - HRC and MHC

The obvious comparisons to be made within this table are between the HRC & MHC generally, between the council members' expressed views and the researcher's observations, and the differing strengths of influence attached to the factors identified.

On first look, factors that most aid council decision-making centre on gathering and exchange of information through discussion, use of informants and gathering of background information. Also, of most benefit are factors that guide decision-making, such as knowing the purpose of the decision, coaching/support and the SG research findings.

Barriers appear to centre on lack of clarity, such as members not knowing where they were up to on issues, not having a clear objective, lack of time for the scale of the issue and insufficient input from other people.

Key factors that also affect decision-making concern the impact of the decision and who is present at council meetings. When comparing these impressions with the detail of the other checklist matrix diagrams for these two councils (Checklist Matrix Tables 1-3 /HRC & MHC), other patterns begin to emerge:

Checklist Matrix Table 1 (HRC & MHC) - Aids

Interestingly, the researcher had not found lengthy discussion of opinions or gathering information to be notable as an aid to decision-making during observations. Whilst both councils' members held a strong regard for the value of discussions amongst themselves at council meetings, the gathering of information was a particular influence according to MHC members. Whilst discussion could reasonably be expected to be a beneficial pursuit, it is the researcher's view that the MHC discussed things excessively at times, perhaps as a strategy to manage confusion, and so the discussion was not always helping them to progress.

In contrast, it is primarily the researcher that identified engagement of informants to be particularly beneficial to councils' decision-making, and on occasions this was expressed by council members during meetings. Yet at interview, use of informants was minimally mentioned. Views differed again with factors that guided decision-making, as the researcher found guidance given to council members by way of coaching/support

and the research findings to be of particular assistance. No council members at interview expressed this view, although the utility of the research findings was mentioned during some observations. There was some agreement that having a clear purpose was helpful, but only between the researcher and HRC.

Having adequate time and options open to them were minor factors to MHC members, but were not an issue for HRC members, nor were they picked up on by the researcher. Otherwise both councils similarly mentioned factors.

Checklist Matrix Table 2 (HRC & MHC) - Barriers

Barriers resulting in a lack of clarity were recognised by the researcher and both councils' members. Unclear council issues were not observed to be a problem within the HRC, whereas they were observed to be a particular difficulty within the MHC. Potential lack of clarity was perhaps offset by the close support of the HRC facilitator and the Policy Council. It is not known what support the MHC received away from meetings, but it may be significant that they did not generally have the direct support of a facilitator. Both councils were observed to get confused as to where they were up to on issues, but this was a particular problem in the MHC. Again, the HRC was kept on track by support mechanisms, whereas the MHC was very self-directed and appeared to bow under the strain of numerous large projects which evidently proved difficult to keep abreast of. Such confusion registered only as a minor factor with both councils' members, with the MHC clearly not seeing the problem to the same extent as the researcher. Yet it is suggested that this failure of the MHC to see how bogged down it was getting with its many large issues, and members continuance to take on more and more, added greatly to the major problems it had in year 2 when it ground to a halt amidst a period of great confusion.

Both the researcher and the two councils identified issues around lack of time and time-scale fairly evenly.

Insufficient input from other people was identified during observation of the HRC, which was also raised by HRC members. For this council, the lack of input by certain people was a significant contributor to the council's slow progress as they lacked the information needed to make decisions. This was identified as a minor issue within the MHC observations and was not identified at all by MHC members.

Financial concerns were factors noted during observations of both councils, although they were more prevalent within the MHC, perhaps simply because a greater number of MHC issues had direct cost implications. At interview, HRC members did not raise finances as an issue, whilst MHC members did.

Lack of information as a barrier was noted by the researcher in the HRC only and also by an HRC member, but was not evident as a factor within the MHC. Again this ties in with who is present, as lack of information, whether that be lack of information to hand or lack of people's input to bring information as requested, resulted in some degree of difficulty.

Lack of support was a minor factor identified by the MHC and the researcher alike, but was not noted to be a concern of the HRC. The MHC was generally referring to lack of external support outside of SG structures, which again ties in with lack of information and others' input.

Checklist Matrix Table 3 (HRC & MHC) - Other Influences

The researcher and the two councils similarly noted the impact of decisions as a particular factor to be considered when making decisions. Also of particular influence in both councils were the people who were present when the decision was being made, yet only the researcher noted this and neither of the councils raised this as an issue.

At the time of observations, the councils' level of authority was less of a concern for the researcher as for the two councils as at individual meetings, level of authority did not appear to be an issue. Also, the high degree of activity of the MHC overshadowed the fact that at times it was doing a lot but not getting very far.

The influence of strong personalities was evident in the MHC and corroborated by MHC members. Another minor factor was the venue of meetings, but only the MHC noted this and whilst members expressed that the Board Room was oppressive for junior staff, the researcher did not detect an impact on their working arising from this factor.

Checklist Matrix Summary Table B - Other Councils

When interpreting these tables, it is important to note that fieldwork pertaining to other Trust-wide councils was far less extensive than for the HRC and MHC and such

reduced exposure will have limited the opportunity to gain evidence of various factors. Also, representatives from all Trust-wide councils were present at most Policy Council and Chairs' meetings although rarely was a MHC member present at the latter meeting forum. At first glance, factors that most aid council decision-making centre on gathering and exchange of information through discussion, use of informants and the SG research findings. Coaching/support was of particular benefit also.

Barriers appear to centre on lack of clarity of issues and insufficient input from other people.

Key factors that also affect decision-making concern the council's level of authority and who is present at council meetings.

Checklist Matrix Table 1 (Other Councils) - Aids

The researcher did not identify discussion as a particular aid to other Trust-wide councils' decision-making, although members themselves have. The researcher noted use of informants and the research findings to have contributed to the decision-making process. Again, these were hardly mentioned by council members at interview, although some of the observations noted that members had commented during meetings as to their utility. These patterns are consistent with findings from the HRC and MHC.

The researcher found guidance and support given to council members primarily through their facilitator, the Policy Council and Chairs' meetings, to be of particular assistance, yet this was not expressed by any council members at interview. This reflects the picture as with the HRC and MHC.

Checklist Matrix Table 2 (Other Councils) - Barriers

Interestingly, two of the interviewees did not identify any barriers to their decision-making on the council and the other only identified one factor. So, whilst the researcher picked up on unclear issues and lack of others' input as barriers, these were not highlighted by council members at interview. These Trust-wide councils also received substantial support from facilitators, Policy Council and Chairs' meetings, yet the researcher maintains that there was at times ambiguity in the guidance given that hampered the council's progress. Also, there were occasions where certain people could have contributed more to assist the councils, but again council members at interview did

not raise this. Again, these identified barriers reflect similar findings to the HRC and MHC.

Checklist Matrix Table 3 (Other Councils) - Other Influences

Main factors that also affected decision-making were members present at council meetings and the council's level of authority. Concern with who was present was mainly the researcher's, reflecting the pattern found with the HRC and MHC findings. This factor mainly related to non-attendance and the helping or hampering effect this had on the meeting. Level of authority was an issue identified particularly frequently during both observation and interviews, although the researcher had not previously noted this as important during HRC and MHC fieldwork. These councils actively discussed the difficulties they had around level of authority during meetings, and so the issue was picked up on by the researcher when observing these particular councils. Such difficulties were not particularly verbalised by HRC and MHC members during meetings, although they did raise them at interview.

Checklist Matrix Diagrams

The full set of matrix diagrams are presented overleaf and comprise:

Checklist Matrix Summary Table A - Factors Influencing Council Decision-Making (Human Resources Council & Mental Health Council)

Checklist Matrix Table 1A - Aids to Council Decision-Making (Human Resources Council & Mental Health Council)

Checklist Matrix Table 2A - Barriers Influencing Council Decision-Making (Human Resources Council & Mental Health Council)

Checklist Matrix Table 3A - Other Factors Influencing Council Decision-Making (Human Resources Council & Mental Health Council)

Checklist Matrix Summary Table B - Factors Influencing Council Decision-Making (Other councils – Research Education, Practice Development, Policy Council & related meetings)

INFLUENCING FACTOR	PARTICIPANT OBSERVATIONS		INTERVIEWS					
			Human Resources Council			Mental Health Council		
	Human Resources Council	Mental Health Council	1	2	3	1	2	FG
AIDS								
Appropriate Time							⌇	⌇
Impact of Decision +			⌇		⌇			⌇
Monitoring Progress		⌇			⌇		⌇	⌇
Options								⌇
Gather Info + +					⌇	⌇		⌇
Informants + + +	⌇	⌇	⌇					
Discussion of Opinions + + +			⌇	⌇			⌇	⌇
Clear Purpose + +	⌇		⌇		⌇			
Coaching/support + + +	⌇	⌇						
Experience			⌇					⌇
SG Research Findings + +	⌇	⌇						
BARRIERS								
?Where up to + + +	⌇	⌇		⌇				
Unclear Issue + +		⌇	⌇			⌇		
Money + +	⌇	⌇					⌇	⌇
Time/scale + + +	⌇	⌇		⌇		⌇	⌇	⌇
Issue Size		⌇	⌇					
Lack of Support		⌇					⌇	⌇
Lack of Info +	⌇		⌇					
Other's Input + + +	⌇	⌇		⌇	⌇			
OTHER INFLUENCES								
Venue		⌇					⌇	
Implications + +	⌇	⌇		⌇	⌇			⌇
Personality +		⌇						⌇
Evidence Based Practice		⌇						
Who Present + +	⌇	⌇						
Level of Authority +		⌇	⌇		⌇			⌇

⌇ = identified factor
+ = strength of influence (moderate +, strong + + , very strong + + +)

Table A – Checklist Matrix – *SUMMARY TABLE* of Factors Influencing Council Decision Making (Human Resources and Mental Health Councils)

INFLUENCING FACTOR	PARTICIPANT OBSERVATIONS	INTERVIEWS		
	All Other Councils (Including Policy Council, RE Council, PD Council, Chairs Meetings & Workshops)	Other Practice Based Councils (RE Council & PD Council)		
		1	2	3
AIDS				
Appropriate Time				
Impact of Decision		⌇		
Monitoring Progress	⌇			
Options				
Gather Info			⌇	⌇
Informants + + +	⌇			⌇
Discussion of Opinions +		⌇	⌇	⌇
Clear Purpose	⌇			
Coaching/support + + +	⌇			
Experience				
SG Research Findings + + +	⌇			
BARRIERS				
?Where up to	⌇			
Unclear Issue + +	⌇			
Money				
Time/scale	⌇	⌇		
Issue Size	⌇			
Lack of Support	⌇			
Lack of Info	⌇			
Other's Input +	⌇			
OTHER INFLUENCES				
Venue				
Implications	⌇			
Personality	⌇	⌇		
Evidence Based Practice	⌇		⌇	
Who Present + + +	⌇	⌇		
Level of Authority + + +	⌇	⌇	⌇	⌇

⌇ = identified factor
+ = strength of influence (moderate +, strong + + , very strong + + +)

Table B – Checklist Matrix – *SUMMARY TABLE* of Factors Influencing Council Decision Making (Other councils – Research Education, Practice Development, Policy Council & related meetings)

INFLUENCING FACTOR	PARTICIPANT OBSERVATIONS		INTERVIEWS					
	Human Resources Council	Mental Health Council	Human Resources Council			Mental Health Council		
			1	2	3	1	2	FG
AIDS								
Appropriate Time							7/221	86
Impact of Decision			2/151		8/186			66 246 89
Monitoring Progress		11-00/43			8/204		7/283	290
Options								86 52
Gather Info					8/183	5/113 5/107 5/116		239 49 19 23 82
Informants	2-00/75 2-00/53 11-99/69 10-99/23 7-00/43	11-00/158 11-00/103 11-00/87 10-00/144 1-01/37	2/161 2/135					
Discussion of Opinions			2/145	6/107 6/105 6/99 6/94 6/93 6/95			7/231 7/238 7/224	82 66 60 38 33 42 263 246
Clear Purpose	8-99/39		2/150 2/129 2/125 2/127		8/185 8/171 8/170			
Coaching/support	11-99/31 9-00/57 8-00/136 3-00/47	8-00/281						
	6-00/36 6-00/27 5-00/97 3-00/38 2-00/58 2-00/17 4-00/29 11-00/29 11-00/23 11-00/26 10-00/136 10-00/110 10-00/95 10-00/69 10-00/39 10-00/7 11-99/75							
Experience			2/141					52
SG Research Findings	7-99/270 9-99/168 5-00/33	7-99/150 9-00/76 3-00/108 8-99/ 82 4-00/50 7-00/87 2-00/50 11-99/178						

Table 1A – Checklist Matrix – *Aids* to Council Decision Making (Human Resources and Mental Health Councils)

INFLUENCING FACTOR	PARTICIPANT OBSERVATIONS		INTERVIEWS					
	Human Resources Council	Mental Health Council	Human Resources Council			Mental Health Council		
			1	2	3	1	2	FG
BARRIERS								
?Where up to	10-99/7 8-00/210	11-00/29 10-00/140 10-00/10 10-00/20 10-00/70 10-00/13 10-00/75 10-00/131 10-00/119 8-00/20 10-00/123 6-00/169		6/122				
Unclear Issue		3-00/62 1-01/57 1-01/46 11-00/73 11-00/87 10-99/243	2/175			5/90		
Money	10-00/160 9-00/146	2-00/14 8-00/230 8-00/185 8-00/73 8-99/115 1-01/43					7/299 7/294	99
Time/scale	10-00/173 10-00/160 10-00/133 9-00/151	10-00/31		6/175 6/57 6/119		5/137	7/267 7/91	199
Issue Size		11-00/58 10-00/19 1-01/46	2/109					
Lack of Support		11-00/134					7/265	102
Lack of Info	11-00/5 8-00/36 8-00/19 7-00/34		2/155					
Other's Input	3-00/14 3-00/21 10-00/62 7-00/101 11-00/46	9-99/11 9-99/74		6/109 6/121 6/99 6/114	8/194			

Table 2A – Checklist Matrix – *Barriers* Influencing Council Decision Making (Human Resources and Mental Health Councils)

INFLUENCING FACTOR	PARTICIPANT OBSERVATIONS		INTERVIEWS					
	Human Resources Council	Mental Health Council	Human Resources Council			Mental Health Council		
			1	2	3	1	2	FG
OTHER INFLUENCES								
Venue		7-00/5					280	
Implications	8-00/47 2-00/78	3-00/152 8-00/142 7-00/101 4-00/30		2/106 2/281	8/188			128 589
Personality		10-00/31 4-00/75						104 134 137 237
Evidence Based Practice		8-99/208						
Who Present	11-00/5 9-00/124 8-00/98 6-00/5 ~~10-99/95~~ 2-00/50 6-00/50	4-01/9 4-01/21 5-01/41						
Level of Authority		8-00/39	2/97 2/131		8/177 8/174			600 618

Table 3A – Checklist Matrix – *Other Factors* Influencing Council Decision Making (Human Resources and Mental Health Councils)

INFLUENCING FACTOR	PARTICIPANT OBSERVATIONS	INTERVIEWS		
	Other Councils (Including Policy Council, RE Council, PD Council, Chairs Meetings & Workshops)	Other Practice Based Councils (RE Council & PD Council)		
		1	2	3
AIDS				
Appropriate Time				
Impact of Decision		1/RE/162 1/RE/146		
Monitoring Progress	RE/8-99/44 PC/3-01/116			
Options				
Gather Info			3/PD/118 3/PD/143	4/PD/133
Informants	RE/8-99/118 Chairs/10-00/31 PC/11-99/26 PD/3-00/37 Chairs/10-00/87 PC/10-00/50 RE/6-00/78 Chairs/10-00/37 PC/2-00/26 PC/8-99/127 PC/10-99/36 PC/9-99/125 PC/11-99/17			4/PD/128
Discussion of Opinions		1/RE/148 1/RE/142 1/RE/150 1/RE/162	3/PD/130	4/PD/124
Clear Purpose	RE/3-00/94 RE/5-00/57 RE/6-00/74 PC/7-99/95			
Coaching/support	PC/3-01/20 RE/3-00/107 PC/9-00/47 PC/2-01/25 PD/9-99/176 RE/10-99/100 PC/2-01/5 PD/9-99/168 PC/2-01/44 RE/3-00/77 PC/6-00/48 RE/3-00/55 Chairs/3-00/76 RE/3-00/10 PC/3-00/26 PC/9-00/101 ~~PC/3-00/53~~ ~~PC/1-00/80~~ Chairs/2-01/31 PC/5-00/43 Chairs/2-01/10 PC/10-00/78 Workshop/2-01/32 PC/11-99/58 Chairs/3-00/48 PC/8-99/178			
Experience				
SG Research Findings	PC/8-00/43 RE/10-99/29 PC/11-99/50 RE/10-99/252 PC/10-00/36 Workshop/11-99/252 PD/4-00/116 Workshop/11-99/12 RE/8-99/64 RE/10-99/212 RE/10-99/12 PD/11-99/23			

Table 1B – Checklist Matrix – *Aids* to Council Decision Making (Other councils – Research Education, Practice Development, Policy Council & related meetings)

INFLUENCING FACTOR	PARTICIPANT OBSERVATIONS	INTERVIEWS		
	Other Councils (Including Policy Council, RE Council, PD Council, Chairs Meetings & Workshops)	Other Practice Based Councils (RE Council & PD Council)		
		1	2	3
BARRIERS				
?Where up to	RE/8-99/129 PC/3-00/88 Chairs/10-00/72			
Unclear Issue	PD/8-99/212 Chairs/2-00/29 RE/10-99/195 PC/8-00/117 PD/8-99/161 PC/5-00/52 PC/9-99/78 Chairs/3-00/39 PC/9-99/193			
Money				
Time/scale	PC/6-00/32 PC/10-00/39	1/RE/186 1/RE/83		
Issue Size	Chairs/2-01/97 Chairs/10-00/63			
Lack of Support	RE/5-00/85 Workshop/2-01/67 Workshop/2-01/43			
Lack of Info	RE/9-99/72			
Other's Input	PD/4-00/40 PC/9-99/137 PC/5-00/98 PC/5-00/65 PC/10-00/30 PC/10-00/41 Chairs/10-00/33			

Table 2B – Checklist Matrix – *Barriers* Influencing Council Decision Making (Other councils – Research Education, Practice Development, Policy Council & related meetings)

INFLUENCING FACTOR	PARTICIPANT OBSERVATIONS	INTERVIEWS		
	Other Councils (Including Policy Council, RE Council, PD Council, Chairs Meetings & Workshops)	Other Practice Based Councils (RE Council & PD Council)		
		1	2	3
OTHER INFLUENCES				
Venue				
Implications	PC/2-00/21 Chairs/10-00/48			
Personality	PD/1-00/14 PD/7-99/18	1/RE/169		
Evidence Based Practice	PC/2-00/9 PC/3-01/38 Chairs/11-00/30		3/PD/106	
Who Present	Workshop/2-01/89 Chairs/10-00/55 Chairs/2-01/55 Chairs/10-00/25 PC/5-00/15 PC/2-01/39 PC/3-01/106 Chairs/2-01/5 PD/4-00/56 RE/6-00/47 RE/7-99/83 RE/7-99/204 PD/8-99/146 PD/4-00/8 RE/5-00/29 RE/9-99/201	RE/6C/209		
Level of Authority	PD/8-99/75 PD/8-99/102 RE/9-99/61 PD/7-99/54 PD/9-99/46 PC/8-99/155 PD/8-99/181 PD/7-99/248	1/RE/193 1/RE/157 1/RE/179 1/RE/110 1/RE/36 1/RE/201	3/PD/158 3/PD/150 PD/9C/231	4/PD/144

Table 3B – Checklist Matrix – *Other Factors* Influencing Council Decision Making (Other councils – Research Education, Practice Development, Policy Council & related meetings)

Checklist Matrix Table 1B - Aids to Council Decision-Making (Other councils – Research Education, Practice Development, Policy Council & related meetings)

Checklist Matrix Table 2B - Barriers Influencing Council Decision-Making (Other councils – Research Education, Practice Development, Policy Council & related meetings)

Checklist Matrix Table 3B - Other Factors Influencing Council Decision-Making (Other councils – Research Education, Practice Development, Policy Council & related meetings)

Time-Ordered Matrices & Causal Networks - Narratives & Diagrams

In this section, basic time-ordered matrices and more advanced causal networks are presented. These serve to illuminate the chronology and tentative relationships amongst the variables proposed within each of the issues that the HRC and MHC have addressed.

For each of the twelve council issues, the corresponding time-ordered matrix diagram and causal network diagram are presented along with a narrative to explain each of them. Note that to present the findings succinctly, only one issue per council is presented in this section. The displays and narratives for each of these issues are presented side-by-side which is intended to show how the analyses developed as a result of the limitations of earlier data displays. The matrix and network diagrams and narratives for the remaining four HRC issues and six MHC issues are presented collectively in Appendix 23 (Time-Ordered Matrix Diagrams & Narratives and Causal Network Diagrams & Narratives). As all narratives are made available to the reader, the choice of narratives to present in this chapter has been a simple one of selecting the first issue addressed by each council.

The two selected diagrams have been inserted at the appropriate points within the text.

Support Worker Issue (HR1) - Matrix Narrative

This HRC issue was suggested by the Nurse Director at the Policy Council. The suggestion concerned development of a new 'support worker' role for unqualified nursing staff to enable them to better support registered nurses. The HRC was charged

with four broad sub-objectives:

- To give an opinion of the principle of support workers.
- Comment on the level of supervision trained support workers will require.
- Define the context of the trained support worker within the nursing team.
- Identify parameters which trained support workers can work within.

On this occasion the suggestion was made clear verbally and supported with the proposed objectives in writing. This item remained fairly clear with the aid of the facilitator who acted as a link between the HRC meetings that they attended and the Policy Council meetings where the progress of the issue was monitored. It is suggested that this close monitoring significantly helped the HRC to keep focused. However, when the facilitator was absent for 3 months, the council progressed less well and even ground to a halt, suggesting that they were a key element in progressing council activity. The initial suggestion was a complex one that was perhaps too difficult a task to be addressed as the council's first issue.

Whilst no formal level of authority was sought, the close liaison with the Policy Council and the facilitator meant that the council remained focused, and so the absence of the level of authority was not seen to be detrimental. Its usefulness is perhaps more with new, unclear issues that have not come from the Policy Council, and need a level of authority negotiating to lead to a clear objective.

Having an identified lead at all times has been helpful in retaining focus, although much is dependent on the organisational skills of the lead. The latter lead here was rather disorganised and failed to keep the item on track. Reasons included the issue being unclear and the lead frequently forgetting where the issue was up to, resulting in heavy reliance on the facilitator. Also, when the lead was absent, the item could not progress, not least because of the absence of forwarded information to the council to be utilised in their absence.

It is the aim of the councils to seek colleagues' views and involvement wherever possible. On this occasion, background information to inform the council's work was sought back in members' own areas and via a survey. The survey appeared to be a good way of eliciting views, not least because the HRC constituency covered a wide

demographic area (all hospital and community areas) and a huge number of Trust staff. It is difficult for council members to cover large segments of that constituency when seeking views on a one-to-one basis on foot, as was expected of them. However, the success of the survey was not optimised by gaining advice on survey design, and so both the findings from the pilot survey and the main survey were deemed useless. It is suggested that timely survey advice would have stopped the councils from doing the main survey with the same tool as the unsuccessful pilot survey, so enabling a more meaningful design to have been used. Instead an opportunity to gain information to aid their work and decisions was lost resulting in several months floundering.

Use of key informants therefore presents an opportunity to add to the knowledge of those around the table when discussing an issue. The support worker role was a familiar concept to the nurses present, but less so for non-nurses. It is suggested that understanding of the role and the writing of job specifications is probably better grasped by the senior, more experienced members of the council and less so by junior ones.

The presence of informed experts, or those in/out of the Trust with particular knowledge of the support worker role, would have been helpful. Whilst on several occasions this was recognised by council members, not enough was done to engage them early on. Either they were not invited or were not chased up once invited. Of particular importance was the refusal of certain key informants to attend. Political issues seemed to be at play here, including tensions around the relationship of the council to existing groups who had human resource issues as their remit. Hence, other groups refused to engage with the council for many months, not even to explain their role. The effect on the council of these senior Trust personnel refusing to help them has been one of frustration and destructiveness. More could have been done by the Policy Council to help deal with these political pressures; however, they did not. Also, the council played down the problem, as they had seemingly wanted to prove themselves. Eventually the Policy Council intervened and the necessary informant was co-opted, and this had a significant positive effect on the council's progress. Another key informant was engaged after many months, although it was identified earlier on that they were needed. That person's involvement also added greatly to the council's progress, as they were able to supply the information needed to make decisions on that members did not have between them.

In working through problems, the council members spent a considerable amount of time in discussion, mostly with each other. However, much of this discussion has been observed to lack focus, often becoming a general chat and exchange of experiences. More focused discussion and activities with a clear purpose may have helped, as there were often no clear outcomes to these discussions. These were then recapped the following month and discussed again. This suggests that knowledge of decision-making processes is lacking, not put into practice or that the council would benefit from a decision-making framework to follow, so preventing them getting 'lost' in discussion. Essentially, this is what the facilitator had been doing - guiding members through the process and suggesting what they should consider doing next. This council has used no recognised decision-making model at any time.

As for outcomes, a level 2 National Vocational Qualification (NVQ) support worker job specification was successfully produced, although the council dissolved before a level 3 NVQ specification was completed. Whilst generally recognised by Trust staff as a 'success', the job specification objective had evolved somewhat from the original four objectives over the lengthy time period over which this issue was tackled. Finally, the effectiveness of the process undergone in tackling the support worker issue has been limited. Whilst less tangible outcomes, such as on staff development, may have been realised, it has taken nearly two years of 5 to 10 staff meeting monthly to arrive at a level 2 NVQ support worker job specification.

Support Worker Issue (HR1) - Network Narrative

Receipt of this issue from the Policy Council led to it being discussed to see if it fitted the council's remit. It did, and so the issue was accepted. The fact that the issue was a clearly presented one and that acceptance was encouraged by the facilitator also impacted positively on the decision to accept the issue. This decision to accept prompted the establishment of a clear aim and a lead to be allocated. Acceptance also prompted the need to gather some background information, which was done by staff consultation in members' own areas and by inviting informants with specialist knowledge relating to the issue. However, the informant did not attend as requested, resulting in insufficient information for the council to work with. This lack of information prompted the setting up of a sub-group as a means of pooling knowledge, and also the development of a questionnaire as a means of gaining further views. Poor survey design skills contributed to the development of a poorly designed questionnaire

tool/survey design, which in turn resulted in the pilot survey findings being inconclusive. This again prompted the decision to invite two informants to help the council, but they were not actually invited. The questionnaire tool was refined, but due in part to the lack of input from informants, the finalised survey remained ill-designed and the findings were again inconclusive. The response to this was to gather more information, and so the Policy Council was approached for advice. Advice was given, yet the council chose not to invite any of the research experts suggested, which had a negative impact on the council's ability to progress.

Several factors came into play to compound this phase of being unable to progress, including the lead being absent, the lack of survey and decision-making skills evident amongst members, the huge scale of the issue and the absence of the facilitator's guidance for 3 months. The perceived lack of skills was identified as a research finding and shared with members, and prompted the delivery of the teambuilding workshop for council members in November 1999, which was aimed at meeting their skill deficiencies, and a decision to invite further informants and a co-optee. Furthermore, the increased input of the facilitator was prompted and a decision was made never to leave the council without a facilitator again. Attendance of the informants and a Human Resources Department co-optee provided the necessary information for the council to work with, so that combined with their newly acquired skills from the workshop, they were more capable of managing the Support Worker Issue (HR1). Whilst it was then possible to draft a job specification, progress was impeded by some members not doing work away from the council that was required of them. Despite this, a draft job specification was completed eventually and given to the Policy Council. The draft job specification also raised members' awareness of training needs for support workers, and this prompted liaison with the Research Education Council regarding development of a training portfolio, for which a sub-group was subsequently set up. Meanwhile, the Policy Council appraised and approved the draft job specification and the council decided to begin a level 3 NVQ support worker document. However, no action was apparent, due to minimal attendance at the following council meeting and members having not done work away from the council. The next meeting was cancelled due to many apologies, at which point the council ceased to exist, as a council reconfiguration was being planned. This signalled the end of fieldwork relating to this issue.

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 – on paper from PC	Re-clarified with facilitator										Re-clarified – job spec needed	Helpful as not verbal and on paper to refer back to. Evolved from original brief somewhat though as time went by
Fit Remit	YES												Yes but may fit other group's remit also
Background Info	YES - To discuss within own areas												Sought background info to inform themselves
Consultation	Seeking staff views			Via survey									Engaged staff via survey
Clear Aim		To address 4 issues re support worker role											Like many items, fell to chair to lead officially or unofficially. Consequent expansion of Chair's workload
Lead Person	NO	Fell to Chair	New lead							Lead absent – Chair took over			No L of A but at least clear objective set by PC. Close monthly liaison with PC helpful to keep on track – when attended!
Level of Authority	NO												Hesitant involvement of informants. Being more timely may have helped inform and get things moving
Engage Informant		Decided on one to invite – never made it			Decided 2 to invite – not invited	Decided on further 1 to invite – chose not to attend		Recognised need for key informant – not invited		Decided to invite informants next time		YES – Some informants present	Difficulty engaging needed informants caused serious difficulty. PC could have helped earlier with this. Could have made better use of a range of informants though. In – sufficient knowledge around table
Decision Model	NO												May have helped despite clear problem. May have prompted use of informants earlier
Work Process	Discussed issue. To ask views in own areas.	Discussion of issue. To bring relevant papers on topic	Discussion and feedback from own areas. Volunteers to develop questionnaire as a sub group	Refining draft questionnaire and agreeing sample. To speak with Clinical Audit re analysis	Pilot findings not felt meaningful. To refine tool. To get SW definition and advice on the questionnaire content	Survey underway. Awaiting completed questionnaires. To speak with Clinical Audit. No facilitator.	No meeting/ many apologies	Felt findings valueless. To revamp with Clinical Audit. PC suggested many others to help. No facilitator.	Unsure how to go forward – to ask facilitator – not present today	Discussed where up to, problems encountered	No meeting - Xmas	Brainstorming contents of Job spec for level 2 support worker	Slow process. Hampered by survey problems. Did not seek survey advice despite encouragement & possible contacts. Both survey findings of little use. Difficulty id way forward with those present. Junior staff and non-nurses having particular difficulty as not used to this sort of work. Needing a lot of guidance from facilitator to keep focused and to remind where up to.
Approval Sought													
Completed													

Time-Ordered Matrix Diagram 1 – Human Resources Council Support Worker Issue (HR1)

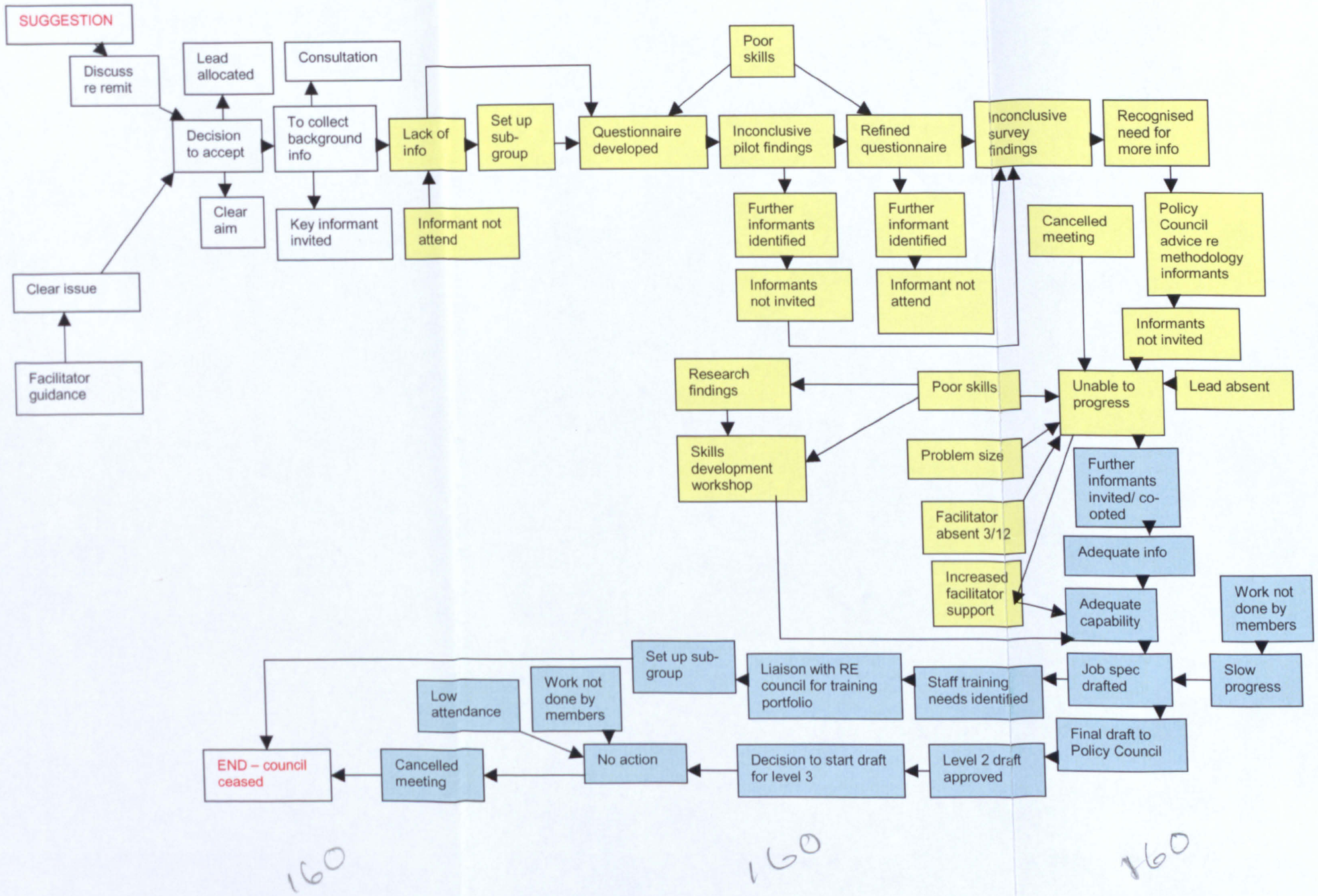
158 158 158

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													
Level of Authority													
Engage Informant	Some informants present	Some informants present	Both key informants present	One informant present	One informant present	Several informants present	One informant present	Both key informants present	One informant present	One informant present			Significantly helped by presence of informants
Decision													
Work Process	Drafting job spec. To check with PC before going further	Drafting job spec	Finalising job spec. Draft to go to HR Dept. Identified need for training package. To ask RE council about a sub group to develop a portfolio	No progress – lead absent	Finalising draft job spec	Final draft agreed. Working on training portfolio with RE council	Considering development of job spec for level 3. Plans to gain more comments	Planning work on level 3. No HR council rep at PC	Working on level 3	Working on level 3. Support worker job spec. Portfolio to go out for comments. Low attendance, work not done so deferred items	No meeting/ Xmas/ Many apologies Council ceased to meet from here on		Absence of lead at meeting/representative at PC not helpful and slows progress. Not a lot done away from council further slows up process as doing work in council meeting perhaps better taken away by a few. Such a big, drawn out issue not helpful in early days of council. Led to frustration of group and disinterest by constituents who saw little output. Never had all seats filled in first place = low numbers present at meetings not helpful. Difficulty engaging constituent's involvement and gaining needed feedback. Constituents ill-informed about council activity and not getting involved.
Approval Sought						Presented at PC and circulated round Trust for comments	One comment received re draft job spec						
Completed													

Time-Ordered Matrix Diagram 1 – Human Resources Council Support Worker Issue (HR1) (continued)

159 159 159 159

Causal Network Diagram 1 – Human Resources Council Support Worker Issue (HR1)



160 160 160 160

Summary of HRC Issues

This is a summary drawn from comparisons of the HRC network narratives with the earlier HRC matrix narratives.

Understanding of each issue has been enhanced, with earlier tentative conclusions being reinforced or challenged. More detail has been elicited around the processes by which issues are accepted by the council and the order of subsequent events. For example, the issue is first accepted, followed by decision regarding an aim, and then collection of background information, with the overall influence of the facilitator at the start of this chain of events. The importance of the role of the Policy Council has become clearer in that the network narratives have showed how lack of support/input by the Policy Council or ignoring of its advice by HRC members has impacted negatively on subsequent events. An example is the inconclusive survey findings, when the HRC did not seek the research support the Policy Council pointed it to (Support Worker Issue - HR1). Also, when no HRC members attended the Policy Council, the opportunity to gain support was lost (Recruitment Pack Issue - HR4; Orientation Pack Issue - HR5). Furthermore, the network narratives have depicted how compounding factors present at around the same time have had a profound impact. For example, particular difficulty arose during the Support Worker Issue (HR1) due to a culmination of lack of skills at survey design and decision-making, absence of the issue lead, key informant and the facilitator, and the large scale of the issue. Better illuminated is how such factors were key in prompting the council members' teambuilding workshop. The inter-connectedness illustrated between the network components also enabled gaps in understanding to be examined, such as why there were hold ups in progressing issues. Thus the negative impact of occasions of minimal attendance by members and lack of work done away from the council became apparent (Support Worker Issue - HR1; Orientation Pack Issue - HR5). The matrix narratives did not give a true reflection of delays being due to lack of a clear aim, key informant or lead, as was evident in the network narrative (Millennium Issue - HR2).

In addition to gaps and difficulties, a further strength of the network narratives was to illuminate when and how factors impacted positively. For example, the emerging research findings were shown to prompt the councils' teambuilding workshop and agreement to always have a facilitator present at future meetings.

Lastly, the network narratives prompted closer examination of recorded events/actions and the tentative conclusions made about them. For example, with the Millennium Issue (HR2), the matrix narrative is interspersed with assumptions and tentative conclusions such as local politics playing a part. Whilst from the researcher's experience during fieldwork, this is considered to be accurate, it is not a reflection drawn solely from the matrix diagram. Therefore, the network narrative omits such assumptions, having thoroughly checked these out by this stage. Instead only inferences that are prompted and evidenced from the data are included. Thus, the network narratives succeed in providing defensible propositions as to influencing factors on council decision-making processes, so lessening the risk of biased conclusions.

Violence & Aggression Policy Issue (MH1) - Matrix Narrative

This MHC issue originated with a council member who suggested that the council develop a policy on violence and aggression management for the Mental Health Directorate.

The issue was clear at the outset and fitted with the council remit. No level of authority was established, and if discussed away from the council at the PSMT, this was never discussed or made clear at subsequent MHC meetings. This did not seem to have any effect on the issue, as there was a clear objective from the outset. The issue was analysed early and systematically to identify what the specific problem and required action was. In this case, it was agreed necessary to get background information from members' own areas to inform the next steps of dealing with the issue. Also a lead was allocated promptly. A hiccup with the postal system meant that all required information was not gathered, and so work was divided up between members.

As this is a large-scale and complex issue, extra time was allocated, on this occasion in the form of an away-day. This full day was set aside to 'blitz it', as phrased by members, and so the issue was not discussed on the next agenda. The away-day proved highly effective in that their work was presented to the PSMT and a draft policy circulated as a direct result of the away-day. Wide consultation was undertaken to obtain comments with which to amend the draft. The key person in driving this forward was the lead, who did not make use of any decision-making model. The draft was in circulation for several months, although Christmas fell in the middle of this period. It was therefore off the agenda for several months, but being driven by the lead in the

background gaining further comments and making refinements.

The council then went through a 3 to 5 month period of being confused as to what its remit was, where it was up to, and how to deal with the issues it was facing, thus hitting a trough in its productivity. Several reasons were observed for this (and substantiated by members elsewhere in the data). Firstly, there had been a change-over of a large number of council members. These new members had received little, if any, orientation to the council and their role as members. Secondly, the council had been addressing a very large number of equally large-scale issues and got over-loaded, so grinding to a halt. Three meetings were set aside purely to reflect on what they had been doing and how they were to do things in future. For example, new members were not oriented to the OARRRs model for managing meetings, whilst others had not been on a LEO course and did not understand some of the language the council used. The council revisited such things as their decision-making models, remit, mission, suggestion form system, roles and so on. However, at the end of this period the chair leading them through it left the council and the replacement chair had only been a council member for a couple of months, and so the confusion was never fully resolved during the remainder of fieldwork.

The Violence & Aggression Policy Issue (MH1) was off the agenda during this period of confusion, at the end of which the lead left the council. When the council reconvened its normal meetings, members did not know where the issue was up to. This was observed to be because the lead had not handed over to anybody before leaving the council and thus such lack of communication became the third reason why the council hit this difficult period. Work done away from the council was not communicated back to the council. The ex-member was therefore invited back to give an update as to where the policy was up to. Incidentally, a new lead had not been allocated and no one had sought to get an update away from the council rather than having to wait for the ex-member to attend. There was no further reference to the Violence & Aggression Policy Issue during the remaining 5 months of fieldwork.

Violence & Aggression Policy Issue - Network Narrative

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 fact that it had 'trust

backing' (as described by council members at interview) also influenced the decision to accept it as a council issue. Acceptance prompted analysis of the problem via brainstorming and allocation of a lead person, which resulted in the establishment of a clear aim and agreement to collect background information. However, a lack of information resulted, which was attributable to a failure in the Trust postal system, as staff had been written out to for information. This lack of information led to a search for more information and the decision to engage an informant. Once collated, the extra information prompted members to appreciate the large scale of the problem, and so it was decided to allocate a full away-day to address the issue in detail. The informant was subsequently asked to attend the away-day and this was done, leading to council members being sufficiently informed and able to develop a draft Violence & Aggression Policy as a result. Furthermore, a designated lead for this issue impacted positively on the away-day and the resultant draft, as they drove the issue forward. The draft was circulated for comments, which led to refinements being made, and it was then re-circulated and finalised.

Following this was a period of inaction by the council due to work being done by the lead away from the council without the council monitoring its progress. This contributed to a phase of confusion whereby the council floundered greatly on all its current issues. Further factors prompting this confusion were 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 substantive 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 members' capability was hindered by the fact that they received no orientation prior to joining the council, which prompted development of an orientation package for new members. The changed membership also added to the general confusion, as new members had little appreciation of what had happened with issues previously, or of 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 issues and working out where they were up to. As a result, the former issue lead was contacted for an update and it was discovered that the issue was continuing to be addressed away from the council. No further feedback was

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 as seemingly anything that relates to MH will fit this directorate based council's remit unless managerial.
Background Info		All to collect											Very good at collating background info as easily accessible within directorate
Consultation									Draft out for comments				Consultation easier as demographically local and not spread out. Community reps seem to manage OK
Clear Aim	YES – to develop policy												Council set objective. Very relevant and needed as V&A is a big issue in Mental Health
Lead Person		YES - Proposer											Clear lead has helped keep thing moving whilst on council
Level of Authority	NO												Members informed as local issue pertinent to all of them but did seek informants where appropriate
Engage Informant							YES - attended away day						
Decision Model		Brainstorm ed options											
Work Process	Discussion whether to take on. Agenda next time	Mind mapped problem. Agreed to collate backgroun d info	Feeding back but only 2 members got form sent out by proposer to fill in. Split info search up between them instead	Lots of info to collate and analyse. Agreed to have an away day to do this	Not on agenda – awaiting away day	Awaiting away day so can draft a policy for next meeting	Had away day. Draft policy out to members for comments. Discuss next time	Feedback on draft. To go to PSMT and then wider for other comments	Draft in circulation. Comments awaited	No meeting/ Xmas	To redraft in light of comments	Being redrafted	Lots of discussion. Lead is driving force working behind scenes away from council and allocating an away day appropriately as too big to do during meetings. All input into feeding back. Efforts made for full consultation made easier by staff who are generally keen to engage with council seemingly because local practice issues that are relevant and know the council members well.
Approval Sought								Draft to PSMT					PSMT meetings not part of fieldwork
Completed													

Time-Ordered Matrix Diagram 6 – Mental Health Council Violence & Aggression Policy Issue (MH1)

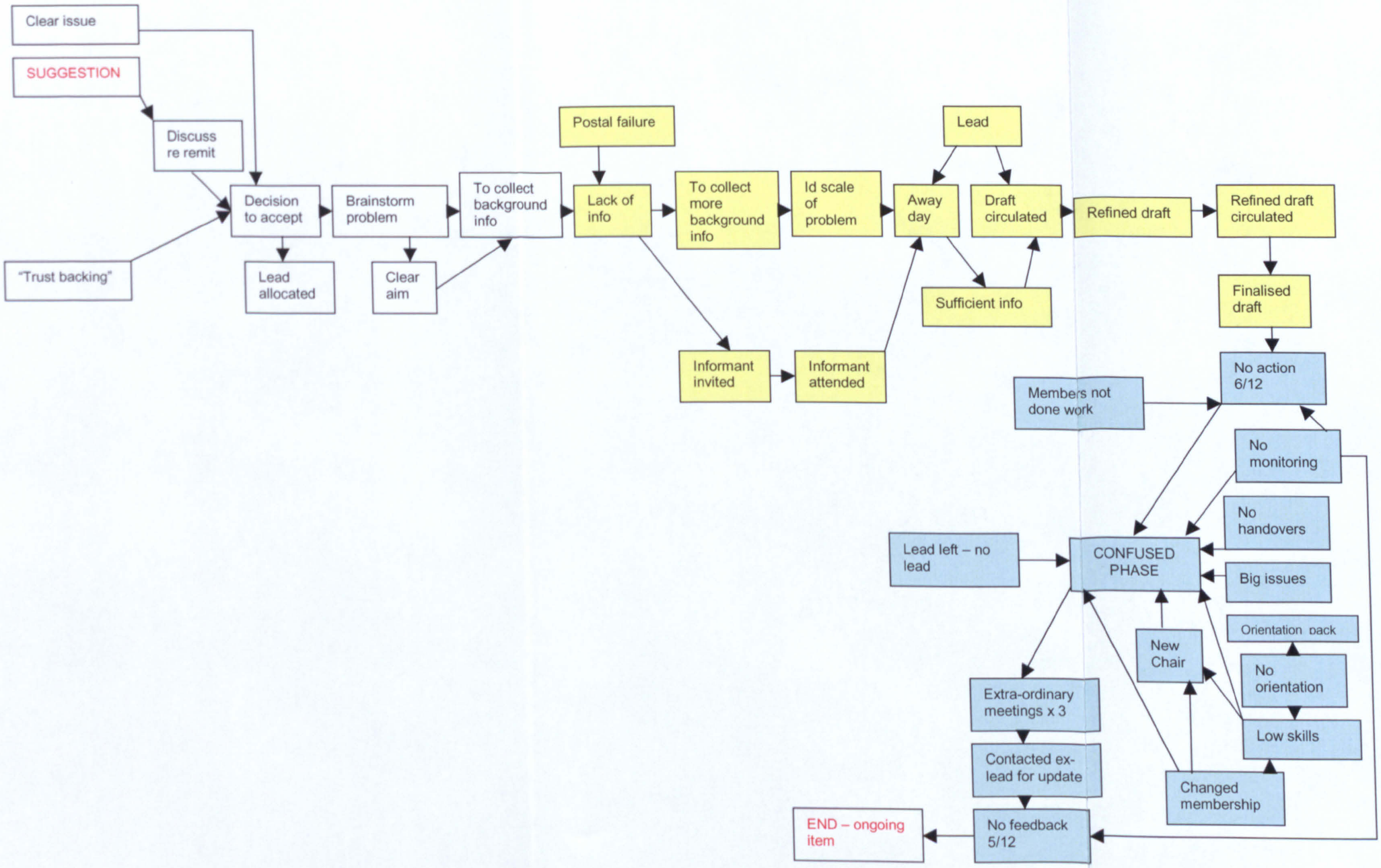
165 165 165 165.

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 has left council					
Level of Authority													
Engage Informant													
Decision Model													
Work Process	Finalising changes to draft	Not on agenda	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 To write to lead who has left council as not know where up to with policy	Ex-lead attended meeting to update. Policy in second draft. To keep council updated. Lots of spin off activity in directorate eg audit of incidents	No meeting/X mas	No feedback	**No further feedback over next 3 months then:** **END OF FIELD WORK**	Got seriously way laid by having too many very large issues on agenda. Having to look at them 1or2 at a time and so many items not addressed regularly just updates being given. Most members changed over in months 13-16 which caused real problems as not know where up to and not oriented to what and how things were done previously by council. Extra-ordinary meetings to sort things out were not too effective. As ill informed, inexperienced and then new chair (also quite new to council). Lead leaving council not helpful.
Approval Sought													
Completed													

Time-Ordered Matrix Diagram 6 – Mental Health Council Violence & Aggression Policy Issue (MH1) (continued)

166 166 166 166

Causal Network Diagram 6 – Mental Health Council Violence & Aggression Policy Issue (MH1)



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received for 5 months, as the council had no system for monitoring such issues, and then the fieldwork ended and the issue remained ongoing in the background.

Summary of MHC Issues

This is a summary drawn from comparisons of the MHC network narratives with the earlier MHC matrix narratives.

As with the HRC issues, examination of all MHC network narratives has presented more detail of the council's decision-making processes than the matrix narratives. For example, with the Violence & Aggression Policy Issue (MH1) matrix narrative, the council was described as having a systematic approach to considering the initial suggestion. In the network narrative, this has been elaborated to show how acceptance of the issue was influenced by it being a clear issue that had 'trust backing', which then prompted analysis of the problem via brainstorming and allocation of a lead person, resulting in a clear aim and agreement to collect background information. The presence of multiple factors having a negative impact at around the same time has again been more apparent within the network narratives, including the size of the issue, lack of orientation of new members, many new members and a lack of hand-over from previous members (all issues except the Bank Nurse Issue - MH3 and Case Notes Issue - MH2). Gaps in understanding have become clearer with the network narratives, such as how updates were not received from issues being dealt with away from the council because no system existed for their monitoring (Case Notes Issue - MH2 and User Involvement Issue - MH4).

As well as identifying gaps, comparison of both narratives for the User Involvement Issue (MH4) permitted superfluous information identified within the matrix narrative to be removed during refinement of the network diagram and narrative. In this case it was originally noted that the chair was casually instructed to seek opportunities for user involvement with all future council issues. This did not happen, but the event was initially incorporated into the causal network and associated network narrative as an influencing factor. Whilst interesting, this observation was actually of limited significance within the decision-making processes, as that particular factor had no discernible positive or negative impact on the decision-making trajectory. So, once again, a subjective decision by the researcher to include an event of minimal importance

had been spotted and omitted from the more accurate network narrative.

For one issue, a particular factor (personality) was notably influential on the council's decision-making process (Ethnic Minorities Issue - MH7) yet had failed to be included in the less detailed matrix narrative. As there was no pattern of this being a particular factor within any other council issue, it was possible to exclude personality as a key factor within council decision-making generally. Thus, the creation of networks and network narratives has facilitated a rigorous approach to researcher decision-making about what to exclude as well as include as significant factors within council decision-making, so informing the development of summative findings.

Summary

A range of basic and advanced data displays and their narratives has been presented. The network diagram narratives have set out the key steps in the HRC and MHC decision-making processes, so illuminating what factors/stages/events lead to, or at least significantly influence, the subsequent factors/stages/events in decision-making in an attempt to establish if and where any causal links exist.

Within the narratives a number of themes have recurred, lending weight to their significance in the decision-making process, such as presence or absence of a lead and the impact that has on decision-making processes. Each of these themes has been considered in the light of evidence from across data sets to substantiate which of these are indeed worthy of note as key factors affecting decision-making, so enabling final conclusions to be drawn. In some of the matrix narratives, assumptions are evident that are drawn from the researcher's knowledge of other data sources such as issues in the MHC seeming more relevant to practice and so relevant to members (Bank Nurse Issue - MH3). Thus, the rigorously developed network narratives present a slightly more evidence-based interpretation of council decision-making pertaining to each issue than in the matrix narratives.

Each network diagram and associated narrative depicts the overall decision-making process for each council issue and the key factors/stages/events found to have had an impact, whether positive or negative, on that process. Thus it has been possible to reduce each decision-making trajectory into its key component parts and critically

examine evidence of their influence or causality upon those processes. The critical analysis of these late stage formative findings has culminated in the drawing of final conclusions, as set out in the next section.

PART 3 - Conceptual Model of SG Decision-Making

Introduction

This section consummates the analysis and presents a conceptual model of SG decision-making (Diagram 5, overleaf). The model illuminates the relationship found to exist between twelve key factors of SG council decision-making. Eight of the factors relate to key *elements* in the decision-making process, and the remaining four represent *conditions* within which each of the elements needs to operate, if effective decision-making is to be promoted. Each factor is considered in turn and linked to evidence from the HRC and MHC, thus illuminating each factor's role, significance and links with other parts of the model.

The Inner Circle Elements

Clear Issue

All but two issues were clear on presentation to the councils for them to address. One of these was later clarified in the intermediate stage of its lifetime on the council agenda and was finally resolved (Millennium Issue - HR2). The other was never clarified and the issue never satisfactorily resolved during its lengthy duration (Ethnic Minorities Issue - MH7). Without a clear issue in the first instance, a clear aim could not be derived and worked towards. The Millennium Issue (HR2) was clarified with the support and guidance of that council's facilitator, as members struggled initially to decide what to do with it. The MHC did not have such a person attending its meetings and so clarity was never reached with its issue, despite several occasions where members acknowledged that they had a problem with defining the exact issue. Therefore the Ethnic Minorities Issue (MH7) resulted in a lengthy confused process and little progress being made. Usually members would clarify suggested issues they had received with the staff member they originated from. Then the suggestion would be presented clearly at the next council meeting for consideration. Ultimately, when

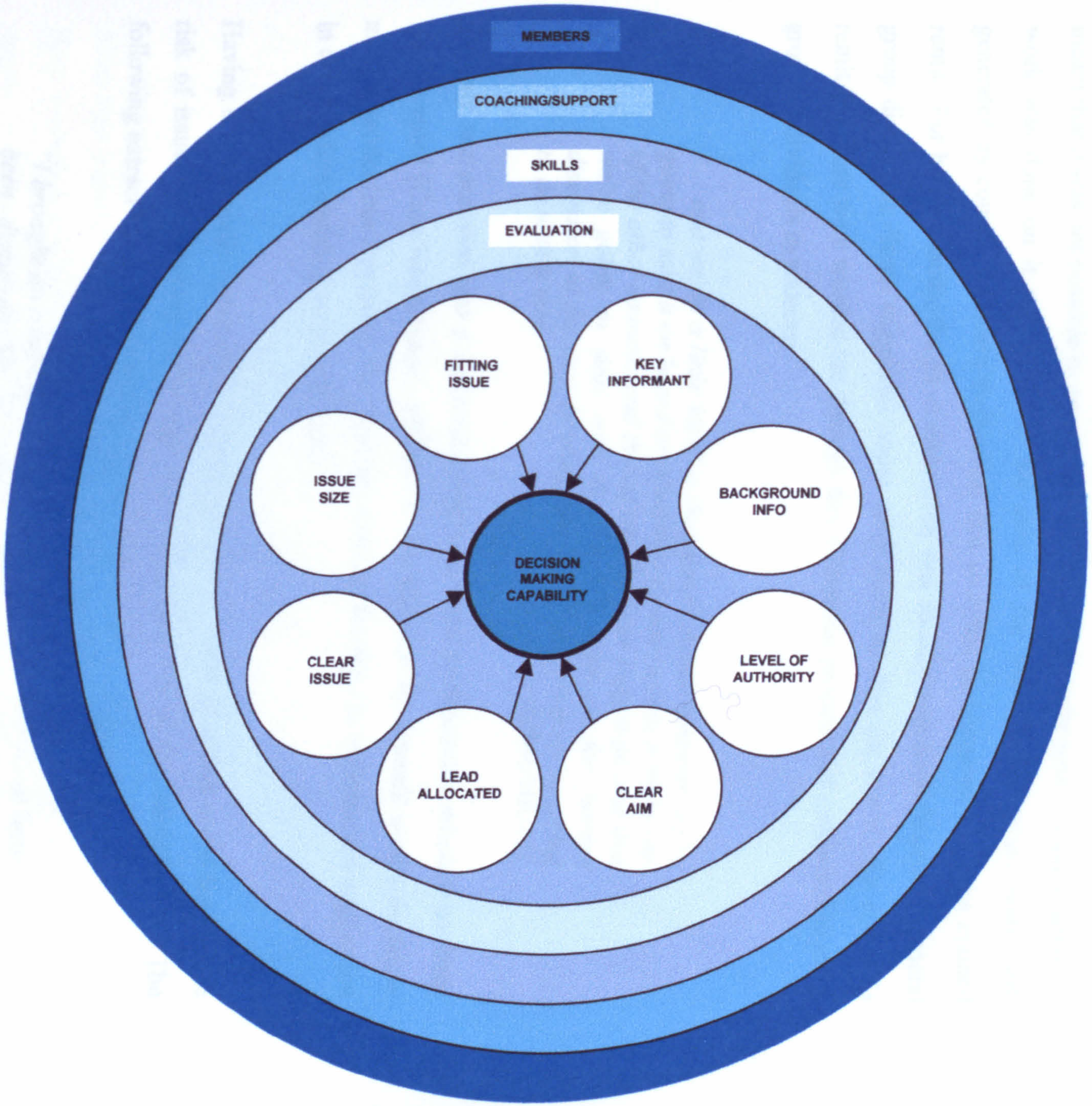

Diagram 5
Conceptual Model of Shared Governance Decision-Making

presented to the councils, the majority of issues were clear and this led to their prompt acceptance and commencement of work to address them.

Fitting Issue

Both councils established that issues fitted their remit within the first two months, with the exception of one MHC issue (Ethnic Minorities Issue - MH7). Lack of a clear issue meant that it was not possible to ascertain the fit of this issue for many months, although work was done on it regardless. In the case of the MHC, most issues were self-generated by council members themselves and so could be expected to fit the council remit. For both councils, the fit of each issue was usually appraised through a general group discussion. Some suggested issues were received that did not fit the council's remit and these were weeded out through this discussion process and redirected to other groups/individuals to address:

> *"... and we do a little bit of a discussion, decide whether we're going to take it on board or whether we need to pass it on to one of the other councils and then if we decide to keep it on and that we're going to deal with it then it's kept on for further discussion at the next meeting and we decide what we're going to do with it."* (DM6/HR/43)

On only one occasion was a systematic approach used to determine whether an issue was accepted (Case Notes Issue - MH2). On this occasion the council used a decision-making model (see Appendix 24 - Problem-Solving Models) to examine the suggestion in detail before deciding what to do with it.

Having no systematic approach to identifying which issues to accept could lead to the risk of issues being turned down that some might say did fit the council remit The following extract shows one member's experience of this:

> *"I brought an issue and I would have expected it to have at least been discussed by the council and I was told it was a management issue or problem. To me it's a practice issue but nobody else saw it like that."* (FG1/678)

Subjective factors were noted to affect whether a suggestion was accepted or not, including whom was present:

> *"Well initially suggestions came through and I had a problem with how they were dealt with because they were just... it was depending on who was most vocal that day or depending on who was actually sitting in the room, and I didn't feel that people's suggestion forms were given a fair enough discussion really..."*
> (DM7/MH/104)

On another occasion an issue was accepted for the MHC by two members away from the council without consultation with other members (DMMH/2-00/55), although the issue never actually got addressed.

The origin of a suggested issue was a determining factor, as those from Policy Council appeared to be accepted without question as fitting the HRC remit:

> *"Well they either come – they normally come via (the council facilitator) or they come by the chair. Again I sort of feel like they do take priority if it's from Policy Council members or if it's (the Policy Council chair) that's said 'you need to look at this' then it's looked at."* (DM2/HR/88)

The HRC experienced difficulty in particular with not being clear about its own remit, hence finding it difficult to inform others so that they in turn could make fitting suggestions to that council:

> *"I mean I think the work we've done has been good and the work we're doing, but how much we're going to be able to continue, how many more topics we're going to... we're not getting a vast flood of issues for ours. And then it's like how do you actually generate them when you're not sure what to suggest to people, this sort of idea or that sort of idea."*
> (DM8/HR/109)

***Issue Size** (manageable, time)*

Both councils had experience of large-scale issues to address, and this presented some degree of difficulty. The MHC accepted numerous large-scale issues, which it did because they fitted the council remit, yet there was evidence that their number and size overloaded the council (DMMH/7-00/15; DMMH/8-00/34; DMMH/11-00/58).

One interviewee, speaking of developing a generic support worker job description for use across the Trust (HR1), said:

> *"It's been difficult, I think it could have been easier if we'd have split it up into areas, like surgery, medicine, learning disabilities, but that wasn't really what we were asked to do, it was for one across the board for everybody. I would have liked to have split it down into groups, I think that would have been easier, it would have taken longer, but I think each individual one would have been easier to do."* (DM6/HR/86)

Another interviewee, speaking of the same issue said:

> *"It was a difficult one because it was... as with all big Trust-wide issues there's so many different directorates and so many different agendas. I think we've finally got somewhere with the job description but I still don't feel that it was kind of like fully dealt with."* (DM2/HR/109)

Council members later acknowledged that they could perhaps have deferred some of these larger issues to a later date or tried a different approach to addressing them, perhaps by another group or sub-group or involvement of non-council members (DMMH/7-00/15; DMMH/8-00/34). At times, members acknowledged that they should not take on further issues as they already had a substantial workload, but still went on to do so (DMMH/8-00/107).

In illustration of the scale of issues addressed, issues remained on agendas for an average of 10 and 19 months (HRC and MHC respectively), with meetings lasting 2 to 3 hours per month, most months of the year. It was generally accepted that work would be done by members away from the meetings, which was at times extensive, particularly for the MHC. For example, when the Ethnic Minorities Issue (MH7) was in need of a lead, members expressed how much council work they already had and one reluctant volunteer said that it was a big job and that they could only do it if they had help (DMMH/3-00/26).

Clear Aim/Desired Outcome

Having a clear issue did not necessarily lead to a clear aim being identified. Two of the clear HRC issues did not go on to develop a clear aim (Millennium Issue - HR2; Personal Development Plan Issue - HR3) and two clear MHC issues did not develop a clear aim (User Involvement Issue - MH4; Face-to-Face Contact Issue - MH5). All of the council issues that had a clear aim had this determined during the first two months. 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.

This point is illustrated by one interviewee talking of the Ethnic Minorities Issue (MH7):

> *"...but I'm still not sure what we're hoping to achieve at the end of it. Are we hoping to solve every problem with ethnic minorities or are we just hoping to put recommendations forward, you know, I'm not sure what we're wanting to get out of the end of it."* (DM5/MH/97)

On occasion, outcomes perceived by members as positive were achieved unintentionally. For example, the MHC worked on a User Involvement Issue (MH4) and contributed positively to development of a user involvement conference, but this was opportunistic and not an original intention on its part.

Thus the presence of a clear aim meant that the later step of collating background information was not impeded, and gave a clearer focus for this stage in the decision-making process.

Allocated Lead

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 HRC issues promptly, within the first three months (Support Worker Issue - HR1; Personal Development Plan Issue - HR3; Recruitment Pack Issue - HR4). MHC issues were allocated a lead person in the first two months, apart from two that were allocated some months later (Face-to-Face Contact Issue - MH5; Ethnic Minorities Issue - MH7). The leads would then co-ordinate the work on the issue and drive it forward with the support of the chair. When leads were not allocated, issues tended to fall entirely to the chair. Correspondingly, chairs were extremely busy and at times became over-stretched and so were less effective:

> *"And then I took over as chair person... it's been difficult, but I've learned an awful lot through it but mainly it's leading the meeting, pulling... or trying to pull things together, trying to get people to volunteer to do things instead of eyeballs hitting the deck, but very difficult, and just following up leads as well."* (DM/HR/35)

A member of this same council said:

> *"A chair you know really is supposed to co-ordinate and they seem to be doing everything as well... but it's easy to let them do it as well. It's hard to say 'well, what do you want me to do', you know it's hard to say but it's hard to actually decide how you could split it up as well you know. Or what could we give – I mean it's like with us in normal work, trying to delegate something that you could actually say yes you could do that and complete it."* (DM8/HR/150)

Whilst leads were generally influential in keeping an issue moving, a number of difficulties were encountered.

Firstly, the variable attendance of leads was a problem, particularly if they did not communicate where their issue was up to and what was required from the council in their absence. Items were regularly deferred at meetings, as there were no leads present to take them forward (CMMH/9-99/11; DMMH/4-00/21).

Secondly, issues fared differently, due at least in part to who the lead was. Some issues were found to be less effectively co-ordinated (Face-to-Face Contact Issue - MH5) whilst others were particularly well driven (Bank Nurse Issue - MH3).

Thirdly, issues were not always shared out equally, so that certain members might be leading on several issues whilst others had none, which at times meant that these leads also dominated the discussions quite heavily (DMMH/2-00/58). Sharing out of issues, and hence workload, amongst leads appeared to work well.

As one member illustrated:

> *"I think one of the most important things about the success of the team is the way the meetings are organised... to allocate leads has worked. As I said earlier on, I think it is that so many people got being the lead on so many different things and you easily get burned out... identify key players, they go off, they have a sub-meeting about it, they come back and feed back then they go off and act upon whatever we've all agreed to. X and Y were the two leads. They went off and did, after the brainstorming sessions, and sent out the questionnaires, and everything was done so that you can't rely upon a huge team like that working at everything."* (DM7/MH/179)

Lastly, the absence of a lead for lengthy periods of time incurred a negative effect. Issues floundered and members often did not notice that they had ground to a halt, as observed within numerous issues (Millennium Issue - HR2; Orientation Pack Issue - HR5; all MHC issues except the User Involvement Issue - MH4). This was mostly due to leads leaving the council whilst their issue was ongoing and not handing it over to another member/new lead. This repeated oversight on the part of the MHC had a particularly strong influence on a period of confusion and inactivity it underwent (DMMH/8-00/7; DMMH/10-00/10) that affected most of its issues.

Level of Authority

Another means of clarifying what to aim for with an issue was to negotiate a specific level of authority with the Policy Council (in the case of the HRC) or Psychiatric Services Management Team (PSMT) for the MHC. Yet for only two issues were levels of authority sought (Case Notes Issue - MH2; Bank Nurse Issue - MH3). On these occasions, the process of establishing a level of authority influenced the decision-making process positively by guiding members as to their next logical step, a view supported by council members (DMMH/8-00/30). In one of these cases, a pilot study was prompted, and in the other development of a business case for a training programme was catalysed. On another occasion a level of authority was agreed amongst members rather than sought outside the council, yet this was less helpful, particularly as the issue had been and remained unclear throughout (Ethnic Minorities Issue - MH7). In this case the self-awarded level of authority added nothing of value. Overall, less clarity of purpose existed where a level of authority had not been gained. The HRC never sought a level of authority, but benefited from comprehensive guidance and direction from the council facilitator instead.

Background Information

A further aid to clarifying and informing each issue was to seek background information. This was done in the majority of cases for both councils and almost always in the first two months. One MHC issue was never presented as a clear suggestion nor had a clear aim. This seemed to cause a delay in seeking background information, as it correspondingly was not clear what information was needed (Ethnic Minorities Issue - MH7). Working on such a range of issues by a council comprising members with diverse professional backgrounds and knowledge meant that it was prudent to gather

sufficient background information to inform the decision-making process. This information gathering was most useful at an early point to inform determination of the overall aim for the issue and before undertaking the bulk of the work during the following months. With the majority of issues, some or all members would gather relevant information within their own areas by consulting with colleagues about current knowledge/practice/activities.

In the MHC, the process was often centred on one or a few members:

> *"I think that's the way they go about it, everybody's ideas initially, generate discussion, generate enthusiasm, see who has the most skill in that area, and away they go and do some work and bring it back."* (DM7/MH/197)

Formal consultation of constituents was done for three issues per council at varying stages, and usually to seek views on drafts or views in general. MHC members were observed to collect extensive amounts of information that were very broad and not always helpful in adding any clarity to the problem being worked on. For example, when faced with addressing the issue of Ethnic Minorities (MH7), members agreed to gather reports and other information and then meet up to discuss it further without ever having clarified exactly what the proposed issue was (DMMH/1-01/89). However, members themselves seemed to find the background information gathering process reassuring and did not often perceive it to be unhelpful or an inefficient use of their time. Having made little progress with the Ethnic Minorities Issue (MH7) several months later, the response was to gather even more information, despite the remaining lack of clarity as to the aim of the issue:

> *"It started from one of the green forms (*suggestions*)... saying that there was a lack of services for ethnic minorities. It was quite vague really, the green form... I knew it was on the agenda, so I did a bit of background reading before the meeting just to see exactly what was out there and I just went to the (*library*) and there's vast and vast amounts of stuff about re-training, what needs are out there, kind of little things like, well, big things like that and then we took it back to the council and we decided it was massive. So we, two members, went off and they started looking at what's out there already, the leaflets and the signs, and somebody went and looked at, they looked at other aspects of it anyway."* (DM5/MH/81)

The HRC undertook such information gathering for all its issues except the Personal Development Planning Issue (HR3) but to a lesser extent than the MHC. General information gathering was the norm, as opposed to having specific objectives:

> *"We ask people then to bring any information that they can that they've got on that subject or anything that they think would be relevant to the next meeting and then take it from there."*
> (DM6/HR/51)

Background information proved helpful to establish if other work had been done or if another group was tackling the same issue already, so that duplication by the council was avoided. When asked how they tackled new issues, one member said:

> *"Quite often we've found that either somebody else is dealing with it but that's good in itself because then we can go back to the people who have given me the stuff to discuss to say look its been dealt with by that person and I've passed your comments on or whatever, which even though we've not actually done something sort of like proactive with it as such at least we can go back and say it is being dealt with."* (DM2/HR/69)

Whilst not undertaken to any great extent, the value of gathering information was recognised as important by one HRC member at interview. When asked what factors were important to promote good decision-making, they gave the following response:

> *" Information, to base the decision on, whether it's looking for information or needs or whatever. If we don't know what people want we don't know what we're aiming for."* (DM8/HR/183)

Key Informant

Engagement of informants with specialist knowledge was done by the HRC for three of its five issues (Support Worker Issue - HR1; Personal Development Plan Issue - HR3; Recruitment Pack Issue - HR4). However, rather than engaging them early to inform the issue, they tended to be engaged several or many months later when the council was experiencing difficulties progressing. One HRC issue addressed without an informant did not require one, as the necessary skills/knowledge were around the table (Orientation Pack Issue - HR5). For the other issue (Millennium Issue - HR2), the required informants did not turn up as requested by the council. The MHC utilised a

specialist informant only once (Violence & Aggression Policy - MH1), as members tended to believe they had the requisite knowledge amongst themselves, being a directorate-based council. Therefore, some issues may have progressed more efficiently had an informant been engaged to inform the council of other relevant work, contacts, and so on. Alternative strategies included pooling knowledge by way of a sub-group of council members and colleagues drawn from their practice areas as with, for example, the User Involvement Issue (MH4).

The Outer Circle Supportive Conditions

Evaluation

Throughout the study, the formative research findings have influenced the council members' decision-making, although not on every occasion they were discussed. It was always the intention that members would be empowered to decide for themselves which findings they wanted to act upon.

Consequences directly attributable to the findings include the councils' team-building workshop held in November 1999 (Support Worker Issue - HR1; Millennium Issue - HR2). Members' preparation had been observed and corroborated at interview (CM6, CM8) to be in need of development. There was misunderstanding of their role and relationship to other councils and groups in the Trust (DMMH/8-00/241) and members generally felt ill-equipped for the role. Additionally, key members such as chairs affirmed that they felt particularly under-prepared for their roles (CM4). After discussion of these points, members requested an away-day event, with the precise content planned with them. The feedback from this was positive in that it met councils' identified development needs. For example, one aspect of the action plan developed on the day was to devise the system of monthly support meetings for all council chairs and vice chairs, which became known as Chairs' meetings.

Another example is the observed lack of orientation of new members and the associated confusion that resulted (all MHC issues except Case Notes Issue - MH2; Bank Nurse Issue - MH3). This finding was responded to by the HRC developing a general orientation pack for new members (DMHR/5-00/33) to also serve as an information pack on SG for the Trust (although the pack was not circulated by the end of the study period).

A further example was how the presence of a facilitator was noted to aid council members (all HRC issues). This finding secured their guaranteed continued presence at all subsequent HRC meetings. Facilitator input was observed to be useful when they suggested actions the council could take. For example, pre-circulating a draft document for comments prior to the next meeting and writing to absent members to ensure their comments were invited (Orientation Pack Issue - HR5). Similarly facilitators encouraged consideration of alternative options and used questioning and challenging techniques to encourage critical thinking by council members (Support Worker Issue - HR1). This view is corroborated by the lack of progress generally experienced at times of absence of a facilitator (Support Worker Issue - HR1; Millennium Issue - HR2). In the first issue, the chair felt unable to begin the item at one meeting without the facilitator being present to remind them where they were up to with it. During the second issue, the council lost its sense of direction after informants did not attend as requested. They were then unable to progress the issue any further without the facilitator's input.

With the MHC, the situation was different in that it did not have a facilitator for comparison of their presence or absence. Therefore, only situations where a facilitator could reasonably be expected to have been beneficial were identified. On several occasions, the MHC may have been particularly aided by additional support and guidance to help it keep focused and work through the difficulties it was experiencing. These include the 'confused phase' experienced in all but one of its issues and in determining a clear aim (Bank Nurse Issue - MH3; User Involvement Issue - MH4; Face-to-Face Contact Issue - MH5; Ethnic Minorities Issue - MH7). This finding led to both councils being encouraged to have facilitator presence, which was done in the HRC but not the MHC as the latter was satisfied that it was coping sufficiently without.

Indeed, there were a number of occasions where the findings were shared with members and action was not taken. For example, the MHC chose not to attend the monthly Chairs' meetings (CMMH/6-00/159). Consequences of this included a lack of awareness of each other's work. An illustration is when the HRC was considering looking at bank nurse training and did not know the MHC had successfully done similar work on this in its area.

At other times, findings were responded to inconsistently. For example, use of the

OARRRs model for organising meetings was reinforced as beneficial (DMHR/9-00/186; DMHR/10-00/197; DMMH/4-01/104), but was only used by the councils on occasion. When not used, meetings were invariably disorganised (DMHR/11-00/49; DMMH/8-00/13) and ran over time (CMMH/10-99/32) with a lack of clear outcomes and action agreed.

Similarly, the suggestion that the MHC take on smaller issues was not heeded (DMMH/10-00/19; DMMH/1-01/46), adding to the difficulties it had in coping with its large, complicated workload.

Skills

Council members demonstrated evidence of varying backgrounds, abilities, knowledge, and skills around decision-making, and subsequent decision-making processes were influenced as a result. For example, progress made at times hinged on the decision of whether to use the OARRRs model and how fully it was used (DMHR/10-00/19; CMMH/10-99/32). Members' expertise around decision-making processes and problem analysis (DM8/HR/211; DMMH/3-00/74) was variable, whilst some members' degree of understanding of problem-solving models (see Appendix 24 - Problem-Solving Models) being used differed greatly (DM5/MH/63).

The only substantive preparation received by members of both councils to prepare them for the role was their undertaking of the Leading an Empowered Organisation (LEO) leadership course. Members were poorly prepared for their roles, especially the chair and vice chairs. As one member put it:

> *"Firstly I was vice chair person, that really I didn't feel as though I was fulfilling at the time because I think we were still all sort of finding our feet and we didn't really understand where we were going or what we were supposed to be doing."*
> (DM6/HR/28)

Subsequent members and those appointed to roles such as chair and vice chair found the transition quite challenging, as again there tended to be little orientation and preparation. One chair openly admitted that they did not know what they were doing initially (CMMH/6-00/23) and three months later admitted to still having no idea what the remit was or what was expected from them (CMMH/9-00/56).

Professional backgrounds of members were also an issue:

> *"I find it quite difficult actually being one of the two CPS* (Clinical Professional Services). *Like with the Support Worker role, I can understand what people are saying but I don't think I've got a lot of input because I don't know the role of the Support Worker so I often feel as though I don't contribute very much especially in the actual meeting itself, and it's not because I don't want to, it's because I haven't got the background to sort of say you know level 2 support worker should be doing."*
>
> (DM8/HR/50)

In the case of the HRC, dealing with Trust-wide issues meant that a huge range of topics could be presented to it to address. However, members' background knowledge and previous experience of those subjects differed between individuals:

> *"It started off very, very slow. I think it was a very difficult one to do (*support worker role*) because there were a lot of people at the council that maybe didn't understand what NVQ meant, what it could actually mean."*
>
> (DM2/HR/62)

Whilst most HRC members interviewed felt that SG had impacted little on their personal development, others felt that it had had an influence. In one case, SG was viewed as having positively influenced their skills around management, writing letters, and discussing things better (DM6/HR/132). Another viewed the LEO course as being the main catalyst for their development within SG:

> *"Yes I used to just sort of sit back and just let other people get on with it. I may not have agreed with what they were doing, but* now (following the LEO*) I do sort of voice my opinions a bit more, maybe not as often as what I should, but I do I think more than I used to."*
>
> (DM6/HR/152)

Amongst MHC members, a more positive view of the impact of SG on their decision-making ability was evident:

> *"Being on the council has, it's totally changed me these last twelve months I can't believe. Before I was quite a shy person and I wouldn't really speak out of turn and now I'm not frightened at all about causing a bit of a ripple, I've learned so much in terms of meetings, involved in kind of management things, so yes, it's built my confidence quite a lot as well."*
>
> (DM5/MH/144)

Again the LEO course was highlighted as particularly influential. Talking about the impact of SG:

> *"On my leadership skills most definitely, linking in again with the LEO and linking in with how I'd conduct my meetings even."* DM7/MH/362)

A moderate level of knowledge was evident amongst HRC interviewees as to what the concept of decision-making was actually about. Views were varied including it being about problem-solving processes needed to reach a satisfactory conclusion to a problem or idea (DM2/HR/115), coming up with a plan and taking it forward (DM8/HR/166), and making decisions and having them taken to the Policy Council and carried forward (DM6/HR/63).

MHC members' understanding of decision-making ranged from it being about a way forward (FG1/8) to being about reaching a consensus of opinions (FG1/6). Members generally agreed that preparation for decision-making was part and parcel of their training for their professions, that is problem-solving technique (FG1/641).

Coaching/Support

The HRC was supported by an external council facilitator from its inception and throughout its lifetime, whereas the MHC had no such designated external support person. The presence and supportive input of a facilitator at the HRC was associated with good progress being made, such as when helping members to make sense of a complex issue (DMHR/2-00/44), ensuring momentum within meetings (DMHR/3-00/83), advising possible ways forward (DMHR/2-00/83), suggesting useful contacts (DMHR/5-00/118) and reinforcing good practice such as collation of comments on a draft document prior to the following meeting (DMHR/10-00/53).

The absence of the council facilitator resulted in members feeling unable to progress due to lack of knowing where they were up to (DMHR/10-00/7) or prompted them to await the facilitator's input and direction at a later time (DMHR/2-00/17). For example, action around changing from doing a questionnaire survey to a focus group approach for collecting staff views on the support worker role (Support Worker Issue - HR1) was deferred because the facilitator was not present (CMHR/10-99/77).

The approach to facilitation tended to be an empowering one, whereby members were encouraged to think through issues themselves instead of looking to the facilitator for answers (DMHR/3-00/38). Also, questions were frequently posed to make members think (DMHR/10-00/69), with answers not freely given, and silence was used to encourage members to find solutions themselves, so coaching members to develop these skills (DMHR/3-00/47). At times, more direct advice and direction was given, the facilitator finding a balance between encouraging members to think and risking making them struggle too much (DMHR/10-00/39) resulting in clear responsibilities and time frames for actions (DMHR/5-00/97).

At times, support was from external invitees that offered to do work on behalf of the councils such as to obtain documents from other departments/trusts (DMHR/9-00/57; DMHR/10-00/95). Additionally, they might provoke thought, as when pointing out likely consequences/wider impact of decisions such as the likely pay award request from support workers if they were to be trained to NVQ level 3 (DMHR/11-00/26).

At numerous times, the MHC was observed to struggle with issues that a council facilitator could reasonably be expected to guide it through, as was frequently observed in the HRC (DMMH/8-00/281). Absence of a council facilitator notably had a negative effect on the councils' progress at times, as members were clearly unaware of the 'wider picture' such as being unaware of work being done elsewhere in the Trust that was of great relevance to their own. Like the HRC, MHC members may have benefited from guidance as to contact persons, approaches to tackling issues, existence of other groups in the Trust and so on, to prevent duplication and share information. Examples include when the MHC struggled to know what to do with findings from the Motivation Survey Issue (MH6), when the council lost sight of what it was trying to achieve with the Face-to-Face Contact Issue (DM5/MH/90), and when it could not decide what the specific problem in need of addressing was with regard to the Ethnic Minorities Issue (DMMH/1-01/57).

Membership

A fuller complement of members, good attendance levels and adequate preparation/orientation of new members had been observed to help councils to sustain effective momentum. The HRC did not have a full complement of members at its inception. The remit of this council was not a popular choice amongst Trust staff, so

that recruitment proved difficult (DM2/HR/5; DM8/HR/9). Therefore, allowing for legitimate absence such as annual leave, at any one meeting there could be 30-60% of its ideal membership present. This low membership presented difficulty, as there were fewer people and so less potential for the meetings to be informed by sufficient members with the requisite skills and knowledge to address the issues faced. No contrasting examples were identified where good progress was made at meetings with few members present, as it was on these occasions that council facilitator input proved invaluable to compensate for these gaps in skills and knowledge. On occasion, the attendance was too low to permit decisions to be made, as the council was not quorate (DMHR/6-00/5; DMHR/11-00/5). At other times the membership was under-representative of certain professions so that, for example, discussions around nursing support workers' role in patient nutrition were limited when the meeting comprised a surgical nurse, a paediatric nurse, a learning disability nurse and two therapists (DMHR/2-00/50). On occasions meetings were cancelled altogether, twice with the Support Worker Issue (HR1) and once with the Personal Development Plan Issue (HR3). At other meetings, agenda items were deferred because leads were absent and had not forwarded information about their issues (Case Notes Issue – MH2; Face-to Face Contact Issue - MH5; Motivation Survey Issue - MH6; Ethnic Minorities Issue - MH7; DMMH/4-01/21).

The MHC also experienced some problems with recruiting and maintaining its full complement of members. Members were informally recruited at the council's inception, unlike the HRC. Subsequently, new members were recruited informally, usually by way of an existing member approaching a colleague to join, with these individuals generally being accepted on to the council unquestioned (DMMH/2-00/28). No democratic system was in place, as there were no other staff wanting to fill the vacancies to warrant an approach such as voting for new members.

Both councils found the original plan to have half of their members step down after a year untenable. The MHC found that members were only just settling into their roles after a year, and felt that 18 months was also too soon a point for a change over of membership (DMMH/1-00/42). Difficulties were notably presented when council membership changed unexpectedly and repeatedly over time, making it difficult to plan for member changes (DMMH/10-00/20; DMMH/11-00/29). Members left for new posts and personal commitments at various points, which at times left councils lacking in

numbers. Particularly for the MHC, a period of large changeover in membership with little warning and associated inadequate preparation of new members was central to the near folding of the council as it struggled to maintain progress through the confusion that ensued (Violence & Aggression Policy Issue - MH1; User Involvement Issue - MH4; Face-to-Face Contact Issue - MH5; Staff Motivation Survey Issue - MH6; Ethnic Minorities Issue - MH7).

A particular problem around membership was the division of council work and responsibilities. During the meetings, work arising from each issue being looked at tended to be divided up between members to do away from the meetings. Some smaller tasks such as drafting newsletter items were done during council meeting time. This work away was not always done by all members, especially within the HRC, where typically one or two members would actually bring comments on a draft/completed work back to the council (DMHR/8-00/74; DMHR/3-00/21). In illustration:

> *"I think there's a few or a couple of council members that are quite happy to just sit there at meetings and not actually participate as such which does make it difficult because I do find at times that there are just certain ones that are taking on board the work. And it shouldn't be like that. It should be us all doing equal amounts if possible and not always the same ones doing it, but that's a difficult one to overcome."* (DM6/HR/109)

Lastly, the MHC was more likely to do the work that had been agreed, yet found a sub-group approach to work best to manage the large quantity of work this council generated. Thus a group of council members would pool input at a dedicated sub-group meeting, with non-council members drawn in to assist, rather than trying work individually around their usual day-to-day jobs. One member described how they would deal with issues within the council:

> *"Identify key players, they go off, they have a sub-meeting about it, they come back and feed back, then they go off and act upon whatever we've all agreed to, I think with face to face contact that had happened in that X and Y were the two leads, they went off and did, after the brainstorming sessions, and sent out the questionnaires, and everything was done so that you can't rely upon a huge team like that working at everything, having sub-groups, having sub-meetings and things is another reason why things have been successful, you know it's, it's being realistic as well, you can't expect a team of thirteen or fourteen to be able to resolve everything in three hours so I think that the way they*

go about it, everybody's ideas initially generate discussion, generate enthusiasm, see who has the most skill in that area, and away they go and do some work and bring it back."
(DM7/MH/189)

Conceptual Model Summary

Twelve key factors identified as affecting SG decision-making are depicted in the conceptual model. Eight factors relate to key *elements* in the decision-making process, for example establishing a clear aim, whilst the remaining four factors represent *conditions* that the former operate within, for example support. No rules about the order of elements occurring or the degree that they are present are proposed, although a logical sequence is suggested that is expected to promote the decision-making process to be more efficient. That is, that clarification of the issue is followed by appraisal of the suitability of the issue in terms of fitting the council remit and its size, followed by allocation of a lead, identification of level of authority and collation of information through a background information gathering process and the engagement of a key informant. However, it is acknowledged that there will probably be overlap of any of these elements within the decision-making trajectory rather than each being a distinct event or phase in the process.

What is proposed is that, ideally, all eight key elements should be present for effective decision-making, although less than this, in any combination, can still result in effective decision-making and so their presence is not conditional of effective decision-making. Furthermore, the four encompassing conditions will promote the likelihood of effective decision-making, but again will not guarantee it. Each condition encompasses the factors contained within it, so that appropriate membership is an all-encompassing requisite for decision-making but within that, adequate support, member skills and evaluation mechanisms ideally need to be in place.

In summary, this model proposes that effective SG decision-making will be promoted if council members do the following:

- Clarify what the issue is.
- Establish whether it fits their council remit.

- Appraise whether the size (scale, time required) is manageable.
- Establish a clear aim.
- Identify a lead to co-ordinate/drive it.
- Establish a level of authority.
- Collate appropriate background information.
- Identify a key informant/s with relevant subject knowledge.

Additionally, effective decision-making processes will be promoted by having present:

- Some mechanism for evaluation/feedback/refinement.
- Adequate skills amongst members.
- Sustained provision of support/guidance.
- Sufficient/appropriate membership to undertake the decision-making.

Chapter Summary

This chapter has detailed the formative and summative study findings. In Part 1, an overview has been given of the wider evaluation study findings that served as the foundation to the study of SG decision-making. These illustrate how tentative assumptions as to the factors affecting decision-making have taken shape as a result of insights gained during early fieldwork. In Part 2, outputs from the development of an extensive range of data displays have been presented. These include basic checklist matrices, more advanced time-ordered matrices and causal networks. Development of the displays and associated narratives led to conclusions being drawn as to the key factors affecting decision-making within this model of SG. In Part 3, the summative findings have been presented as a conceptual model of SG decision-making. This comprises twelve key factors affecting SG decision-making. Each factor has been explored and linked to examples of supportive evidence from the fieldwork. In the next chapter, a reflective account of the research journey that has culminated in these findings is presented.

CHAPTER 7

REFLECTION

Introduction

Action research is problem-focused. Such approaches require the investigator to make sense of a situation and identify problem foci within it, which has been described as a mode of 'interactive naming and framing' (Greenwood 1993). Understandings that have led to a course of action in response to a problem may not be obvious. Thus investment in reflection during and after research encounters are key components of any research that recognises the contribution of the researcher as a research instrument. Equally important is the need to recognise the impact of the research on the investigator; thus, it is appropriate to invest in meaningful reflection to establish the impact of the study on them as an individual. As personalised accounts, personal perspectives and understandings are drawn upon, as opposed to formal reference to the supporting literature, as is commensurate with reflective writing.

Accordingly, this chapter presents a substantive insight into the reflective processes employed during this study. The decision to self-disclose reflective material in this way, whilst not unusual in action research endeavours, is a critical one aimed at helping the reader to fully appreciate how courses of action within this study were arrived at.

The chapter is divided into three parts. Part 1 introduces the topic of reflection and summarises key notions related to it, including professional knowledge and reflection-in-action. Part 2 presents a detailed account of key stages in the reflective journey experienced within this research study of SG decision-making. Part 3 considers the impact of the research experience on the researcher.

PART 1 - Approaches to Reflection

Introduction

This section identifies key elements of the reflective process that act as a guide for writing of reflective accounts. It clarifies the importance of reflection and presents a model for reflection used subsequently in the chapter.

Professional Knowledge

In extensive writings on the subject of reflection, Schön (1991) suggests that traditional professional knowledge is inadequate when applied to complex, ambiguous, unique, unstable and constantly fluctuating practice settings. He is referring to 'technical rationality', commonly viewed as the dominant epistemology of practice, and argues that this approach is inappropriate for addressing problems in practice arenas, as it suggests the separation of research and practice. Furthermore, research is considered to have a higher status than practice, the purpose of the former being to precede and so inform the latter (Schön 1991). He adds that 'technical rationality is the Positivist epistemology of practice' and is embedded in Western institutions (Schön 1991). Yet inadequacies of the Positivist philosophy, a perceived gap between professional knowledge and real world practice, and poorly defined, puzzling problems prevalent in practice settings are ill-suited to application of scientific research techniques. This has led to the pursuit of alternative approaches to professional knowledge.

Reflection-in-Action

One approach to developing professional knowledge is 'reflection-in-action' (Schön 1991). He argues that it is often the case that professional practitioners draw on tacit knowledge to reflect on practice situations and arrive at tacit judgements and skilled performance without conscious application of scientific research theory. Reflection-in-action concerns itself with reflecting on a problematic situation, trying to elucidate what the specific problem is and how it may be solved in order to gain an understanding that will inform subsequent action. The professional encountering a problem situation repeatedly may develop a response that is almost unthinking or 'second nature'. Thus a particular problem may be the loss of ability to reflect on what is happening as practice

becomes more spontaneous and the practitioner has 'over learned what he knows'. To rectify this, reflection can be used to critically examine understandings that have developed in practice, leading to some sense of them being made (Schön 1991). Importantly, reflection-in-action is based on a collaborative relationship between the professional and their clients and is not one of the expert professional imparting solutions to others' problems (Powell 1991). As well as reflection during action, a 'cognitive post-mortem' has been advocated as a means of reflecting on the whole experience in order to examine new understandings arising from it (Greenwood 1993). This latter process has been labelled 'reflection-on-action' (Schön 1991) as it occurs after the event or experience and is a conscious application of knowledge. Although intuition may also be drawn upon, that is less straightforward to ascribe a rationale to (Atkins & Murphy 1993).

Reflection as Part of a Research Study

While research is undertaken to contribute to knowledge for the scholarly community to which the researcher belongs, it is also undertaken for personal, reasons including learning and personal development (Reason & Marshall 1987). Reflection throughout a research endeavour enables researchers to evaluate their practice by noting what they did, what happened, what it meant, what their thinking was and whether there a better way of acting (Hart & Bond 1995). This is necessary to promote self-consciousness and critical examination of personal motives and the effect of the researcher on the methods and findings (Marrow 1998). Thus, it can be expected that reflection will lead to learning.

Reflexivity is a term often used interchangeably with reflection and some would argue that they are the same. Others believe reflection focuses more on things after they have occurred, as opposed to reflexivity, which is "...a more immediate, continuing, dynamic, and subjective self-awareness" (Finlay 2002:533). Cutcliffe (2003) suggests that presentation of a reflexive account may add to the trustworthiness of research findings by illuminating the judgements made by the researcher, thus making them more accountable.

With regards to undertaking reflection, Atkins and Murphy (1993) identified a range of necessary skills including self-awareness, description, critical analysis, synthesis and

evaluation. They propose a Reflective Processes model for use in framing reflective processes that comprise three integrated stages of the reflection process:

- Becoming aware of uncomfortable feelings and thoughts.
- Critical analysis of feelings and knowledge of the uncomfortable situation.
- Arrival at a new perspective.

Thus a reflective account could be expected to begin with illustration of the problem or issue that caused some concern or discomfort in the first place, so warranting reflection upon it. Then the reflective practitioner would analyse the issue, drawing on personal knowledge such as past experiences, previous learning, the known literature on a subject, personal views and so on. These are then used to critically analyse the issue until their perspective is either reaffirmed or altered through application or generation of new knowledge. In this way, learning has been the outcome. A personal value judgement on the final perspective is usually made (Atkins & Murphy 1993). Reflective accounts therefore enable the reader to gain a clearer insight into the research processes within a study through this process of self-disclosure by the investigator.

Summary

This section has outlined the purpose of reflection in research as a means of evaluating practice and making judgements about how things have been done and can be done better. It is an endeavour commonly undertaken throughout a qualitative study and not in distinct stages or collectively at its end. Self-disclosure through a reflective account promotes transparency, enabling the findings to be further scrutinised by the audience of the study's findings.

PART 2 - Reflective Journey

Introduction

This section explores in some detail an array of reflective encounters experienced at various stages of the research journey. For presentation purposes, the text is organised around Atkins and Murphy's (1993) Reflective Processes model, thus identifying i) the

object of reflection, ii) its critical analysis and iii) the perspective gained or reaffirmed as a result of reflection, for each encounter. Each encounter is labelled from A to I as follows:

A. The Need for Reflection
B. Research Relationships
C. Promoting Involvement
D. Sharing of Findings
E. Targeted Feedback
F. Change Agent
G. Researcher Participation
H. Leaving the Field
I. Dissemination

A. The Need for Reflection

i) *Object of reflection*. The issue of building reflection into qualitative inquiry was apparent to me from the study outset. The difficulty presented was how this should be undertaken to ensure it was done in a meaningful way.

ii) *Critical analysis*. My awareness of this issue arose from previous research training and familiarity with the views of qualitative writers. A number of authors advocate use of a reflective diary or journal. Whilst I commenced a diary on day one of the study, this felt to be out of some kind of sense of duty, and when I reviewed the diary a few weeks later it seemed to have little value. I rapidly realised that I needed to give reflection more consideration if it was to be both meaningful and beneficial.

I knew that recollections of issues faced and addressed over the time-scale of a lengthy study could be forgotten or blurred with the passage of time. I also knew that particularly large amounts of data could ensue from a qualitative study. Attempting to maintain a diary at my bedside at the end of a long working day did not work for me. Making entries felt 'forced' and I was invariably tired at the time of writing. Attempts at reflection felt detached from the fieldwork I was becoming heavily engaged in, and so felt like an 'add on' task. Whilst initially confident that I would remember the detail of

key reflective moments at a much later date, my common sense told me that I would be likely to forget much of it if I did not make accurate and comprehensive records. During early fieldwork, numerous occurrences were exciting and felt like they would be remembered forever. Yet I had never undertaken a study of this magnitude before and knew that advice received from my supervisor amongst others was drawn from years of that very experience that I was lacking in, and was to be heeded. I also recognised that as well as providing a record, writing up of my reflective endeavours would also produce materials for comparison with each other, any emerging insights and the formative findings. Thus as I became more attuned to being a qualitative researcher, I increasingly recognised the potential benefits of reflection. I decided to ignore the comfort I gained from some student peers who told me that their diaries had similarly been under-prioritised, some to the point of non-existence, and address the problem. What I needed was a mechanism for reflection and a form of recording my reflective activity that was workable for me.

iii) *New perspective.* I read up on the development of theoretical memos and these made sense to me. I had begun maintenance of memos as written notes attached to all fieldwork episodes at the outset of fieldwork and I recognised that these documents were where I could also record my reflective activities (see Appendix 10 - Sample Field Notes). Their location seemed appropriate as these notes were kept side by side with field notes and so felt 'close' to the data. Immediately after each episode of fieldwork, I chose to reflect on the event and make initial notes. Then after transcribing participant-observations, and later interviews, I would revisit the reflective notes so that my memos and reflections became intertwined. I also kept separate documents to record particular events and my reflections on them. Examples include notes following a visit made to the Revans Action Learning Centre to gain advice on writing up action research, my thoughts following my Interim Assessment process and my views following particular advice from the Research Advisory Group about the study design.

To challenge my evolving perspectives, I engaged the support of a research assistant employed by the Trust for the SG wider evaluation study and other projects, to act as a 'critical friend'. This was a role I had gained an understanding of through attendance at research seminars coupled with further reading. Sometimes the research assistant and I would have observed the same episode of participant-observation and would compare views and interpretations about what we had seen. We would also play 'devil's

advocate' and at times challenge each other's views. This helped in critically analysing what was behind some of the interpretations I had arrived at. Thus my reflective writings acted as adjuncts to the theoretical memos and as such became valuable tools and aids.

B. Research Relationships

i) *Object of reflection.* The issue of building and sustaining relationships with participants was apparent to me from the study outset. The difficulty presented was how to manage these, in view of my having previous professional relationships with several participants and by continuing to be a Trust employee throughout the study.

ii) *Critical analysis.* I knew from the research literature that acting as an insider action researcher can lead to tension concerning the relationship between researcher and employer. This is especially so if the latter is also the research commissioner, a key stakeholder and/or gatekeeper authorising access to the field. My understanding of empowering action research is that there is an intention of bringing about change and this may result in any variety of altered relationships, working practices and shifts in power. Employers, or indeed participants' managers, may be supportive of action research if they believe it will lead to changes they themselves desire. Difficulty may arise when less desirable outcomes ensue, particularly if it is they who have to change or endure a shift in power. Other research approaches may produce a report of findings at the end of a study, which is easier for recipients to reject if they do not approve of its contents. With action research, it is more difficult to ignore undesirable issues because of the collaborative relationship of researcher and participants and the regular, cyclical reflective nature of the approach and sharing of formative findings. Ultimately, I was aware that as a researcher, I had a duty to my employer, but also that this could conflict with my responsibility to be true to the participants. In this study, my line managers were SG project leaders and participants in the research. Furthermore, the focus of the research and its objectives had been negotiated with these individuals.

There were two main tensions with the remaining participants. Firstly, in health services research it is often the case that the researcher will belong to a profession and have a registerable qualification. As a registered nurse myself, I was aware that complications could present should I become privy to situations that posed a professional dilemma that

would require me to act as part of my professional code of conduct. I was aware that this issue has been frequently discussed within nursing literature, as researchers in clinical areas in particular have had to address poor practice they have observed despite the potential for damage to their research relationships.

Less clear is how the nurse researcher should act in situations that do not breach their code of conduct but that would probably have disastrous effects on the situation being researched. The dilemma for me would be whether to intervene to prevent the undoing of months of work or let the situation unfold unimpeded and observe the consequences? This is bearing in mind that as an action researcher, I would want to have a positive impact on the research situation. This issue became apparent to me in a situation I will now describe by way of example. Participants got sidetracked during one of the council meetings and began discussing an incident of bullying. A manager was alleged to have bullied a subordinate, which is both a disciplinary offence and an incident that I would be obliged to act upon as a registered health care professional. Yet to do so would likely have led to my being refused to re-enter the field, as participants would possibly view me as having been disloyal to them. In this instance the participants minuted their discussion about the bullying despite these minutes being widely available public documents, maybe not the most tactful of decisions on their part, but one which alleviated the dilemma for me. I decided against suggesting that they not do this, as I did not see it as my place, within a researcher role, to impose this particular view on them. I did, however, take the step of giving early warning to the SG project leaders once the minutes were made public, which enabled calm handling of the otherwise volatile situation that could have ensued had the minutes landed without warning on the desk of the manager concerned.

The second tension concerned my nursing post prior to undertaking this research study. As a Nurse Clinician, I had been employed by the Trust as a senior nurse with out-of-hours clinical, nurse staffing and site management responsibilities. In many respects this was considered helpful as I could communicate well with clinical staff and senior managers alike. I was aware that several council members had worked with me before in a clinical capacity. Some will have been affected by some of my less popular actions within that role, such as moving their staff to help other wards, refusing extra staff or insisting that patients were admitted to their ward against staff wishes. I was aware that I might be viewed as having a degree of organisational authority myself, not least as I

remained within the senior nursing team during my research fellowship. I knew that having position power such as this was well documented in the nursing and research literature and is one of the key difficulties of being an insider researcher. This being so, I also knew that it would be easy for me to manipulate participants by being directing rather than facilitative, such as when promoting discussion about findings and how to act upon them. Another opportunity for misuse of my position might be in making people feel obliged to be interviewed when really they would rather refrain from participation. However, I hoped people would take me on face value and I was reasonably confident that any staff who knew me recognised that I was very committed to staff welfare. On reflection, I realised that it might be the very people who had *no* pre-conceptions about me that I had to concern myself with most as I would have to establish myself with them and gain their respect and trust. My awareness of this was one of the reasons that I wanted to meet with participants at the preparatory workshop they attended prior to the study commencing (see page 93). I knew there was evidence that people tended to make their mind up about a person quickly after having first been introduced. I therefore saw the workshop as a public relations opportunity to portray myself to participants in the way I wished to be perceived, that is, professional, honest, loyal, rigorous and committed to them as well as the study.

iii) *New perspective.* Having analysed these situations and discussed them with my academic supervisor, I came to a number of decisions. Firstly, to reduce reliance on the SG project leaders for access to the study setting, I established a multi-disciplinary Research Advisory Group. This was invaluable in providing a safe environment to air concerns and seek advice about how such sensitive issues should be dealt with and to gain their support for accurate representation of findings. It also acted as a forum to strengthen relationships with SG project leaders and make alliances with other senior personnel by consulting them and involving them in the identification of solutions to some of my difficulties. I believe this helped to foster a sense of ownership of the study and its outcomes amongst them.

My existing perspective on how to handle instances of unprofessional practice was reinforced. It was helpful to consider how I might react in certain situations in a research setting, although in practice the only difficulty I had with this regard is the one outlined in the example given above. My view was that my responsibility to staff and patients was paramount and that any research study I was involved in would be

secondary. I cannot justify harm coming to somebody just to minimise any impact on my research endeavours. I recognised that it was a matter of judgement for the researcher to decide where a situation required them to step out of their researcher role and into their registered professional role. I think these issues further illustrate the importance of quality academic supervision to discuss issues such as these, which I was fortunate to have but I am aware that some researchers do not have. In future research practice, I now know to raise the issue of my proposed actions in the event of witnessing professional misconduct at the point of individuals consenting to participate. They will then be informed that not all that they do or say will necessarily be bound by researcher confidentiality in certain circumstances.

In terms of establishing research relationships with colleagues and other participants, my view has altered slightly. Whilst I maintain that there is merit in doing all that is reasonable to promote good relations, these cannot be guaranteed. It is not always possible to be liked or trusted by all participants, and so I think there comes a point where researchers should do the best they can, be able to justify their actions and be true to themselves. Even positive change can be stressful for some participants and they cannot be expected to like all outputs from a research study. Some tensions therefore have to be managed rather than alleviated completely. Additionally, my commitment to minimising bias and preventing manipulation of participants remains high and so has only been reinforced as a result of this reflection. Fortunately my previous and existing senior nurse identity did not appear to affect the research relationships to any discernible degree in the study.

C. Promoting Involvement

i) *Object of reflection.* The issue of promoting the involvement of participants was apparent to me at the study outset. The difficulty presented was how to promote maximum involvement of participants, particularly the practice-based council members, as it was they who were being empowered by the SG project leaders (also participants).

ii) *Critical analysis.* As an action researcher, this was an issue at the forefront of my mind and I quickly made myself familiar with a large quantity of action research literature. I also had an existing sound appreciation of consumer involvement issues, having read around the subject to fuel a personal interest of mine. This material raises a

number of issues around involvement, including the need for involvement and methods of promoting it and potential problems including token involvement, consultation being construed as participation and little consideration of involvement in espoused action research endeavours.

I was aware that wherever possible, involvement should be fostered from an early point in a participative endeavour. Advocates of consumer involvement in research suggest that ideally, participants should be involved in the selection of study topic and design and not merely be consulted at some later stage, such as for an opinion of the findings. Both the research participants and myself indicated a preference for research done with them and not on them, which action research demands. I wanted to promote participants' ownership of the findings, as my understanding of change theory was that changes made collaboratively in this way were more likely to be sustained. I also wanted to integrate the research and SG initiative so that evaluative components were in-built which, according to evaluation theory, would promote the likelihood of success of a new service development initiative such as SG. There was a three-month gap between my being appointed and the SG initiative commencing, and so it was not possible to engage practice-based council members in the original research design, which would have been my preference. I was confident that involvement could and would be fostered as soon as possible.

Having read of the experiences of other action researchers, I was keen to ensure any involvement was meaningful. I felt that limited attempts at participation could be construed as tokenism, which I wanted to avoid. I had no desire to manipulate participants into thinking they had a say when they did not, and I was aware from the literature that participative research approaches had been misused in the past to impose what was really a top-down change. In early meetings with participants, I sensed their curiosity as to whether they were to be truly empowered or whether SG was a guise for what was really mere consultation. I did not want to act in any way that could be taken as being disempowering, preferring to embody the principles of SG as much as possible. To not involve participants was, in my view, undemocratic, and I recognised that my personal viewpoints and values had a significant impact on this intent to promote participation and act as a role model for SG.

The main locus of involvement of participants was mutually agreed as being the

decisions to act, or not act, on the study findings. How this was to be effected in practice was to be worked out between us, yet mostly left for me to address as the researcher. Ultimately, participants recognised that they were to be somewhat pre-occupied with grappling with their new roles as council members. Indeed the research literature draws attention to the issue of co-researchers not needing to have as substantive research role as the main researcher in an action research project. I agreed to seek out opportunities for participants' involvement and they collectively agreed to highlight opportunities they themselves identified to me. For example, dissemination of findings was a further possible option for involvement proposed by me (see section I. Dissemination).

iii) *New perspective.* My earliest opportunities to foster involvement of participants have been detailed earlier. In summary, the research topic and original research proposal were developed in close consultation with the overall SG project leader. Thus this participant's views were incorporated into the outline study design. An Access to Site & Data Agreement was developed in collaboration with the project leaders that secured my access to the research setting and data collected within it (see Appendix 3 - Access to Site & Data Agreement). Furthermore, a Research Advisory Group (see page 91) was initiated to provide support and guidance for me in my research role and was also partly comprised of the SG project leaders. At times this group advised on methods, sampling and promoting of action and so influenced the evolving research design. Immediately prior to the SG initiative being launched, a preparatory workshop (see page 93) was held for newly identified council members who would form the majority of the study participants. At this event, issues of consent were addressed and participants agreed to the timing and mode of research feedback generated within the study. From the preparatory workshop onwards, maximum involvement of the practice-based council members was promoted in a range of ways.

The primary means of involvement, that is action arising from the study findings, is discussed later (see section F. Change Agent). Other ways in which involvement was promoted are presented here. One example concerns recognition of a need to establish council members' workload in relation to their council roles. My reasons for this included a concern with the workload of chairs in particular, which seemed challenging to manage. It was assumed that if council members needed assistance with their new roles, then evidence would need to be provided to support any requests such as

increased administrative support. I had also become aware that a significant number of participants were expecting to undertake many of their council duties in their own time, including attendance at meetings on their days off. As a supplement to my observations, I recognised value in knowing how much time was spent on council duties away from the meetings, such as visiting constituents in their wards and departments to raise the profile of SG and identifying issues for the councils to address. Upon discussion, several council members echoed these concerns; thus, a Council Activity Sheet (Appendix 19 - Council Activity Sheet) was developed in partnership with a volunteer participant to be completed by all practice-based council members on a monthly basis for 18 months. The sheets prompted inputting of information that was useful to me and also information that council members wanted to know, such as other meetings they attended to discuss SG, whilst also promoting their ownership of this activity.

Following another discussion about promoting awareness of the councils within the Trust, participants highlighted how few suggestions of issues to address had ever been received from constituents. They suggested how it would be useful to know if staff were aware of the councils' suggestion form system. Furthermore, they asked if this information could be obtained through the Trust Shared Governance Survey (part of the wider evaluation study) that was due to be undertaken. In response, I ensured that a relevant question was added and a few weeks later I was able to inform participants that 50% of respondents were unaware of the suggestion form system. Thus, participants' involvement shaped a small element of the survey design and the results informed their plans to promote themselves better in the Trust. Overall, participation was fostered in a number of ways due to being vigilant in seeking out opportunities for it.

D. Sharing of Findings

i) *Object of reflection.* The issue of sharing study findings was apparent to me at the study outset. The difficulty presented was how to share formative findings throughout a study in terms of what to feed back, if, when, how, and who to, and not simply to share summative findings at the end.

ii) *Critical analysis.* A key objective of the action researcher is to effect change and bring about social action, and so it is important to consider what prompts that change. A key, purposeful stimulus for change is the act of communicating study findings. At

some point a decision has to be made as to what is important to focus interest on in the first place and subsequently what findings to share from that inquiry, to whom and when. I found these issues to be little discussed within the action research literature.

In adopting an action research approach, I have acknowledged individuals as participants as opposed to research subjects. This makes the job of deciding *what* to feed back even more difficult. As participants, and co-researchers, it can be argued that they have a right to all data ensuing from the study. Yet this would present a number of problems. Harm may come from the sharing of sensitive data that may detract from the positive effect that I, as an action researcher, openly seek. To share only a selection of data could be construed as disloyal and manipulative and seeking to fulfil my own agenda. In part, this is the case as action researchers do indeed set out with an agenda - to change practice. However, their duty lies in being true and fair to participants. With this in mind, it is considered appropriate to avoid harming the participants in any way. Yet bringing about awareness amongst participants of the need for them to change behaviour can be a painful process, however sensitively it is managed, and such discomfort cannot always be avoided.

I knew from the general research literature that problems are more likely to ensue from findings that are clearly sensitive. To illuminate this point, an example is given from early fieldwork whereby a finding was distinctly critical of the behaviour of one of the SG project leaders. The dilemma comprised not wanting to present a 'negative' finding but acknowledging the need to address it, if the project's success was to be promoted. This is a specific issue that I have come across in the research literature concerning the need to maintain good relationships with those acting as 'gatekeepers' to a study. My responsibilities lay with all participants whether they were council members or project leaders and I felt that I could not avoid giving constructive criticism just because it was a project leader on this occasion. To make the situation more delicate, this issue arose very early on in the study when trust was still being built. In this instance, the particular finding was presented with the maximum of tact to the project leaders, was not well received by the individual concerned and I had to give apologies and reassurances to that person to restore good relations. From there on, there were demonstrable, longer-term benefits as a result of this particular finding, following the changed behaviour of the project leaders as suggested. Whilst I had recognised not to share the finding with the majority of participants, I still caused some embarrassment, which incurred much

reflection on my part.

Another aspect of sharing findings that I reflected on substantially pertains to the cyclical process of 'observe, plan, act and reflect' within action research. I had the responsibility of deciding not only *what* to share but what *not* to share at a given point in time. Decisions had to be made concerning whether an emerging issue should be allowed to 'run its course' longer. To share an emerging finding too soon would mean having lost the opportunity to see what would have happened, which may have been more valuable than highlighting it prematurely. Also, a longer period of observation may be beneficial for accumulating more supportive evidence or contradictions of an emerging picture, prior to arriving at a tentative conclusion for sharing with participants. However, to leave feedback too late can equally risk missing a timely opportunity to prompt a change in practice. According to the change theory I was familiar with, an undesirable practice or behaviour may be more difficult to change if it has become firmly established in day-to-day practices. I was concerned that any time frame chosen for sharing of findings would provide sufficient opportunities to present findings and prompt action. Otherwise a delay in sharing findings could mean that the behaviour or practice in question might have had far-reaching negative effects.

A further element of this issue of findings feedback concerns *how* it should be done. In participatory action research, it is recognised that the research participants should be involved in this decision. The dilemma for the researcher is agreeing a time, place, frequency and mode of sharing findings that is acceptable to both. It can be difficult to empower participants in such a situation when they probably have limited knowledge of the research process compared to the researcher. Yet the research literature suggests that they do not need to be expert researchers and can still express an opinion. I gave a lot of consideration to how I might feed back, whether it be verbally, in note form, as a written report or presentation, and how frequently. I wondered how much say participants should have when they would be basing their views on an aspect of the proposed study that they little understood. Yet I also wanted to promote every opportunity for their participation. Equally, I imagined that the findings would be better received, and more likely to be valued, in a mode and time frame to suit participants. Having thought about it, I reasoned that the best way forward was to ask them their views.

As well as immediate participants, there were the other stakeholders of the study findings to consider. These included other Trust personnel, the funders of the study, other organisations implementing SG in the UK and beyond, the academic community and other interested persons such has health care staff generally and health care policy makers. Participants and myself shared a common view that findings should be shared openly with others so that other health care communities could learn from our insights from this study. Assurances were given that I would attempt dissemination through a range of means (see section I. Dissemination) throughout the study and afterwards. Again I was entrusted to share findings appropriately. Knowledge that there was a lack of UK SG literature, and personal awareness that there was a risk of Trust staff not directly engaged in SG feeling excluded, were particular drivers to share findings fully. It was expected that these measures would help reinforce SG implementation in the Trust and generate further interest in it nationally. I believe this to have been a particularly strong element of the study.

Lastly, there was the issue of *who* to feed back to. The research literature highlights one problem of the insider researcher as being their susceptibility to requests for snippets of findings inappropriately, often by those in positions of organisational authority, and before other participants. Previous research training and experiences have highlighted such problems to me and on reflection, drew parallels to the local politics that I have experienced in nursing as a profession. I mentally prepared myself for such situations, although on the small number of occasions they occurred I experienced some, hopefully hidden, anxiety in warding off inappropriate enquiries. I believe it is up to the researcher to ensure that the findings are shared in the first instance with the research participants and to resist pressure to do otherwise. This is partly good practice to check their validity prior to wider dissemination but also a duty the researcher has to be true to the co-researchers and equip them with the information upon which they can act.

iii) *New perspective.* These experiences led me to change a number of my perspectives around the management of findings. As there were so many anticipated difficulties with the sharing of findings, it was agreed with the project leaders to have adequate time to address concerns with participants at the preparatory workshop held prior to the study commencing. Issues and options around findings were discussed at length with participants in an honest and open fashion. Some participants wanted findings from once-monthly, two-hour participant-observations to be shared every two months! It was

unrealistic that any meaningful findings would be available in this time frame, and so we negotiated a compromise of feedback every three months at each council meeting. As requested by participants, these findings were to be informal verbal presentations by me followed by discussion, as opposed to formal presentation using an overhead projector as was my initial preference. Findings were to be minuted for future reference.

The dilemmas around sensitive findings, timing and selection of what to share and what not to share were also discussed openly. Participants were accepting that much of my research practice would have to evolve as the study progressed, and we learnt together what worked. Reassurances were given that careful attention would be paid to sharing findings appropriately and that any omissions or delay in feeding back findings would be underpinned by good intentions, and not meant to be unhelpful. Participants grasped these issues well and we agreed to reflect on the mechanisms for sharing findings as well as the findings themselves at our quarterly feedback sessions.

In my earlier example, I illuminated how I had shared a negative finding concerning a particular respondent inappropriately. After the event, I considered how I could do things differently in future and discussed these thoughts with the person concerned. Following this evaluation of the situation, I decided to change my future actions by only sharing a sensitive finding pertaining to an individual with that individual if possible and not more widely amongst their peers. I could still then observe for any discernible change in behaviour that might be attributable to that finding. In the course of events, future findings were received well in that nobody expressed any upset by them and constructive criticism, where given, was duly considered by participants, not disregarded out of hand.

During the decision-making phase of the study, it was necessary to reveal findings more selectively than I would have done in the earlier SG wider evaluation study. This was because by this stage, I was focusing closely on key elements of council activity, in order to check out assumptions and tentative conclusions I was arriving at concerning decision-making. I was concerned that I did not prompt introduction of any new changes in participants' behaviour while I did this. At this time, the Trust research assistant was continuing the evaluation study and sharing her findings quarterly with participants, which I added to in a carefully considered way. I also pre-planned, with her, what findings she was going to share so that they did not impede any of the focused

decision-making work I was doing at the time. The only problem I encountered with this was that one of the two councils I was focusing on disbanded. This meant that the remaining six months of fieldwork were concentrated on one council in particular and so I was ready to share summative findings at a slightly later point in the fieldwork than I had planned for. This meant that I had to withdraw from the field soon after summative findings were shared and, whilst they were received very positively, I had insufficient time to evaluate their impact fully.

Ultimately, I decided that it was my role as the researcher to make an informed judgement about each particular situation, such as whether the greater good would be from delaying certain feedback or giving it promptly. It is my view that it is for the researcher to determine the best point for giving feedback, bearing in mind that any 'failure' by the researcher is just as valuable a source of research data as actions considered successful. Thus, what happens as a result is to be reflected on, learnt from and action refined as considered appropriate.

E. Targeted Feedback

i) *Object of reflection.* The issue of group feedback of findings to participants was apparent at the study outset when participants requested this measure. The difficulty presented was whether to target feedback at specific individuals or generalise findings so as not to point to individuals, and how to maintain the anonymity and privacy of participants.

ii) *Critical analysis.* I was aware from the research literature that it is expected practice to make every effort to anonymise any presentation of findings. This standard is particularly concerned with making sure participants cannot be identified from the presentation of findings to the wider public and that their permission is sought where this is difficult. Yet participants also have the right to privacy before findings have even left the field. I was aware that participants in this study would not want to be put in an awkward situation publicly, even within the confines of a council meeting with their peers. In action research theory, ethical tensions relate to the need to effect change, often by changing individual and/or group behaviour. I felt that to do this, individual participants would sometimes need to know what data pertained to them so that action could be agreed and their behaviour changed. Yet my agreed forum for feedback of

findings to participants was at the council meetings. Hence my dilemma. Despite the fact that they had agreed to group feedback, I felt a need to protect participants from embarrassment and wondered how I might anonymise findings without losing their impact on individuals, or alternatively deliver findings to individuals in a different forum.

As well as wanting to protect individuals' interests, I recognised that by bunching findings pertaining to individuals and groups together, I was heavily reliant on those participants to identify the parts that were relevant to them and to act. Alongside this was the assumption that they had the skills of reflection and self-awareness required to appraise the findings in this way. I wanted to encourage full consideration of the findings and not just a focus on findings of obvious relevance, or those that were less challenging to their existing views or behaviours. I knew from previous mentorship training that some people's response to criticism might be to ignore it or be selective, and so I recognised a need to balance any findings that might be perceived negatively with positive feedback, as well as putting findings across constructively in the first place. What I needed to develop was a means of raising individuals' awareness where findings pertained to them as individuals, whilst also protecting their privacy in a group situation.

iii) *New perspective.* Once aware of these issues, I reasoned that it was the researcher's responsibility to make clear where any feedback was being directed, despite the fact that it can be uncomfortable for the participant/s concerned. In most instances within this study I was able to give general, cross-council feedback, as most findings were relevant to varying degrees across the councils. On occasion, I did feel it necessary to feed back council-specific findings to the individual councils, such as when attention needed drawing to specific issues pertinent to that particular group.

I decided that it was ethically inappropriate to refer to an individual's performance within the group setting unless it had been positive. Yet, as my experience of giving feedback was practised and developed during the study, I was increasingly able to be constructive even where performance had been particularly poor. I tried different ways of phrasing my comments and highlighting issues without apportioning criticism. For example, when a council chair had been particularly disorganised for some time, I highlighted what was only a small improvement in a way that demonstrated that

significant progress was being made. I then advised the chair to build on that good progress and, once the participants verified this issue as one in need of action, asked them for suggestions of other ways that the council (not the individual) could organise its work differently.

As previously learnt, feedback that could only be perceived as negative was to be shared on a one-to-one basis in private, although this actually never happened as, with due thought on my part, all feedback could be given in a encouraging and supportive way. So the solution to the problem was one of *how* to feed back and not *where* to feed back. Thus my own practice improved by learning experientially from feeding back in different ways and seeing what worked best.

F. Change Agent

i) *Object of reflection.* The issue of my role as a change agent was apparent to me at the study outset. The difficulty presented was how to stimulate change and my role within that process.

ii) *Critical analysis.* At first, having had substantive involvement in practice development activities during my career led me to expect the change agent element of my researcher role to be relatively straightforward. I had a good knowledge of change theory including change promotion, barriers and aids to change, facilitation and coaching skills. Yet as my understanding of the action research role developed, I became acutely aware that promotion of change within an action research endeavour was going to be quite complex.

According to the research literature, self-awareness of the qualitative researcher is paramount. Researchers need to be aware of how their values, experiences and perceptions may affect a situation through their own behaviour and choice of actions. Researcher views and preferences may be inadvertently transmitted to participants who may respond accordingly, especially if they view the researcher as an authority on their particular situation. As well as communicating their opinions, researchers may stimulate change in unintended ways, such as the cues they give off through their body language, and not just by what they say or do overtly. My knowledge of interpersonal communication highlighted to me the care I would need to take with how I presented

myself during fieldwork. I realised there were many traps whereby I might deflect or encourage change by my actions and non-actions, whether or not they were intended.

Essentially, action researchers need to keep a record of the change prompts they make in the field so that any impact can be discerned. This may in turn influence how they change their own future action based on what they have learnt. A judgement is required to decide whether any change is as a result of the action researcher's direct or indirect input. There may be some other variable/s at play, including the participants themselves or some external factor, which may or may not be discernible at the time and need further investigation. Other factors may never come to light, such as an experience a participant had away from the fieldwork setting. Indeed, a change may not occur at all as existing practice is reviewed and reinforced due to no change being considered necessary.

Sharing of emergent findings can be a particularly big impetus for change. It is up to the researcher to judge what findings to feed back and when (see section D. Sharing of Findings). To prompt change in several ways at one time can make it difficult to identify the individual factors at play and their impact. Understanding I had gained from the social research literature informed me that this 'fuzziness' is not uncommon in research involving social situations. This prompted me to think further about how I could monitor events in such a way as to keep focused on the individual aspects of interest, such as reaction to a particular finding, whilst keeping a sense of the whole situation.

Initially I thought it would be useful to share findings with participants in a similar way – same order, choice of words and so on, to observe how participants received the feedback and to make comparisons between councils. Over time I found some councils to be more receptive than others, with the latter councils at times thanking me for the feedback and changing the subject. My knowledge of action research told me that whilst I could not make participants want to consider acting upon the findings, I could present them differently. Sometimes it is not the contents of findings that are necessarily a problem, just the way they are communicated. I knew from the management literature that airtime given to an item at a meeting was often dependent on the position it was given on the meeting agenda. I noted that discussion time for the emergent study findings was usually at the end of the council meetings when time was short.

A further issue concerning findings as a precursor to change involved the way participants responded to study findings shared with them. On occasions, findings were either validated but not acted upon or not agreed with at all. This was quite difficult for me, especially when I believed that a change in behaviour would be particularly beneficial. I personally believed that the supportive evidence I offered for my claims added sufficient weight for them to prompt change, which stemmed from my valuing of evidence-based practice. What I recognised was that others did not necessarily share this view and possibly had a different way of working, a different value for evidence, or simply thought the need to change was not so pressing. Therefore, subjective opinions seemed to have as much weight as rigorously collated evidence in whether participants acted or not.

iii) *New perspective.* On reflection, I recognised the need to manage the way I conducted myself in fieldwork by choosing my words and behaviour carefully in any interactions with participants. Thus I recognised that during participant-observations in particular, I needed to address such things as:

- Who I gave eye-contact to.
- How long I maintained eye contact for.
- Not to look more interested in any one line of discussion.
- Not to write field notes more fervently for certain issues.
- To be aware of and minimise any bias in what caught my attention.
- To actively look for less obvious/striking occurrences.
- To choose a more neutral seating - not next to the facilitator or chair.

I paid particular attention to recording in my theoretical memos how changes appeared to have come about, or indeed failed to come about. I looked for supportive evidence from the participants themselves as well as judging subsequent events for myself. I noted any contradictory evidence as well as looking for supportive evidence and kept in mind that if the evidence existed at all, that it might not be observable. Therefore, some avenues could be explored at later interview to gain those participants' views on how changes had come about. I looked introspectively as well as in the field itself. These considerations formed a substantive part of the development of action research cycles, with several cycles being studied at any one time (see Analysis Chapter Part 1 - Action

Research Cycles), and extended throughout the analysis stages. In illustration of these points, a number of examples are given.

Example 1. An example of an insight that was reaffirmed through searching for supportive and contradictory evidence from varying sources was lack of clarity around the Human Resources Council (HRC) remit. It was my early and continued view that the HRC remit was never satisfactorily clarified. My enquiries included participant-observations of the council, during which times instances were noted where the council remit was verified as unclear, as well as times when it appeared to be gaining some clarity. Other sources included asking three HRC members their views of the remit at interview. I also asked a member of the Trust Human Resources (Personnel) Department for their view and how the council related to that department. Perspectives evident at the SG Working Party meetings, Policy Council meetings, Chairs' meetings and in associated minutes and newsletters were also noted.

The decision-making theory I am now aware of certainly supports the notion that not all decision-making is rational, and it may be subject to a range of influences including values, emotions and past experiences. Despite being uncomfortable about some findings being seemingly rejected, I acknowledged that these feelings were not unusual and had been experienced by other action researchers seeking to empower others. Examples are given in the participative research literature of change not taking place as intended, and that this is the unpredictable nature of involvement and empowerment. Participants have choices, and these may well be different to the researchers' views as to which choices would best enhance the situations being studied. Participants have the right to not act at all. This made me realise that whilst non-action may be a conscious decision, there may be other times when I needed to communicate more strongly in case my point had not been relayed successfully. There might be a need for gentle encouragement with further occasions in need of more strongly put advice. Ultimately, the participants need to make the choice of whether to act or not and in what way, and the researcher needs to take care not to manipulate the situation to achieve their personally preferred outcome. Usually I found this latter approach fine in practice, but it was frustrating at times to have what were in my view important findings disregarded despite mounting evidence. Naturally, I made every attempt to ensure that this frustration did not show during fieldwork, not least as it was interesting and valuable to see what happened in the event of non-action by participants. Furthermore, I recognised

these periods of frustration as being 'danger zones' when I knew to use my critical friend or take issues to academic supervision for discussion.

Example 2. Some findings were rejected outright. One example was my encouragement for the Mental Health Council (MHC) to liaise with the other practice-based councils to avoid a 'them and us' situation developing further. Limited inter-council liaison was observed and on questioning participants, none expressed any need for inter-council communication. In part, the councils' teambuilding workshop that I prompted at the end of their first year of inception was to encourage councils to be aware of each other's work, minimise duplication and share good practice. Due to difficulties in the way the day was organised and MHC members' perception of it, little teambuilding between councils was achieved. Very rarely did the MHC chair attend the monthly Chairs' meetings that developed from the teambuilding workshop, thus missing opportunities to learn from each other and gain support from the SG project leaders. I identified the reasons for the MHC's lack of engagement as being that it saw no benefit, it would mean extra work contributing to the Trust SG Newsletter in addition to its own newsletter and would necessitate more meetings to attend. Despite reinforcement, minimal inter-council liaison occurred.

Example 3. An example of how I shared findings in different ways to encourage action is the use of the OARRRs model. This was a model of organising meetings suggested by the council facilitators which they presented on flip charts to members at their respective council meetings (see Appendix 18 - OARRRs Model). The MHC readily adopted the model at its subsequent meetings and displayed OARRRs on newly prepared flip charts at each meeting for the chair to complete. As it was consistently observed to help organise meetings in that council, I encouraged the remaining practice-based councils to consider its use as a possible solution to difficulties they were encountering, such as forgetting where items were up to and forgetting to identify a lead for each item. As no action ensued and the difficulties mentioned continued, a change of tack was needed. Instead of simply highlighting the merits of OARRRs, participants were encouraged to go and observe a MHC meeting for themselves, thinking this might capture their imaginations rather than trying to describe its virtues to them. When this was not responded to, a suggestion was made to invite the MHC chair to come to show other council members how to use OARRRs. In the end, members indicated that they no longer understood the model and so I suggested that a pro-forma was developed that

would guide them (see Appendix 20 - OARRRs Pro-forma). This was agreed to and developed in partnership with volunteer members. When used fully, the OARRRs pro-forma proved helpful but its continued use needed a lot of reinforcing on my part. Members often wanted not to bother with it. As a consequence, these meetings invariably became muddled with few clear outcomes, unclear responsibilities for work that was required and vague records being made of what was discussed.

Example 4. The opportunity to use an alternative means of presenting study findings arose with the MHC after members were observed to be getting muddled up with where they were up to with many of their issues. Council members had expressed being very frustrated, as they felt they no longer knew what they were doing. Having evaluated the situation, I agreed with participants to apportion a significant part of the next council meeting agenda to review progress and summarise the findings to date. I felt that stronger reinforcement was needed, as participants were noted to be continually repeating unhelpful practices that they had agreed were not working. At the next feedback of findings session, instead of having a 15 minute informal discussion about the latest findings, participants allocated an hour for this part of the agenda. Therefore the action research cycles were not overtly covered as usual; instead, a summary of findings to-date was distributed prior to the meeting and an overview given at the meeting of all the cycles to-date. This summary was also sent to members who had not attended this particular meeting to ensure that the information reached them. This was also in part response to a further review of my feedback mechanisms that highlighted a difficulty when participants missed the feedback sessions and the meeting minutes lacked detail and accuracy of what I had fed back. A further response was to supply the council's secretaries with material to include in this section of the minutes, so those absent participants did not miss out. Presenting the findings in this alternative way to include substantial revision of former findings was aimed at facilitating the large number of new members to see the flow of events that had brought them to their present state. All present agreed that this approach to the feedback had made things much clearer. They responded, following discussion, with an action plan comprising steps that included exploring their recognised need for a council facilitator, clarifying roles and responsibilities for the chair and vice chair, and taking on one big issue at a time alongside several smaller, more manageable issues.

Example 5. A further example of the study findings being shared in a different way was

demonstrated at the council members' decision-making workshop in June 2001 (see Appendix 25 - Decision-Making Workshop Materials). As the study was coming to an end, I was aware that some findings verified as accurate and important by participants had still not been acted on or clearly rejected by them. I decided to facilitate participants to be active co-researchers for most of the one-day event so that they could draw some conclusions of their own from the data I had collected and summarised. I split participants up into small groups made up of members from their own council and asked them to list factors that they felt had been aids and barriers to their decision-making as councils as a basis for discussion. I then gave each group three of the Time-Ordered Matrices pertaining to their council. Each group was asked to examine the matrices and identify peaks and troughs in their activity and to identify what had helped or inhibited the progress of each issue. They were also asked to add anything they felt was missing or highlight any inaccuracies in the displays. This activity was aimed at facilitating participants to see how I had come to my conclusions and how these compared with their own. This session was extremely well received and participants found it hugely illuminating. When asked how they would like to act on what they had interpreted, they set about developing action plans to take away with them so that they could improve their decision-making in the light of what they had learnt. Whilst there was nothing new in the content of what had been presented, participants found that being able to identify problems and areas for improvement themselves had really crystallised the findings for them.

Example 6. Throughout the study, the formative research findings have positively influenced council members' decision-making. One example is participants' decision to develop an orientation pack for new members. This arose following feedback that highlighted how new members that had joined the councils in preceding months had visibly struggled. Several new members were observed to appear confused at the use of terminology that was specific to the councils and other phrases known only to staff who had undergone the Leading an Empowered Organisation (LEO) course. These new members were observed to spend several meetings trying to grasp how the councils operated and frequently asked for clarification of issues such as how councils made decisions, how they organised their work, how members engaged constituents and so on. Speaking to these individuals further confirmed my suspicions that they felt they were floundering as they struggled to grasp the councils' ways of working. At the next feedback of findings session, these insights were raised to participants, who

acknowledged that there were no means of orientation being practised. A former suggestion by members to ensure a period of shadowing for new members prior to them joining a council had rarely happened. Participants agreed that some kind of orientation was needed. In the discussion that ensued, options around shadowing, pre-meeting briefings and an orientation pack were discussed. I encouraged the idea of an orientation pack as it could be simultaneously used as an information pack to generate interest in joining, rather than just being for orienting members who had already been recruited, thus responding to two difficulties observed. I could then study whether there was any impact on recruitment and orientation through observation and speaking to any new members. This suggestion was verified as being most useful by the new members, its development was agreed by all participants and development of a pack became an agenda item.

Example 7. A simple example of a change in council's behaviour due to the research findings was during the Ethnic Minorities Issue (MH7) being addressed by the MHC. Members had been made aware of how they repeatedly accepted sizeable issues, which gave them a noticeably huge workload. Within minutes of beginning to address the Ethnic Minorities Issue, the Chair pointed out my earlier warning and said "...remember what Tracey had said about not taking on the world." Another member then suggested selecting one of the council's preferred problem-solving models (see Appendix 24 - Problem-Solving Models) to break the topic down before going any further so that they could address a manageable element of it.

Example 8. A further example is when the behaviour of the MHC chair changed in response to being made aware that issues were observed to get overlooked as they were missed off agendas and then forgotten about. From the subsequent meeting, the chair managed sizeable agendas by recapping each meeting's content and carrying over items not discussed onto the agenda for the following meeting. This was a simple but effective measure.

Further examples of changes directly attributable to the findings include:

- Holding of a council members' teambuilding workshop in November 1999.
- Monthly Chairs' meetings.
- Targeted SG marketing and promotion events.

- Presence of a facilitator at all Trust-wide council meetings.
- Assurance of prompt LEO training for new council members.
- Review and reconfiguration of the Trust council model February 2001.
- Development of a Good Practice Guide for council members (see Appendix 21 - Good Practice Guide).
- Improved processes (e.g. allocation of leads for issues, designated member for publicity, forwarding information if members were absent from meetings, reinforcing use of OARRRs model for managing meetings, use of OARRRs pro-forma, early co-option/invite of informants, early negotiation of a level of authority, streamlining agendas).
- Development of action plans to further improve decision-making at a decision-making workshop in June 2001 (see Appendix 25 - Decision-Making Workshop Materials).

G. Researcher Participation

i) *Object of reflection.* The issue of my own participation as a researcher was apparent to me at the study outset. The difficulty presented was how to maintain my role as a participant-observer when faced with pressures to adopt more of an observer-participant role.

ii) *Critical analysis.* Once familiar with the action research and SG literature, I was committed to an insider participant-observer role within the study as it complemented the underlying philosophy of both the action research and SG approaches. I did not think that an observer-participant role would permit sufficient personal influence for me to achieve maximum change. I was aware that there is a trade-off between the action and research dimensions of an action research endeavour that will be influenced by a number of factors. These include the purpose of the research, whether it has a personal interest, whether there is a personal stake in the outcome and whether it is a funded study.

I also knew the expectations of other stakeholders, including the study participants would impact on my means of involvement. I valued this highly, as I believe participants should have a high degree of say in my role and the study design, although

final decisions are mine to make as the researcher. I was similarly aware of the influence I had as an insider researcher, having formerly held a senior nursing post in the Trust. The research literature highlights that an issue exists around the researcher's position having initiated contact with the participants and so immediately being in a position of potential authority. Also, there may be constraints due to limited access to involvement opportunities, time constraints to how fully I could engage and limits to how much personal participation I could manage and record accurately. I knew of the risks of involvement, including manipulation of study participants, yet believed that I could minimise any risk by being rigorous, transparent about my choices and motives, and reflective on the whole research process.

iii) *New perspective.* Having discussed my role with the Research Advisory Group, SG project leaders and other participants, the preferred role they alluded to was one that I suggest leant more towards that of observer-participant. This was reinforced by participants' requests for quarterly feedback as opposed to my integrated input throughout all of the SG council meetings during fieldwork. In contrast, my role within the SG Working Party meetings was much more participative as a member of the group, able to discuss at length emerging insights and have these inform decisions made by the SG project leaders about the overall SG initiative.

On reflection, whilst I valued both my role as a researcher and promoter of action, the former role was my primary concern as I wanted to ensure my research commitments were fulfilled because the study was to be submitted as a thesis. This does not mean that the action element of my role was secondary in any way. If a thesis had not been a goal, then I would probably have preferred a more participative role myself than was achieved. In reality, I rarely participated in council meetings other than when giving research feedback or discussing issues related to the feedback that had been given or discussing issues related to the design of the study. I think that this role, which fluctuated between observer-participant and participant-observer, was appropriate and worked well. It is with good reason that I varied my degree of participation in line with participants' wishes and the context I was working in. I am aware that I could have promoted much more change if I had been more participative, but I feel the extent to which I could have kept aware of my contributions and monitored their impact and so on would have been difficult. This was in part due to the size of the project. With a single council and a much smaller group of people I would have found a more strongly

participative role more manageable.

Furthermore, my post as a senior nurse meant that in a fully participative role such as that of a council member, I would have been the most senior clinical person there. There would have been a real risk that much of the change I prompted would be due to my seniority, leadership and practice development skills and I fear that in this study context, my research contribution may have suffered from such integration.

I felt that being less participative than originally intended helped me to be more empowering and facilitative. At times, participants would try and engage me and ask my opinion on their discussions during council meetings. In response to these requests for direction I would generally manage a smile, shrug or raised eyebrow and pass the question back. My aim was to empower them to think through the problem themselves to see if they had learnt from earlier events within the field. I reserved my opportunity to directly question choices or prompt action through advice and suggestions at the quarterly feedback sessions. I was careful not to blur my role with that of the council facilitator. I wanted my participation to be one of improving their decision-making, not engaging in that decision-making myself, as I could have easily done. Because of my background, I could have contributed to the development of clinical policies, recruitment packs, job descriptions and so on, but my research questions did not require it. My purpose was not to directly influence the content of the councils' outputs, but to improve members' decision-making. This could of course be expected to impact positively on the decision outcomes, but this was secondary and not the focus of this study. There are numerous occasions that I could have steered things to happen differently but did not, as these inputs would have been based on my opinions as to the best way forward and be overly subjective, not based on action research evidence.

Overall, I value participatory techniques highly. Some researchers may have difficulty in managing their participation in a sufficiently rigorous way to reduce any improper pursuit of their personal agenda. Participatory inquiry will always lend itself to misuse by unscrupulous or ignorant researchers who use it as a means of imposing change. Yet I think that the benefits of involvement in certain ventures can be very necessary and worthwhile.

H. Leaving the Field

i) *Object of reflection.* The issue of 'leaving the field' presented to me early on in the study. The difficulty presented was how execute the gradual retreat from the field that had been planned in the light of unexpected changing circumstances.

ii) *Critical analysis.* This issue first became apparent when one council disbanded at the end of 2000. I realised that to gain the exposure to the remaining councils that I needed for the decision-making phase of the study, I would need to continue fieldwork a few months longer than anticipated. My new plans to withdraw were to hold a decision-making workshop to disseminate summative findings in June 2001 and to complete fieldwork by the end of that month. The majority of formative findings had been shared by then and this event was symbolic at marking the conclusion of the study whilst providing opportunity for verification of the lattermost findings. This would leave me seven months until the completion of the fellowship in which to progress the analyses and begin writing up. Whilst this was a restrictive time frame, I felt I needed to remain in the field up to this point. I was aware from research literature that there is a danger of being overly subsumed by fieldwork, so that withdrawal from the setting is left longer than necessary, and also that the researcher could become emotionally attached to participants, particularly after an extended research relationship in which they have worked closely. In recognition of these issues, I agreed with participants that I would attend council meetings less frequently during the late stages of the study and withdraw gradually, so that they too did not feel suddenly abandoned in any way. Finally, following discussion with them, it was agreed to have the decision-making workshop for all practice-based council members to feed back the summative findings and a date was earmarked.

A problem arose when I was asked by the SG project leaders to take over the role of council facilitator for the Practice Development Council and Research Education Council (that had now subsumed the former HRC) from July 2001, immediately after I ended my researcher role. This request was made only a couple of months before the fieldwork was scheduled to complete and was totally unexpected. It was proposed to me as an opportunity to reinforce my findings further and promote the success of the SG initiative even more.

My relationship with participants at this time was such that I believed they would be understanding of the situation and would probably welcome the continued support of a facilitator, and likely be satisfied with me undertaking the role. I discussed the issue at the next available opportunity and participants were indeed accepting.

I knew from the action research literature that changes were sometimes not maintained after the researcher had left the field. My knowledge of local Trust events was such that I knew the SG project leaders wanted to commit their time to a new initiative and my role as an SG council facilitator would help free them up. Whilst I could see the merits from the Trust point of view, I felt that this was not a good move for me as a researcher, however I did not feel that I was in a position to decline. Again, the issue of being a Trust employee, soon to be returning from secondment and needing to find a new post, was at the forefront of my mind.

I also appreciated through discussion with my supervisor and knowledge of the research literature that full withdrawal from the field would be beneficial for the in-depth summative analyses I was planning. I felt that there was a risk to be managed were I to be analysing data after fieldwork had ended but still spending many hours each month facilitating council meetings and supporting council chairs away from the meetings. I did not feel that full immersion in the analyses would be possible without having to make extraordinary efforts not to be tainted by my continued presence in the former research setting.

I was also concerned about managing my workload, which in practice did prove difficult, as facilitation equated to two days per month of council related work for me. Whilst the workload itself was difficult, the main problem was the intermittent nature of the work. As well as the two council meetings per month, council chairs needed one-to-one in-person, email and telephone support throughout the month, documents needed working on, new members needed recruiting, and I took on the role of writing the Council Information sheets that summarised monthly progress. I sensed a large dip in council members' morale and motivation as many expressed feeling abandoned as the new Trust initiative was viewed as taking precedent. There was a feeling expressed amongst participants that the Trust should be consolidating its existing SG initiative prior to embarking on a new, ambitious project. I was also fairly involved in the new initiative the Trust was signed up to and was involved in writing documents and

gathering evidence for this Magnet Accreditation (quality award) process. This was an important objective for the Trust and I was more than happy to give it my support. However, I felt that these activities interrupted my concentration on the research analyses and made this latter stage of the study much more difficult.

iii) *New perspective.* Whilst initially very clear about my plans to withdraw, I recognised following reflection on the above, that research plans in a qualitative inquiry will often necessitate revision due to unforeseen events. I therefore believe that it is the responsibility of the researcher to remain responsive and negotiate new ways forward in discussion with participants. Thus participants remain involved in decisions made and so ownership is promoted of the changes that ensue. With regards to this dilemma, I felt that I had little scope for negotiation. The only way I could compensate for the non-research work was to make up time lost in my own time. I did not feel I could take this issue to the final Research Advisory Group in June 2001, and so simply informed members that I was taking on this role. Having evaluated my new situation, I recognise that such a group is best kept functioning after fieldwork ceases, to pick up on such late stage issues.

I. Dissemination

i) *Object of reflection.* The issue of dissemination became apparent to me early on in the study. The difficulty presented was how to ensure appropriate dissemination of the study findings.

ii) *Critical analysis.* Recognition of the need to disseminate had developed through a longstanding personal exposure to the nursing literature. From this and personal experience, it was known that nurses often did not disseminate research findings they had generated either within their practice areas or beyond. Often findings would be communicated in the popular nursing press, with some achieving publication in academic journals. This meant that there were issues about which mode of communication would reach which target audience. It is my belief that the popular press is generally regarded as a means of reaching a mass audience of practising nurses and the academic journals are more likely to reach nurses working or studying in higher education settings. Knowing that nursing research was poorly disseminated, I wanted to address this imbalance in my own work. I believed that as well as the communication of

findings, that these activities would also help raise the profile of the Trust, the SG initiative and participants' achievements and my own profile, so fostering networking opportunities in particular. Previous study and instruction in communications and marketing strategy development further stimulated my thinking. Furthermore, a stimulating workshop on writing for publication had made me further aware of the need to disseminate and common barriers to doing so. I also enjoyed presenting seminars and workshops and consciously wanted to develop these skills further.

The general research community and literature with which I was in touch as a university student further highlighted to me the importance of being able to defend my work against interrogation. I recognised and welcomed this as an opportunity to have my work constructively criticised in ways I may not have thought to do myself. Presenting findings in person meant that questions asked of me by an audience could be useful in challenging my approach to the research and prompting me to explain myself better. This had potential for immediate feedback, unlike written material. A lack of UK SG literature also meant that there was a niche needing to be filled, not least as there has been a growing interest in leadership initiatives such as SG in the NHS in recent years.

My interest in evidence-based practice was added to by the collaborative nature of action research. Whilst I recognised the value of dissemination and my own part in it, I was equally keen to encourage the research participants to engage in publicising their work also. As co-researchers, I saw it as my role to develop participants' research awareness.

iii) *New perspective.* Rarely did participants seek out dissemination opportunities. Whilst this was discussed with them, and they acknowledged they had a role to disseminate locally, this was done minimally in practice. As for wider dissemination, I acknowledge this was more of a concern for me than for them, but it was my personal objective to encourage their involvement as much as possible. I accept that whilst my intention was good, I was imposing my view on them with this regard and that I have a permanent sub-agenda of encouraging all colleagues to disseminate. With regards to this study, I did not view it as an option not to disseminate. Options merely concerned the particular media to be used. SG project leaders initiated a Trust SG Newsletter, although maintenance of this by participants, whilst encouraged, was little heeded. One council independently developed an annual report, whilst another developed its own newsletter

which was detailed and regularly produced. A Trust SG Bulletin was initiated by council members and later refined in the light of feedback from Trust staff.

A range of dissemination measures were taken by me with the major ones listed in Appendix 26 - Dissemination Activities. A SG Information Leaflet was also developed and distributed Trust-wide. Several attempts at publication have met with variable success. Attempts at co-authoring a book chapter with two project leaders did not come to fruition due to time constraints, and so I wrote this chapter alone. Various summaries of findings and the study's progress were submitted to the Trust SG Newsletter, MHC Newsletter, Trustee (Trust newsletter) and Shared Governance European Network Newsletter. I have been able present at seminars within the Trust and at local universities as well as conferences at local, regional, national, and international level. My efforts to engage participants in these endeavours were occasionally successful including a council chair co-presenting at a local hospital's best practice conference and presenting a poster at our own Trust's best practice event. Furthermore I have acted in a consultancy capacity to three newly developed directorate-based councils in Primary Care, Maternal and Child Health and the Learning Difficulty Service.

In terms of evaluating these efforts, I think dissemination has been very successful and extensive. The area in need of strengthening is publication in academic journals.

Summary

As has been demonstrated, reflection was not undertaken in discrete stages and at many times issues were revisited, re-examined in the light of new experiences and, where appropriate, new perspectives were realised. Reflection has enabled problems and events in the field to be defined and critically analysed. Thus action taken on my part has been shown to be grounded in my previous knowledge and experience and refined in the light of application of new knowledge and understandings. This section has illuminated the effect that I personally have had in the research setting due to the participative nature of my role. It further demonstrates the self-awareness that is a pre-requisite for this kind of research endeavour. The foci of reflection have included issues around the role of the researcher, promotion of involvement, feedback of findings and promotion of change. It has been illustrated that the role of an action researcher is a responsive one that cannot be mapped out neatly in advance. Responsibility for the

conduct of action research lies with the researcher, and common concerns about the welfare of participants and facilitating rather than manipulating change have been explored.

PART 3 - Impact on the Researcher

Introduction

In this section, insight is given as to the effect this study of SG decision-making has had on me as the researcher. To not do so would render the reflection process incomplete. The section includes what I have learnt along the way and how I have developed personally.

Learning

The study has impacted on me in a range of ways that I am aware of, and these are summarised here.

Knowledge

Whilst some of my learning has been done through taught mechanisms, my most beneficial learning has been through 'doing'. Understanding of research design, methods and their application have been enhanced through modules, workshops, conference attendance and reading and so on. The most exciting part of learning has been the integration of what I have learnt into my practice. Only in that way have I been able to fully appreciate the importance of matching the nature of the inquiry with a research approach founded on complementary principles. From an appropriate approach, suitable methods will follow, bearing in mind there are no wrong or right methods, just those that are most suited in the researcher's opinion. Whilst methods should be suited to the research questions, it is up to the researcher to convince others of their appropriateness, although by the time methods are highlighted, preceding arguments about methodological approach should perhaps have made implicit what methods would be appropriate. This I believe has been achieved by researching SG with action research.

Creativity

I now have a greater grasp of the scope for creativity in research design. I no longer believe that accepted methods need be viewed as prescriptive, but that they can be refined accordingly to fit a situation. What is important is that a rationale is given for choices made so that others can appraise these actions and also learn from them. For example, I have not identified advanced data display use within any other action research studies, yet these fitted with this particular enquiry that focused mostly on the processes of decision-making. Other action research studies use quantitative approaches, and whilst not common, I would not suggest these as inappropriate in any way, more that action research simply favours qualitative approaches over quantitative ones.

Familiarity

One effect on my learning is the recognition that not all research practices feel comfortable and yet these should not be avoided because of this. There is a real risk of only using methods with which we are familiar or experienced in using already. This could mean that inappropriate methods are used and future learning concerning new approaches may be inhibited. Other tactics could be avoided, as their utility is not seen by an under-receptive researcher. For example, in my experience many students seem to dislike writing reflective diaries and learning agreements, yet it does not mean they are not valuable just because their relevance or future value cannot be seen immediately.

Mastery of Qualitative Approaches

Qualitative research is not the easy option. Whilst I knew this to some extent before the study, I can now confirm it with renewed vigour! Understanding and application of the components of qualitative inquiry is a complex and time-consuming process. Much of this is to do with the evolving nature of the design and the duty of the researcher to be responsive to ever-changing circumstances. Whereas with quantitative designs, most details are finalised and adhered to from the beginning. I know qualitative work to be mentally challenging and at times physically and emotionally demanding, as fieldwork situations can require prolonged concentration for hours at a time. Interpretation and constant questioning of those interpretations is a difficult task. To then write up interpretations and conclusions in such a way as to convey a clear message to others is equally challenging.

Gaining Experience

Research experience is gained by doing. Researchers have to acknowledge themselves as learners even when they are very experienced so that they remain receptive to new insights and ways of undertaking an enquiry and prevent stale repetitive research that adds little to our understanding of a phenomenon. There is a view that researchers should become expert around a defined programme of research and add to the body of that knowledge. Whilst I see the merits of this, I now view that there is also benefit in being involved in a variety of study types as a means of pushing a researcher's boundaries. I suppose this stems from my interest in promoting research capability and reflection on what I have learnt by taking a risk and trying what were, for me, challenging new approaches within my research. I therefore more fully appreciate the potential for working in research teams as opposed to being a lone researcher, as a means of infusing a range of perspectives and skills into a project.

Participation

I have a better grasp of the value of engaging participants as co-researchers in an enquiry. At the outset to the study, my view of participants was mostly that they were a means of promoting ownership of change and validation of findings. I now view their involvement as much more than that. Despite participants in this study having little by way of research experience, they have proved to be invaluable in questioning my approach to the study that in turn enabled me to critically analyse my own assumptions and actions and improve the design and my own performance. I have learnt that much rests on being able to negotiate an agreed way forward so that hopefully a win-win situation results. However, it is acknowledged that not all decisions will suit all people as each has different expectations and values. What is helpful is to establish these differing perspectives and be responsive to them as deemed appropriate. Yet ultimate responsibility for the research rests with the researcher. It has been reinforced to me that this is one of the reasons that transparency of decisions made within a study, especially how findings were arrived, at is central to achievement of a quality study.

Subject Knowledge

As could be expected, I have learnt a significant amount about the concept of SG and action research methodologies. Combining the two in this study has developed my appreciation of how SG will vary in its application in different contexts and honed my analytical skills for reviewing its application. This has been demonstrated by being

consulted as a modest authority on the subject of SG in terms of being asked to speak on it at conferences and at networking events and at Trust visits by colleagues from other NHS organisations. My knowledge of the subject and my understanding of the need to be critical have put me in a position whereby I can advise others wanting to implement SG appropriately and not make sweeping recommendations that are ill-founded. Thus, I know the limits to my knowledge with this regard. Ultimately my SG knowledge is now underpinned by local knowledge of its application and not based on mere rhetoric.

Research Tools

I also came to realise that learning about doing research was not just about developing skilled application of methods, but gaining a sound appreciation of other research tools. Examples include use of learning agreements, the role of the supervisor, critical friends, research advisory groups, access to data agreements, reflection and so on. Making considered use of these as adjuncts to a research project can add significantly to its conduct and promote its successful completion.

Personal Development

I have become aware of my personal development in a number of ways. In summary, by far the biggest impact of this research endeavour on me has been the enhancement of my critical thinking skills. This has been useful in both my research and non-research work. In my clinical work situation, being critical is central to exploring issues fully, seeking alternative explanations for things and considering choices before taking action. I think being thorough in this way is generally advantageous. Yet at times I have wondered if this has stifled some of my practice that is based on tacit knowledge, as I think through things thoroughly and am sometimes guilty of over-analysing even simple situations. I am even aware that this has spilt over into my personal life too, as I have tried to view the majority of things in 'black and white' with a displayed intolerance for anything 'grey'. I imagine that this will settle once I am not heavily engaged in the study and partake in studies of a less intense, all-consuming nature.

Additionally, I have developed a range of practical skills pertaining to use of a range of research and computer equipment. Skills acquired, such as use of the Internet and evidence retrieval, are directly applicable to my non-research activities and have had a profound effect on my ability to perform in my professional life. Yet other skills such as

use of statistical packages have been short-lived, due to not using them on a regular basis.

I have further developed my thinking and writing skills through practice, responding to feedback such as that from my academic supervisor, and being aware of the need to communicate differently for different audiences. This has helped me when writing research bids, progress reports and business cases and when mentoring others undertaking academic work.

My interviewing technique has improved through practice and reflection upon it and by close examination of the responses I received to some questions. These skills are again transferable to my professional work when gaining the views of patients, relatives and colleagues. Similarly, my presentation skills have notably improved through practice at seminars, conference papers and poster presentations. Important elements such as keeping to time, anticipating and responding to questions, responding to different audiences and delivering a clear message have been practised and refined.

I have generally benefited by a broader knowledge base, which is in part due to being situated within an academic community during the research study. This has made me more aware of issues relevant to the research and higher education sectors and it has been useful to have this greater appreciation. Most useful has been a greater insight into national research and development strategy and debates, including research governance and the Research Assessment Exercise and how these affect my own work.

Looking to the future, I identify my immediate development needs as concerning writing for publication, student supervision at Degree and Masters level and further involvement in research projects. In the long term, having consolidated my learning further, I would like to develop my teaching skills with an emphasis on research, research management and supervision of doctoral students. I am already making steps towards my immediate goals, which will in turn underpin my latter goals.

Summary

This section has set out the key areas of knowledge development during the research study. These pertain to the research topic itself, the skills and good practices required to

undertake research of a high quality and practical, technical skills. The impact of this knowledge and the effects of the research on my personal and professional development have been outlined. The section concludes with identification of my future researcher development needs.

Conclusions

This chapter has presented an overview of reflection principles and a model for organising reflective activities has been presented. Key issues addressed during reflection in this study are presented along with examples from practice. As illustrated, there is substantial merit in the process of reflection and in sharing some of the insights from these processes with those who are to judge research findings. To draw on reflective elements is also viewed as beneficial in fostering a degree of transparency concerning all stages of a research project. The alternative may be presentation of a 'sanitised' account of a research endeavour that gives little insight into the evolution of the study design, the influence of the researcher on findings, or the challenges, tensions and successes experienced along the way. The chapter has concluded with consideration of the impact of the study on my learning and my personal and professional development.

CHAPTER 8

DISCUSSION & CONCLUSIONS

Introduction

This final chapter is comprised of four parts. Parts 1 and 2 adopt a methodological stance. Part 1 provides a critical discussion of the action research approach used within this study, and Part 2 presents a critical examination of the methods used, including concept analysis, case study, participant-observation, interviews, secondary data and data displays. Strengths, weaknesses and limitations are identified. The discussion then moves on in Part 3 to examine the substantive findings of the study, which are compared with the relevant theoretical and research literature. The chapter and thesis conclude in Part 4 with presentation of the study conclusions, the implications of findings for policy and practice and areas in need of further research.

PART 1 - Research Approach

Introduction

This section will now look at how an action research approach has been used to enhance understanding of SG decision-making. Framing of the discussion around Waterman *et al*'s (2001) guiding twenty questions for assessing action research studies was considered but found to be of limited value. This is because these authors wittingly include guidance of a generalised nature that is not specific to action research. Instead, as previously, the discussion centres on the seven elements of action research identified by Hart and Bond (1995). This approach is thorough in ensuring that all of the key components one would expect to be evident in a quality action research study are examined.

Use of Empowering Action Research

Action research has evidently been a most appropriate approach for investigating and strengthening SG decision-making. Each of the seven elements of action research (Hart & Bond 1995) as applied in this study is now discussed.

1. Educative

As demonstrated in Chapter 7 - Reflection, use of action research has had a considerable effect on the researcher's learning about the study setting, the participants and their views, actions and abilities, and the researcher's own personal development. This is attributed to the strong reflective elements that are intrinsic to action research, both within the action research cycles and during the overall reflective practice that is common in such endeavours. The intention of this study to improve decision-making has been met well by the ongoing learning processes of discovering what works in practice and then applying these to other situations. Most learning was evident at a local SG council level, although wider organisational development in response to ongoing local learning processes has been evident. Examples include other directorates that have been informed and aided in developing their own SG models and the wider changes made to Trust strategy such as the merging of clinical governance and SG strategies.

For learning to be transferred to the organisational level a number of pre-requisites have been suggested. These include the uncovering of new knowledge and ability to adapt to it, planning for learning and the valuing of learning catalysts in the learning processes (Lorange 1996). The Trust has demonstrated its commitment to learning from SG implementation by its decision to make a substantive researcher appointment to study the SG model, by its expressed preference for an empowering action research approach, through appointment of several SG project leaders, and heavy investment in Trust-wide leadership development training to support SG. It has been beyond the scope of this study to measure organisation-wide learning attributable to it, which suggests this as an area for future research. Within and beyond the organisation, a potential for further learning has been made possible by the presentation of the conceptual model of SG decision-making within which earlier learning is reflected.

Whilst significant, further local level learning could have taken place, given more

investment in release time for participants to reflect on their learning and emergent findings throughout the study period. Much is also dependent on whether participants are willing to learn, especially as in this case, they had lots of other demands for their energies placed upon them. Others argue that reflection is still somewhat new even within nursing, and staff struggle with this practice (Meyer & Batehup 1997). In this study, opportunities for participants to reflect occurred mostly in group situations, which may not have been the best forums for them to share personal feelings, experiences, inadequacies and successes (Smith 1998). McGill and Beaty (1995) counter this argument and suggest that more rich and challenging learning may ensue from shared reflection. Other action researchers (Titchen & Binnie 1993b) have recognised the value of time out for participants in the form of away-days to examine data and explore interpretations and solutions to problems. On considering these issues, learning is to be maximised by ensuring that both adequate time and suitable group and individual forums are available, in which it can take place.

2. Individuals in social groups

Working with Trust staff in their working environment has promoted outcomes that are socially and scientifically valuable (Greenwood *et al* 1993). Shared understandings have been made possible through participants' involvement in the study design and in making sense of the insights gained. Methods used in this study have enabled individual and group perspectives to be obtained and compared to promote further understanding. Participants have grasped well the mechanisms of action research and both recognised and acted upon the need to be evaluative of their development within the SG initiative from the outset. Fortunately, gaining access to the groups, which is a potential problem of empowering action research endeavours, was not problematic, due partly to participants' enthusiasm and the type of researcher role adopted. A key risk involved in action research is ensuring that it is not used as a means of imposing a managerial change under the guise of an empowering approach (Hart & Bond 1995) although action research has openly been used to implement top-down change (Searson 2000). Meyer (1993) has further argued that participants may be vulnerable if a study has organisational approval to take place and so may feel obliged to participate. This was not the experience here, as participants were very receptive to SG implementation and the study. Participants shared a number of other unrelated apprehensions quite openly and understood that they had a true choice in whether to be involved.

A minor difficulty noted at times concerned the fact that the empowering approach adopted by the researcher contrasted with what was personally viewed as a more instructional approach by the SG project leaders. In practice this was illustrated by direction being given to participants by the project leaders rather than giving them choices or encouraging them to identify options, as was the researcher's preferred approach. An example of this was when participants and the researcher shared a view at one stage as to how the Trust SG model could be refined, yet this was not accepted by the project leaders who adapted it a different way. Whilst discussion, presentation of evidence and negotiation were used as tactics to try and overcome this difficulty, the project leaders had firmly made their minds up concerning their preferred model. Similar difficulties have been reported in other action research case studies when senior hospital managers had badly received constructive findings despite them being validated with participants (Hart & Bond 1995). In the case of these authors, this breakdown in researcher-client relationships contributed significantly to the near demise of their project. In this present study, boundaries to how far the researcher's empowering influence could extend were identified. Such influence was found to preside in the councils, yet influence beyond these groups required a degree of negotiation with final decision-making residing with the project leaders.

3. Context-specific, problem-focused, and future-orientated

As detailed in Chapter 1 - Introduction, the climate in the Trust at the time of the study was suited to both SG implementation and use of an action research approach to investigate it. Underlying principles of SG have been found to be similar and so complementary to action research, including empowerment and participation. Through participative processes, the clear problem-focus of SG decision-making was identified from within practice, and an aim agreed to investigate and prompt improvements to future decision-making. Susman and Evered (1978) point out that action research implies systems development as it encourages generation of problem solving and communication mechanisms and modifications to a system within its surrounding environment. Correspondingly, systems development is a key goal of SG. The Trust was evidently dedicated to development of a whole-systems strategy to governance (see Appendix 1 - Whole Systems Governance Strategy), thus adding conviction to the claim of appropriateness of action research use in this study.

4. Change intervention

As is commensurate within action research, change was determined in close collaboration with participants, unlike other action research approaches whereby change is planned by the researcher ahead of time (Holter & Schwartz-Barcott 1993). As an empowering action research typology had been adopted, participants identified or were made aware of aspects of their practice that might benefit from change. They then validated these prior to deciding what action to take. However, at times, findings were not validated and change was prompted anyway, or change was not achieved at all (see Chapter 7 - Reflection). Participants each have their own view of a situation and it is recognised that agreement on what constitutes a desirable improvement and a way forward is not always possible (Lyon 1998). In such situations, making recommendations or presenting options to participants is perfectly acceptable within an action research framework, as has been done here.

The researcher's desire for learning as well as change meant that less change was achieved than if a more facilitative approach had been adopted by the researcher (see Chapter 7 - Reflection). Yet it was believed that the approach taken promoted ownership of changes rather than them being perceived by participants as being the property of the researcher. Ultimately, action research can only be successfully applied in settings where participants recognise a need to change (Greenwood *et al* 1993) and are motivated to actively participate (Meyer 2000). Being able to draw on examples from participants' own practice did however help to promote the uptake of findings. Engagement of participants in the design of the study wherever possible helped to establish a study focus that they had some ownership of. This is also believed to have helped in addressing the aforementioned problem of some research being viewed as irrelevant to those it is intended to influence (Susman & Evered 1978).

The nature of the study has meant a focus on generating practical knowledge, as is common in action research. Yet being grounded in practice in this way does not mean that this enquiry has been more concerned with change than theory development, as has been suggested in other action research endeavours (Waterman *et al* 2001). Instead, a contribution to theory development has been made within this study that is rightly underpinned by investigation of the practice of decision-making. This may be indicative of the practice orientation of the researcher and participants in seeking understanding

that has considerable practical utility. This view is mirrored by McNiff (1988:8) who claims that:

> *"...a theory has no real value unless it can be demonstrated to have practical implications."*

Thus the criticism that action research focuses less on theoretical concerns has been defended against by using methods to gain an understanding of how and why decision-making practice was executed in the way it was.

Hart and Bond (1995) point out a risk of empowerment of participants as being the slowing down of the research process, but suggest that this process cannot be hurried. Yet Gill and Johnson (1997) believe a more active involvement by the researcher, rather than encouraging the participants to decide action, is more appropriate at facilitating greater degrees of change. During this study, change processes were at times fairly slow, as experienced by other action researchers (Waterman 1996) yet it is recognised that hurriedly implemented change is less likely to have been sustained. Despite Holter and Schwartz-Barcott's (1993) earlier suggestion that it is acceptable for the change intervention to be pre-determined by the researcher, this was not the preferred option. What was important was that exploitation was maximally avoided by placing a considerable degree of responsibility for change in the hands of participants.

As warned by Holter and Schwartz-Barcott (1993) difficulties were indeed experienced as participants resigned from their council seats. This was particularly due to the lack of handing over of information about where participants were up to with council issues, causing remaining members to flounder. In this case, the stepping down of participants and orienting of new ones was addressed but still presented a particular challenge as hard earned progress was quickly undone when participants left abruptly. Such difficulties are not uncommon in healthcare action research compared with educational action research, whereby the former has a tendency for higher participant turnover rates (Waterman *et al* 2001). Other health care action researchers have been challenged by the repetition of new participants joining a study with resultant difficulties in trying to maintain changes already made (Meyer 1993) as has similarly been experienced here and addressed through orientation processes.

5. Improvement & involvement

Following accepted guidance (Dick 1999), the study purposefully drew on decision-making theory mostly at the end for comparison with findings. This accessing of literature late on is a measure aimed at minimising the tainting of insights emerging in the field with preconceptions developed through in-depth knowledge of existing theory. However, the integration of practical and theoretical insights is recognised as a valuable strategy for promoting learning and action. The alternative approach of combining some of this theory with the insights gained through practice during the study may have further strengthened participants' learning and led to further improvements being made. However, this can only be surmised and not predicted with any certainty. This was not a desired step to be taken in this endeavour, as the study sought new understanding of SG decision-making with minimal preconceptions and intentionally did not examine accepted decision-making theory early on. Instead, the integration of accepted theory and change promotion may be worth considering in future research endeavours that focus more on changing practice and less towards theory development (see page 65).

At times participants did lose direction. Lewin (1946) has warned that this is a potential problem when empowering participants to determine for themselves what improvements are to be made. This was viewed as an acceptable part of their development. Participants often demonstrably learnt from their experiences, including their mistakes, and constant intervention to keep them on course was not considered the best way of reinforcing their learning. An example is when the one of the councils recognised that its acceptance of a large and ambiguous issue to address contradicted earlier advice about the size of council issues, and resorted to use of a problem-solving model to simplify the issue (see Chapter 7 - Reflection). This element of action research has been particularly demanding and has required a fine balance to be achieved between allowing participants to work through challenges and intervening.

6. Action research cycles

The process of using action research cycles has worked well in practice. This process, with similarities with the nursing process (Hart & Bond 1995), involved constant comparison elements comparable to the longer-established approach of grounded theory (Strauss & Corbin 1998). The substantive evaluative component of action research

cycles has been fitting in exploring primarily process issues around what works and identifying possible improvements for decision-making. The main advantage of the cyclical approach to action research has been its rigour, as insights and tentative conclusions are checked out again and again. Validity is enhanced through this process of corroboration as assumptions about causal relationships are tested out (Karlsen 1991). Furthermore, the systematic approach to development of cycles through observing, planning, acting and reflecting has made it possible to have focused discussions concerning their composition with the Trust research assistant acting as a critical friend. Thus a more objective and critical view was gained in addition to the researcher's own necessarily subjective view of these important cyclical processes.

A further advantage is the way that the development of cycles permitted formative findings to be shared throughout the study, thus avoiding the limited application of findings when only made available at a study's end (Kennerly 1996). Others have found the evaluative element of these cycles to be of particular benefit in their own development of clinical supervision practice through action research (Lyon 1998). Use of this cyclical approach maintained interest and involvement of participants and stakeholders as they were regularly engaged in considering emergent findings. It has been possible to relay findings in a timely manner, thus realising immediacy of impact and maximum utility. Where findings have not had an impact as expected, learning has often still occurred and so positive outcomes from the research process itself have been realised (see Chapter 7 - Reflection). This view is supported by Meyer (2000) who comments that it is important not to judge action research on the size of its impact as the learning along the way can be just as important. Therefore, to adopt an alternative strategy that rested mainly on summative findings being presented at the study's end is likely to have reduced both impact and learning.

Reporting on the findings of action research is not without its problems. Waterman *et al* (2001) note the difficulty presented by the cyclical nature of action research and how it is not always easy to communicate the repetitive movement between these phases within research reporting. This was a problem in this study as for a time, in the early stages, it was difficult to show how findings were arrived at. Processes for developing findings appeared ambiguous to the untrained eye and a decision trail was not clearly evident. Additionally, establishment of causes is recognised as difficult within action research when numerous contributory factors may be at play (Waterman *et al* 2001).

Once these issues were identified as problematic in this study, steps were taken to rectify them, which were achieved primarily through use of data displays. These proved to have some explanatory power as well as being a useful means of communicating findings. A further step was to create some movement between an empowering and a more experimental action research typology. This enabled considerable focus on the research element as well as the action element, thus further supporting identification of causal relationships in group dynamics (Hart & Bond 1995).

7. Participation

Participation is a key element of action research and has been optimally promoted throughout the study. Such involvement is a means of harnessing experiential expertise and it has been said that those who do a job often know most about it (Whyte 1991). This has been a successful measure at cultivating meaningful involvement of Trust staff in a study aimed at making improvements to their work practices. In their writing on learning organisations, Pearn *et al* (1995) suggest that workers should be equipped to analyse their own needs and develop action plans, as this will promote more commitment than the imposition of plans by others. Such participation has been appropriate in this study in view of the empowering philosophy of SG and probably reduced the potential for top-down change to be imposed. Opportunity for participation was however limited to council meetings and workshop events. More time for participation and review of emerging findings in additional forums created for this purpose, would have been ideal but this was not available.

The researcher's own participation in a researcher role capacity has been valuable. Whilst Morse and Field (1996) suggest that outsider researchers may benefit from enhanced researcher credibility, the experience here has been comparative. To prompt change in people's working lives has been viewed by the researcher as a big responsibility. McNiff (1988) goes further and suggests that action research becomes political as it impacts on people's lives. It is believed that participation as an insider researcher, familiar with the Trust context and ways of working, and having a health care background when working with Trust staff, has been advantageous in understanding the perspectives of participants and their situations. Furthermore, being an insider has meant having the authority to act as a change agent (Titchen & Binnie 1993a). It is recognised that the insights gained may not have been grasped so well in a

study using a less participatory approach. In addition to this necessary closeness to the setting, a degree of distance that is essential for good analysis has been assured by not having had previous experience of the research topic (Richards 1998).

The danger of manipulation through participation (Meyer 1993) has been guarded against and substantive efforts made to use reflective processes as a means of ensuring that participatory techniques were used appropriately (Greenwood *et al* 1993). The collaborative nature of action research has been a crucial element that has fostered positive and trusting researcher-participant relationships. This has been demonstrated through the joint decision-making pertaining to study design and actions to be taken, evident throughout the study (see Chapter 7 - Reflection). Additionally, this closeness of the researcher to the issue being investigated has been an asset that has enhanced validity (Waterman *et al* 2001). A similar view is evident in Chisholm and Elden's (1993:294) comment on collaborative research:

> *"...an open research process and a collaborative role, oriented to discovering together with members how the system functions, tends to lead to generating information that is valid both internally and externally."*

Yet Waterman *et al* (2001) also note that closeness to the data is conversely regarded by some as a weakness that promotes unclear researcher roles and subjectivity. Possible threats to validity through the researcher's close involvement were countered by means such as continual validation of emerging findings with participants, verification of data displays and use of a critical friend to challenge emerging interpretations. Even the actual processes of enhancing validity have been found to further build trust, as in Titchen's (1995) study that involved collaborative research with a group of hospital nurses.

Summary

This section has evaluated an action research approach as being appropriate and successful at achieving the aims of this study. It has been fitting with the insider researcher role required to realise sufficient closeness to the data as to gain an understanding of the SG decision-making situation being investigated. The degree to which the key criteria of action research have been achieved has been appraised. The

choice of action research has subsequently been demonstrated to pay dividends concerning the education and development of the researcher and participants, the adoption of a rigorous cyclical approach to integrated data collection and analysis, and the facilitation of owned change. These claims as to the strengths of action research have been balanced against the weaknesses identified within the approach that have consequently been minimised. These include the risk of researcher bias, potential for manipulation of participants, and difficulties around informed and ongoing consent. Overall, action research has been demonstrated to be a suitable vehicle to realise the study purpose.

PART 2 - Research Methods

Introduction

This section examines the qualitative approach and various methods used within this study including i) Concept analysis, ii) Case study design, iii) Participant-observation, iv) Individual and focus group interviews, v) Secondary data and vi) Data displays. All methods have advantages and disadvantages over each other and it is up to the researcher to determine the best fit to answer the study aims and questions. The degree of success met by each of the methods selected for use in this study is considered here. Similarly, each method has different means of enhancing reliability and validity and the extent to which these were achieved is also discussed.

Use of a Qualitative Approach

Epistemological choices frame qualitative research, and in this study a qualitative approach has been the most appropriate to embrace an action research study. A qualitative approach has been essential, as the nature of the research aims have required democratic generation of knowledge with and by people (Drisko 2000). Researcher involvement as a change agent, describer and collaborator are known to influence later analytical decisions (Drisko 2000), which is not compatible with a quantitative approach. Furthermore, qualitative enquiry has enabled a closeness to the phenomena being studied that is not possible through quantitative approaches (Parahoo 1997) enabling a substantive understanding of SG decision-making to be gained.

The concepts of reliability, internal and external validity, and objectivity are sometimes exchanged for the alternative terms of consistency, truth, applicability and neutrality in qualitative theory texts (Lincoln & Guba 1985). Reliability and validity of data affect the ability to draw wider inference from qualitative research and are dependent on employment of suitable methods. Yet qualitative research is more concerned with validity, which is a strength of such approaches, than reliability, as multiple realities are generally assumed to be present in the field, making replication an impossible and undesirable objective (Morse & Field 1996; Parahoo 1997).

Steps have been taken to promote optimum validity, and reliability where appropriate, to ensure the rigorous application of qualitative methods. Choice of study topic in conjunction with participants has helped in promoting 'neutrality' (Lincoln & Guba 1985), which is the degree to which findings have not been based on the researcher's biases, motivations, interests or perspectives. Appropriateness of methods has been demonstrated through giving a detailed rationale for their selection. Participation as an insider researcher has been a particular means of promoting internal validity. Familiarity with the setting has helped shared meanings between the researcher and participants to be arrived at whilst avoiding the pitfall of 'going native' (Morse & Field 1996). Concerns when initially selecting a qualitative approach, such as the researcher's practice orientation leaning towards qualitative research (Strauss & Corbin 1998), have not presented a problem and have worked well, as the participants' orientation has been one of hospital-based health care delivery also. Any recognised potential for bias has been countered by making explicit the conceptual framework underpinning the study, identifying one's personal paradigm and reflecting on these during theoretical memo development. Similarly, other concerns around the lack of understanding and immaturity of a concept (Morse & Field 1996), in this case SG decision-making, have made for appropriate use of a qualitative framework.

Application of Methods

i) *Concept analysis*. The undertaking of a concept analysis has been an essential technique within this study. Concept analysis aims to identify and define phenomena to be studied to maintain a clear focus and identify extraneous variables for exclusion in a research endeavour. It is based on a positivist philosophy that values reduction as a means of clarifying components of a concept (Coyne 1996). In this study, the concept of

SG has been shown to be ambiguous and variously defined, which could have made its investigation much more difficult. Indeed a lack of clarity as to what this concept comprises is a particular problem recognised within the SG field (Hess 1994). Use of Walker and Avant's (1988) model of concept analysis has been found to be effective in discerning the similarities and differences of SG with related concepts such as participative management. Although not identified sufficiently early on in this study, alternative concept analysis models exist, for example the Rodgers model (Coyne 1996), which others may consider using.

The model has been of further benefit in considering the generalisability of study findings. By establishing the components of the different types of SG models in the way required for concept analysis, comparison between SG models and findings pertaining to them is made more meaningful. Identification of like-for-like SG models is made possible, whereas the alternative would be attempting comparisons between widely different SG models. Thus, concept analysis can minimise the risk of sweeping statements of generalisability being made. Construct validity is promoted by use of concept analysis (Walker & Avant 1998) and in this study this has been achieved through operationalising the concept of SG by identification of its defining attributes. Thus the erroneous investigation of a related concept, thinking it to be SG, has been avoided.

As with any model, there are limitations. The main one concerns the suggested step of identifying an imaginary case. Its suggested use is as a means of gaining a true picture of a concept by applying it to an invented situation. Following initial attempts, this step was finally omitted from the analysis due to no perceived benefit being achieved by it. Other investigators have similarly adapted the model for their own use by omitting this step in the analysis process (Hokanson-Hawks 1991; Rodwell 1996; Wilkinson 1997).

ii) *Case study design.* Use of a single, embedded case study design has proved appropriate in investigating the Rochdale model of SG. The review of the literature has shown, that whilst similar to other councillor models in the UK, this particular model differs in that it is multidisciplinary and comprises both councils with a Trust-wide remit and directorate-wide remit. The purpose of exploratory case study design is to investigate phenomena about which little is known, and so it has been suited for use here.

A key advantage of the case study method has been to maintain a clear focus on the design and direction of the research. This is done in part by clearly stating the unit/s of analysis within case study research, thus ensuring that the concept/s under investigation are defined giving the investigation clear boundaries (Yin 1994). This has been achieved in this study by using the complementary method of concept analysis. Thus together these two methods have helped prevent any unintentional deviation from the intended study focus. The case study method has permitted investigation of the council model as a whole and broken down into its component parts, that is each individual council and members within them as sub-sets of the overall case. This process of identifying components of the case significantly aided the theoretically guided sampling processes used within the study. It conveyed the councils from which a sample of two contrasting councils could be selected and illuminated the population of council members from which a sample of individuals could be drawn. Thus it was made possible to identify maximum diversity samples that would be likely to meet the research aims.

However, the framework offered by case study research should not be confused as being constraining. Indeed, a key benefit of the case study method as realised here is its flexibility to adaptation as a study progresses (Robson 1993). This is important because a study context can change over time (Yin 1999) as has occurred in this study when the SG councils reconfigured and one of the sub-cases (the Human Resources Council) was no longer available. The fact that this unexpected event occurred further justifies the attention paid to sufficiently appreciating and illuminating the context of the research inquiry as part of the case study. This was done as a means of promoting understanding of the setting as well as accounting for changes in the case/s being studied, hence the dependability of the study has been enhanced (Marshall & Rossman 1989).

Another advantage has been the utility of the case study method at incorporating a range of methods as a means of triangulation (McDonnell *et al* 2000) and as a means of countering the shortcomings of one method by use of another (Barbour 1998). The methods used within this study have fitted well with a case study design and have enabled cross-comparisons to be made within and between the data as they were collected. As Smith and Cantley (1985) argue, a study can be at risk of being 'method-bound' if a single data source is depended on. Thus, seeking rival explanations and integrating these into the study design (Yin 1999) has enhanced the overall case study

quality. The use of a case study approach has permitted an evolving research design in the light of emerging insights, which is fitting with the overall action research approach. Therefore Morse and Field's (1996) view that suitable approaches are needed to reduce the risk of invalidity has been heeded. Furthermore, in congruence with Bromley's (1986) standpoint, rigour has been promoted by use of mixed methods.

A particular expectation of the case study method had been its fit with an action research approach. On reflection, these have worked well together as, through action research, a contribution towards explanation of SG decision-making has been realised as opposed to exploration only. The rigorous approach to analysis demanded by action research and responded to in this study has enabled a key weakness of case studies around inadequate analysis (Yin 1994) to be avoided. The marriage of case study method and action research has been recognised by others as being compatible (Gill & Johnson 1997) and having great potential value to nursing research, which is often undertaken in practice settings (Sharp 1998).

A further weakness of the case study method is acknowledged around generalisability of findings. It is argued that those who believe the case study method lacks representativeness (Hamel *et al* 1993) do not appreciate that the actual goal is one of gaining a greater understanding of a particular case (Stake 1995). Qualitative sampling as used here is expected to achieve an atypical sample, as sampling is not based on demographic characteristics but qualities of the informants (Morse & Field 1996). Instead, theoretical generalisability has been made possible within other settings; hence a degree of external validity has been achieved. That is, in addition to a correlation being found between a sample and the wider population from which it was drawn, an explanation is offered as to why the correlation exists in principle (Sharp 1998). In this case, not only have factors affecting SG decision-making been identified, but the relationship between them has been proposed also. As Sharp (1998:788) points out:

> *"...one crucial determinant of whether it is possible to make a theoretical generalization is whether the case to be explained has certain features in common with the case where the explanation was developed."*

The theoretical sampling used here has achieved relevance as opposed to randomness and representativeness (Popay *et al* 1998). Therefore it is argued that those who wish to

consider the application of these study findings to their own SG situations will be aided in reaching their conclusions by the clarity of definition and description of the case, its context and sampling within it afforded by the case study method.

Arguably, a further weakness of this study design is its lack of a pilot case study (Yin 1999). Yet it is counter argued that there was insufficient time and other resources to do this, even if it had been a design preference. The action research approach and flexible case study design adopted meant that refinements could be made to the design in the light of learning once the study was underway. Thus a lack of a pilot study has not been found to be a particular weakness in practice.

A further suggestion concerns use of control groups (Gill & Johnson 1997). There are several reasons why 'traditional' control groups, perhaps by way of a multi-site study, were not incorporated. Firstly, the single case study design was appropriate for investigating the Rochdale Trust due to its distinctiveness as an integrated hospital and community provider and its combined Trust-wide and directorate-wide SG model. Secondly, there exist limited numbers of UK SG organisations for comparison and subsequent access to these would likely have been difficult. Thirdly, control groups would risk a loss of the naturalism that has been a desired feature of this study. Lastly, limitations of being a sole researcher would have prevented the research aims being addressed fully in more than one setting. Instead, alternative 'internal' comparison techniques were employed. For example, comparisons were made between the two most contrasting councils and amongst a broad range of participants. The methodological techniques adopted further permitted comparison of events and occurrences in the field, across data sets, and between interpretations and data displays. Comparison of study findings with those from other SG sites was achieved through examination of the SG literature.

iii) *Participant-observation.* Use of participant-observation as the main method within this study has proved very appropriate. As a means of investigating phenomena in their natural surroundings, participant-observation has enabled in-depth exploration of council members' decision-making in action. A key criticism of participative approaches concerns the lack of critique of the intended degree of participation versus the realised extent of participation (Greenwood *et al* 1993). In view of this, and as discussed in Chapter 7 - Reflection, it is important to point out that the researcher role

achieved leant more towards that of observer-participant than was originally expected. However, this worked well, as more pure observation prevented an unmanageable blending of researcher and agent of action roles to occur. Susman and Evered (1978) point out that once a change is initiated, the researcher should rightly stand back and look to see if the outcome expected by the change is achieved. They say that to not do so would nullify the significance of the prediction. Furthermore, not feeling too 'at home' and keeping some sense of 'distance' is essential to ensure maintenance of a critical and analytical approach (Hammersley & Atkinson 1995). Strong participative elements built into the study at various points ensured that a meaningful participant-observer role was ultimately achieved.

The method worked particularly well alongside interviews whereby observations could be followed up at interview and ideas resulting from interviews could be followed up during observations (Graziano & Raulin 1993). For example, it was only possible to uncover participants' views around their observed tendency to have extensive discussions about council issues when at interview. Thus, interviews were invaluable at eliciting participants' explanations for occurrences. Similarly, issues raised at interview gave a greater insight into council members' feelings, such as lack of confidence and need for development, that was not evident from observation alone. To not undertake participant-observation would have been a missed opportunity to understand the participants' environment by engagement in it. Interviews alone would only have permitted participants' accounts to be uncovered and analysed, as opposed to observing phenomena first hand (May 1993), which was considered insufficient.

A further advantage of participant-observation is the degree of flexibility afforded by the method (May 1993). During the study, it was possible to adjust lines of enquiry in the light of earlier reflections. For example, having perceived a negative impact by the repeated absence of one of the council facilitators, it was possible to focus on what that person did within their role when they were present and examine the impact of their presence.

One disadvantage presented by participant-observation concerns the potential for the researcher to focus attention in the field based on personal biases. Such 'observer bias' (Robson 1993) has been identified and limited by the extensive attention given to promoting rigour in data collection and analyses including the writing of theoretical

memos and reflective notes that prompted examination of personal biases. In practice, on few occasions were such biases noted and responded to. For example, for some time it was considered that the Mental Health Council (MHC) was so competent and organised that it did not appear hampered by absence of a council facilitator. On critical reflection of this personal assumption, it became evident that the MHC could perhaps benefit from some guidance from such a person, a point later raised by participants themselves and corroborated elsewhere in the data.

As advocated by Parahoo (1997), care was taken to avoid being perceived as a threat by participants. As set within an empowering action research enquiry, there was no question that the observer role should be an overt one and a climate of trust with participants and partnership working was realised as intended. Early and ongoing discussion with participants around the researcher and participant roles is believed to have furthered the ease and maintenance of access into the study setting as suggested by May (1993). As new participants entered the research setting, their trust was built through giving of comprehensive information and assurances. Subsequent consent was gained verbally for participant-observations in an ongoing manner as suggested by Merrell and Williams (1994), and this worked well without incident. Meyer (1993) has argued that it would be difficult for individuals to withdraw from a study of a group once the research was underway. Although no participants requested or indicated a wish to withdraw, this would have been accommodated as discussed at the study outset in terms of not making reference to them in field notes and presentation of findings. To manage such dilemmas, involvement of participants in decisions concerning ethical issues such as consent and the presentation of findings was employed, as has been a similar tactic adopted by other action researchers (Williamson & Prosser 2003). Participants were similarly involved in planning the end stages of the present study. In terms of leaving the setting, in view of the known danger of participants feeling abandoned by too sudden a departure by a researcher, this was planned with them to take place gradually. This was successful up until the point of undertaking a new non-research role in the study setting at the study's end (see Chapter 7 - Reflection). However, again through honest discussion of the issue, participants' acceptance of this situation was gained.

As experienced by other qualitative researchers (Meyer 1993) and anticipated here, participant-observation took a great deal of time to undertake. In total, over two hundred

hours were spent on participant-observation including the wider evaluation study, and around eighty hours of this time was spent during the decision-making phase specifically. Yet time spent proved an investment and a necessity, particularly when the researcher's activity shifted to development of data displays to capture detailed decision-making processes. The vast majority of material for this work arose from observations and display development would not have been feasible without them. It is questionable whether less participant-observation may have resulted in the same findings and some conservation of research time. However, this could not have been known ahead of time. Whilst some authors talk of reaching a 'point of saturation' of new insights emerging from the data (Morse & Field 1996), what occurred in practice is that a judgement was made by the researcher to determine the point at which data collection should cease. This was based on spending sufficient time in the field to prevent inaccuracy over whether actions observed were instances of an emerging pattern or "...idiosyncratic to the person, time or event observed" (Sánchez-Jankowski 2002:155). Furthermore, whilst time consuming, extensive observations enabled a thorough search for supportive and contradictory evidence and so have further assured confidence in the findings presented. Thus 'adequacy' has been achieved whereby the researcher has spent sufficient time and gained adequate focus to be able to be confident that nothing of major importance has been missed, whilst similarly avoiding overly general data (May 1993).

iv) Individual and focus group interviews

Use of interviews to gain individual and group perspectives has proved beneficial. These methods have been appropriate in gaining insights not possible through observation alone (Patton 1990) and have complemented the other study methods employed. Use of semi-structured interview guides has been fitting as participants' responses have indicated new areas for enquiry. At no point did responses deviate inappropriately away from the interview topic, as is a recognised risk. On the rare occasions where this threatened to happen, the interviewer as moderator, or other participants in the case of focus groups, successfully guided the conversation back to the interview topic. Techniques aimed at putting interviewees at ease, including allowing them to choose the interview venue and beginning the interview with small talk (Morse & Field 1996), were effective. In the case of focus groups, no obvious disclosure of sensitive material or reluctance to speak in the company of others was

noted or raised post-interview, as was an anticipated risk of group interviews (Smith 1995). The likelihood of participants being at ease in a group interview situation was promoted by their origins being within natural groupings (Frey & Fontana 1997), in this case with peers from within a council, directorate and professional group with whom they were familiar.

An instance of near domination of a group interview by a particular participant did occur as warned by Kvale (1996). With use of interview moderator skills, this challenge was managed and the interview length extended substantially from what was expected to ensure all participants had opportunity and encouragement to make their full contributions. In part, this issue appeared to be due to having the larger number of eight participants in the group. Participant numbers have been noted to be a recognised problem in affecting response patterns in a group situation (Frey & Fontana 1997). Whilst within recommended limits (Morrison & Peoples 1999), it is argued that having eight participants leant itself to two or three participants remaining quiet whilst others did the talking. This scope for individuals within focus groups not to participate in discussions is a recognised problem (Barbour 1998). Yet in the focus group that comprised five participants, the smaller number made it difficult for any one participant not to contribute, as their silence was more conspicuous. The larger group was more difficult to moderate also, especially when more than one person began talking at once. Yet as expected, the conversations of some participants sparked off reactions in others (Lofland & Lofland 1995) and so a wealth of data was elicited. On reflection, focus groups of between five and six participants would have been preferable.

The eight participants selected for individual interview proved adequate and no further interviews were indicated. The verification gained through interview of these eight participants sufficiently supported the formative findings. It was possible to check out a minimal number of new insights raised by interviewees, such as the effect of personality on decision-making, with subsequent interviewees. Thus confidence in the adequacy of previously collected data and the appropriateness of this selection of interviewees was assured.

Whilst the focus group interview with the Human Resources Council (HRC) members did not take place following this council's disbandment, all planned individual interviews with three of its members had already been undertaken. Therefore, omission

of this particular interview was not considered detrimental. Flexibility in the interview sampling meant that an additional focus group interview with Clinical Professional Services (CPS) staff could be undertaken, having detected a slight nursing bias within data collected. On reflection, this bias was more an indication of the characteristics of the council member population, as nurses dominated the councils' membership. Yet as only one participant representing CPS had been interviewed individually, further insight into the CPS viewpoint was theoretically indicated. Thus the CPS focus group was organised in response to this issue.

In contrast, the focus group interview with ward managers proved of limited value. The data elicited did not help gain further insight into SG decision-making, but more the impact of SG in the practice setting. This interview had been suggested by the Research Advisory Group to gain ward managers' views on council members' decision-making practices back in the clinical area. In hindsight, this interview would best have been avoided, or perhaps a variation of it undertaken by the research assistant performing the wider SG evaluation study. However, at the time, it was considered important to accommodate this suggestion as some members of the Research Advisory Group were study participants, and had a right to input into the evolving design of the study.

Internal validity has been promoted through the transcription procedures. These have importantly noted requirements for accuracy including pauses, exclamations and expression (Morse & Field 1996). The researcher undertook the interviews with a few exceptions due to unforeseen circumstances, at which times the Trust research assistant following instruction undertook them. Whilst some interviews were not performed by the researcher, the risk of differing sensitivity and interview techniques was not viewed as a major disadvantage to internal validity. The research assistant was an experienced interviewer and was fully briefed. The researcher listened to each tape recording and read each transcript made by the research assistant prior to making amendments to ensure accuracy in the transcribed documents. The interview material and personal thoughts on it were discussed with the research assistant. Whilst the researcher not undertaking all interviews posed a potential threat to validity, this was successfully countered by these measures to train and support the research assistant and to quality control the interview work done by her. The research assistant's main contribution has been as a critical friend whose role it has been to contradict the researcher's emerging interpretations so that the researcher can subject these to further criticism before

arriving at tentative conclusions (Marshall & Rossman 1989). The advantages of the research assistant's involvement far outweighed any risk to reliability in ways such as distortion of interpretations. Additionally, 'consistency', as a means of promoting trustworthiness in the conclusions and findings presented (Lincoln & Guba 1985), was enhanced.

Finally, it is believed that within both interviews and participant-observation, risk of unreliability due to subject bias, whereby participants seek to please the researcher (Robson 1993) has been minimised. This has been achieved through the adoption of a more participatory research approach that has avoided giving participants a sense of research being done 'on' them. Also, the researcher's extended time in the field has enabled participants to retain familiarity with the researcher and so react less due to her presence. This has further reduced subject error (Robson 1993) whereby participants' performance on certain occasions may be affected by such things as being tired or unwell. Therefore, extended fieldwork has enabled insights gained at interview to be extensively compared with observable behaviours and events in the field and *vice versa*. Group interviews are also a recognised means of validating what has been observed in the field or raised at individual interview (Frey & Fontana 1997).

v) *Secondary data*. Within this study, secondary data have had a modest yet valuable use in informing the development of contextual insights into the study setting. Contextual information is valuable at various stages in a study from development of a research question, selection of a study site, data analysis, interpretation and reporting of findings (Rousseau & Fried 2001). In this case, it has predominantly aided a full description to be given of the study site, which will help those appraising the findings to consider their application beyond the study setting. As access to the setting and participants was maintained at a high level throughout the study, and because an insider researcher role was adopted within the researcher's own workplace, much contextual information was already known. Data in the form of newsletters and meeting minutes helped maintain an appreciation of other events and their chronology that occurred in the Trust during the study period. Where possible and indicated, other sources of secondary data were generated, such as the council member profiles that elicited individuals' characteristics, thus informing theoretical sampling for the individual interviews.

A further use of contextual material is in comparison of a study with previous research as a means of assessing generalisability (Rousseau & Fried 2001). In practice, modest to moderate amounts of contextual information were identified in the research literature pertaining to SG, thus aiding some comparison to be made with it. Consequently, the importance of ensuring presentation of sufficient contextual information was recognised and acted upon here to aid comparison of this study's findings with future studies. Thus 'applicability', a measure of trustworthiness of the findings, was made possible (Lincoln & Guba 1985).

vi) *Data displays*. Whilst not utilised in any other identified action research studies, data displays are recognised tools in aiding analysis within qualitative research studies (Averill 2002; Hunter *et al* 2002; Miles & Huberman 1994). Furthermore, they provide a valuable means of managing copious amounts of data. Seeking causality through qualitative research has been criticised by some for being useless, as events are not simply and singly caused (Stake 1995). Whilst some argue that qualitative research is about understanding as opposed to explanation (Everitt *et al* 1992), it is here that the data displays had a key role to play.

The researcher's view is that in this study, insight into the connections between variables that affect SG decision-making was needed. When attempting to establish *how* factors affect decision-making in order to strengthen it, it is insufficient to merely know *what* affects decision-making without some explanation as to their relationships. This is a view developed and grounded in practice during the *checklist matrix* stage of analysis. This work successfully identified which factors had contributed significantly and consistently to decisions made by participants. The key limitation of this type of display was their inability to illuminate connections between these isolated variables. This is reduced somewhat by the common practice of writing narratives to describe each display including inferences as to what these relationships may be. It was reflection on this stage of the analysis and the research aims that prompted checklist matrices to be evaluated as insufficient.

As detailed in Chapter 5 - Analysis, the inadequacies of the checklist display method spurred development of *time-ordered matrices* to gain a more objective insight into decision-making processes and connectedness of decision-making factors. Once again, the limitations of these tools led to use of more advanced data display methods to create

causal networks. These were successful in identifying the key factors affecting decision-making, establishing their relationship in terms of direction of impact whilst depicting chronology.

It could be argued that the earlier data displays were unnecessary, based on what is known now about the effectiveness of the causal networks. This is strongly contested, as what the development of this range of tools demonstrates is the refinement of analyses in response to emerging interpretations. For some endeavours, basic displays are perfectly adequate with conclusions drawn from them being highly inferential.

It is not uncommon for researchers to progress through display types as analyses deepen (Miles & Huberman 1994). In view of the intention for this study's findings to directly influence action, it was considered appropriate to be able to show participants how and why their decision-making was affected. To some extent, time-ordered displays achieved this goal, as witnessed at the decision-making workshop in June 2001 when participants examined examples of these and drew similar conclusions to the researcher. Yet these were unwieldy time-ordered matrix displays comprising many words and so difficult to absorb. Whilst useful to the researcher, they had less utility for the participants, who still had to discern the factors of most importance from the many pages. Feedback from participants concerning these displays was valuable in informing extended analyses using causal networks.

At a later point it was possible to share copies of the causal networks with a participant from the HRC and MHC for them to verify. After spending a few hours examining the displays and associated narratives, a high degree of agreement was reached about their validity. These processes prompted a return to the data to check minimal queries raised by participants, although after a rigorous search, only minor adjustment to the networks was required. Use of data verification pro-formas (see Appendix 6 - Verification Pro-Formas) as advocated by Miles and Huberman (1994) proved invaluable in guiding participants' critique of the networks. This process provided opportunity for participants to raise their own issues whilst prompting them to consider points of particular concern to the researcher.

Following refinement of the network displays and further analysis, development of a final display in the form of a conceptual model of SG decision-making became possible.

This was similarly forwarded to a small number of participants to appraise its "...faithfulness to their own experience or thinking" (Titchen 1995:42). Importantly, several elements of the conceptual model were found to be reflected in the SG Decision-Making Flowchart (see Appendix 27 - SG Decision-Making Flowchart) developed by participants at the decision-making workshop following their analysis of time-ordered matrices. This further verified the conceptual model as having validity with those who undertook SG decision-making - the participants themselves. This 'consensus validation' as it has been described (Karlsen 1991) is a recognised means of corroboration of findings amongst participants within an action research study. Since in qualitative research it is recognised that there may be multiple views of reality (Morse & Field 1996), this process of establishing validity has added confidence that the reality of participants' decision-making has been accurately relayed in the study findings. Hence further confidence in the 'truthfulness' of the findings (Lincoln & Guba 1985) has been established.

Whilst successfully used here, data displays have been described as 'template' approaches that are orderly and formal (Drisko 2000). It is acknowledged that for some researchers, the systematic and rigorous approach to developing displays may be misconstrued as imposing excessive logic and stifling creativity. Yet data displays can evolve as analysis develops, although this essentially requires a degree of creativity on the part of the researcher. Hunter *et al* (2002) argue there are a number of psychological barriers to creative qualitative analysis, including preference for order, intolerance of ambiguity and reluctance to let ideas incubate sufficiently. Thus successful use of data display methods may in part depend on the creative aptitude of those who devise them.

Done properly, any kind of qualitative analysis can be expected to be a lengthy process. Data display development proved to be a complex activity added to by constant reference back to the data to check for inconsistencies and patterns. However, this was a valuable means of triangulating the data within the displays with other data from interviews and participant-observations. Miles and Huberman (1994) warn that even simple display development can be time-consuming, not least as their development involves a degree of trial and error in discovering what works. The key to successful display use is ensuring methodological rigour in their development (Averill 2002). The process has been simplified here by having adopted meticulous data management techniques. Keeping organised records has made retrieval of stored data a much simpler

task and is invaluable should other researchers wish to examine the data (Marshall & Rossman 1989). A further key to success has been fostering of the aforementioned climate of creativity. Fortunately, barriers to creative qualitative analysis, including deadlines and lack of solitude (Hunter *et al* 2002) have not been too great a difficulty in this study.

A further common criticism of qualitative studies is that they too often present inadequate details of the overall methods used to be able to judge the quality of a study (Popay *et al* 1998) and insufficient information as to how the end products of analyses were arrived at (Mays & Pope 1995). Data displays promote a transparency within qualitative analysis procedures that is helpful to readers and researchers alike. Not only do they permit illumination of the route from analysis to conclusion-drawing but they can also be traced backwards. Hence a logical chain of evidence (Hunter *et al* 2002) has been created by use of displays in this study. The narratives that have been developed for each data display have further made it possible for others to grasp the researcher's emerging thought patterns concerning connections between the data. Furthermore, they represent an effective means of communicating study findings (Averill 2002) in a visual and simple way.

Summary

This section has critically examined the methods used within this study and demonstrated their appropriateness in realising the study aims. The strengths and weaknesses of each have been considered, so illuminating the trade-offs and compensations made through using this particular range of methods. Wherever applied, measures taken to optimise consistency, truth, applicability and neutrality have been revealed. The importance of concept analysis has been highlighted as a means of clarifying the phenomenon under investigation. The case study method chosen has been demonstrated to have embraced the research methods and sampling required to develop the necessary data sets to answer the study questions. The value of participant-observation alongside interviews has been shown to include cross-comparison of emergent findings and extensive opportunity to confirm or disconfirm conclusions being drawn. Secondary data have had modest utility and have been used mostly in establishing contextual information that is essential for comparison of the findings with other SG settings. Lastly, the extensive use of data displays has been shown to have

framed data analyses and progressed these from description to explanation. Thus, relationships between SG decision-making factors were made identifiable, with findings not being limited to viewing the components of decision-making in isolation.

PART 3 - Study Findings

Introduction

This section presents a discussion of the summative study findings on SG decision-making. Parts 1 and 2 of the Findings chapter detail the formative findings that have underpinned development of these summative findings, and so discussion of these is incorporated here. The summative findings comprise twelve factors affecting SG decision-making as represented in the Conceptual Model of SG Decision-Making (see page 170). Each of these eight elements and four conditions for effective decision-making is now discussed in turn. This is followed by a discussion of the conceptual model as a whole. For the purpose of this discussion, the view of Cooke and Slack (1991) concerning the relationship between decision-making and problem-solving is shared. They suggest that whilst the terms have slightly different meanings, they are sometimes used interchangeably. In their opinion, it is more accurate to suggest that the two are interrelated concepts as "...decision making is *part* of the larger process of problem solving" (Cooke & Slack 1991:4).

Inner Circle Elements

i) Clear issue

Having clear issues presented to council members to address was not sufficient for clear aims to be derived from them, although most clear initial issues did lead to clear aims and so these issues tended to be readily accepted. In this present study, the process for inviting issues was found not to be clear to Trust staff (Williamson & Petts 2000) and so at times proposals were vague. Lack of clarity experienced at this point was found to be related to later problems for councils around confusion and lack of progress. This is a problem area identified in communications theory that suggests that inaccurate or incomplete understanding of the actual issue will result in erroneous conclusions

being drawn (Schoonover-Shoffner 1989). A key role of the council facilitator was illuminated within the part they played in clarifying new issues and assisting members to define the problem or need each issue presented. No particular mention of referral processes has been uncovered within the SG literature with which to compare these points.

ii) Fitting issue

An issue needed to be clear to establish whether it fitted a council's remit or not. Yet unclear issues were still accepted and worked on, suggesting that members did not recognise a need for clarity and were satisfied with a 'see how it goes' approach. Collins (1996), who has written about teamwork within SG, supports these suggestions. She comments that during team development, members often do not progress past the early stages of development, these being forming and storming, because members want to get on with the task they are facing. Collins (1996) goes on to recommend establishing operational norms, clarifying roles and responsibilities and gaining an understanding of each other prior to embarking on the task, as a means of minimising later difficulties. Whilst some early attention was paid to clarifying council remits, roles and responsibilities by SG project leaders within the Rochdale model, this was limited and goes against the advice of Frusti (1996) and Miller (1997) who suggest such clarification is essential to effective working.

Self-generated issues by members tended to be fitting, whilst those suggested by non-council members tended to be ill-fitting. As the findings have suggested, this may further be an indication that some council members themselves did not fully appreciate their councils' purposes and remits. Such difficulties around unclear remits have presented problems in other council models, resulting in frustration due to lack of leadership (Edwards *et al* 1994) and disillusionment (Burnhope & Edmonstone 2003). It is understandable that an unclear remit would make it difficult for members to explain to others what they did not understand themselves. Yet perhaps it is only to be expected that council remits evolve over time, as the needs of the organisation within the new SG framework become apparent. This has been the experience of another SG model that subsumed one council into another once the former council's remit was evaluated as being inappropriate (Frenn & Schuh 1995). As Hibberd *et al* (1992) suggest, the type of decisions councils should be making and those that should remain with managers ought

to be made clear, as was not always the case in Rochdale. For example the introduction of Trust car parking fees was an issue the HRC had wanted to address. If there had been more clarity around the decision types to be addressed by councils, then more appropriate issues might have been referred to them.

It is indicated that Trust staff did not appreciate councils' remits, which may be in part attributed to a lack of communication and promotion work by council members to their constituents. In another SG approach that reportedly had few problems around communication with Trust staff, this success was attributed to its communication strategy (Buchan 1999) although this author does go on to highlight lack of information as a particular barrier to non-active staff becoming involved in SG. As with the present study, maintaining non-council members' appreciation of the SG councils' structure and work was a major hurdle identified within Beck *et al*'s (1994) SG model and a finding within Brooks *et al*'s (1998) SG study. This was also a finding within Ash *et al*'s (1998) evaluation study, and these authors identified improved communication to be evident where Trust staff routinely came into contact with council members within their practice areas. They also acknowledge time to communicate as a particular issue. Thus having sufficient membership, able to be released to cover the ground would appear to be an important issue. Ash *et al* (1998) further advise the development of job descriptions to help with the problems they too identified around release time to undertake council duties.

The source of suggestions of issues to address was a clear factor affecting acceptance, as those from the Policy Council were automatically accepted. This may be indicative of the authority held by Policy Council members that included the SG project leaders and the expectation that they would know what issues were appropriate. Thus, some reliance on senior Trust personnel was apparent, as these individuals gave guidance and a sense of direction that was welcomed by practice-based council members. Again, there is scant mention of issues around council remits within the SG literature with which to compare these observations.

iii) Issue size

Some difficulty was noted as a result of the acceptance of large-scale issues that were complex and required much time to address. Often such issues were addressed early on

in the councils' lifetime before they had established themselves. Time is recognised as the likeliest most common constraint to decision-making activity in any scenario (Dearden & Foster 1994). It is suggested that greater concentration on some smaller, easier to solve issues at first, as has been successful in other councillor models (Frenn & Schuh 1995), might have been beneficial in terms of seeing what works and learning from early successes and failures. Also, it is recognised that confidence building can ensue from 'quick hits' that then foster further success as confidence and ability develop. This view is shared by Collins (1996) who adds that whilst this process can be slow and somewhat draining, it is very worthwhile in the long run.

A further problem experienced by councils addressing large issues is that the rest of the organisation had to wait a long time to see tangible achievements by the councils, thus risking a waning of interest amongst Trust staff not directly involved in SG. This time-consuming nature of SG decision-making has been the experience of other council models, although time spent is considered an investment, as decisions are considered well examined and logically determined (Morris & Smith 1993). However, for council members in one model, delays were found to lead to significant frustration being experienced (Burnhope & Edmonstone 2003). Delays were compounded because there was a tendency for councils to address several large-scale issues simultaneously, which evidently overloaded them. Members did not seek to complete tasks prior to taking on further ones and generally accepted any issue that they felt fitted their remit. A similar experience was had by another SG model whereby a council was inundated with issues to address, incurring a huge workload, although the council later merged with another to cope with the problem (Edgar *et al* 2003).

No information pertaining to the duration of council issues from inception to resolution and reasons for any delays has been identified within the SG literature, despite others recognising this as a needed research topic (Frenn & Schuh 1995). Management theory suggests that effective decision-making may well be time-consuming. It was noted in the present study that the usual practice of consensus decision-making was especially time-consuming, as a multitude of views had to be gained, as has been others' experience (Frusti 1996). This contradicts Jenkin's (1993) earlier suggestion that consensus decision-making is time efficient due to partnership working. As Pheysey (1993) points out, the alternative may be 'muddling through' whereby quick decisions are made about an unclear problem which may be more about the organisation getting

rid of an unwanted problem than the achievement of a goal. Important decisions can be deemed to require thorough analysis, especially if their impact is great (Koontz & Weihrich 1990). Within this study, the councils tended to address issues that had far reaching consequences within directorates or in determining Trust-wide policy, and so deliberation could be expected, not least because within councils, members are accountable for decisions made.

iv) Clear aim

Where clear aims were agreed, these were noted to be devised promptly following proposal of issues to councils. On occasions where unclear aims evolved from clear issues presented, these were noted to occur several months after the original suggestion, having lost any sense of focus. Identification of a focus and clear objectives must always be the central concern of decision-making activity, according to Dearden and Foster (1994). Yet during extensive nursing research and teaching, Taylor (1978) has observed that nurses tend to seek decision alternatives prior to defining the primary problem. Early determination of a clear aim is desirable to focus subsequent activities. Evan *et al* (1995) concur that a focus on outcomes will result in members being able to determine their roles in the preceding processes, leading to achievement of those outcomes. Thus it can be expected that clear aims will help to focus later information gathering, as was the Rochdale experience. Additionally, it is said that clear objectives provide unity and a motivational force, plus a basis against which to measure performance activity (Dearden & Foster 1994). Whilst there is scant discussion available on the relationship between decision processes and outcomes achieved, Morris and Smith (1993) have expressed the view that SG decision-making in their councillor model has resulted in few decisions having to be remade.

A clear aim was not necessary for a positive outcome to be achieved for an issue. In the absence of a clear aim, positive outcomes were at times achieved, but unintentionally so, and were not the result of an earlier agreed goal. It is not unusual for good outcomes to occur by chance in decision-making, although the original decision was the most appropriate at that time (Pauker & Pauker 1999). Issues around clear aims within SG decision-making specifically, have not been identified within the literature for comparison. Yet a common and relevant distinction within group decision-making literature is that of structured (programmed) *versus* non-structured (non-programmed)

decision-making. Vroom and Yetton (1973) suggest that it is more difficult to solve non-structured decisions as these are not straightforward, the required information is widely distributed amongst people in an organisation, and alternatives are not known at the outset. Others argue that group forums are perhaps most fitting for this kind of difficult decision as talents can be pooled (Gibson *et al* 1997). In this study, councils' ability to derive clear aims was notably affected by the complex and ambiguous nature of certain non-structured issues they were asked to address. One example is the MHC's failure to derive a clear aim from the Ethnic Minorities Issue (MH7) proposed to it (see Appendix 23).

v) Lead allocated

Allocation of leads for issues, especially when done early on in an issue's lifetime, tended to promote a co-ordinated approach to dealing with those issues. When not allocated, council chairs would lead and so become overloaded, with poor co-ordination often being the result. Leads were most effective when they attended meetings to discuss their items. When absent from council meetings, these individuals often did not forward information or updates on their activities, resulting in a lack of progress. However not all leads were as effective in their role as others were. Variable skills and abilities at leading were demonstrated. Effectiveness diminished when single leads were responsible for several issues, incurring them a particularly large and difficult to manage workload. Progress was severely impeded when leads left the councils without handing over their issues.

Whilst no specific reference to leads for items can be found within the SG literature, Evan *et al* (1995) comment on the need for strong leadership within councils if effective decision-making is to be achieved, but say little else on the subject. Thus explanations have been sought in other theoretical bases. Teachers of health services management have highlighted a core stage of decision-implementation planning as specifying who is going to do what and when (The Open University 1991). Yet, delegation of work to a key person has been recognised as a calculated risk that can be minimised by delegation of responsibilities to capable individuals with clear expectations being made of them (Adair 1988). In the councils' case, such expectations were rarely made explicit and the performance of leads was very much left up to the individual. As well as appointed leads, Vroom and Yetton (1973) have differentiated between formal leaders and

informal leaders within a group and the potential of each to exert significant influence over decision-making. Similarly, although leads were mostly allocated for council issues in this study, other individuals were noted to display particular influence over the direction that decision processes took. This varied between being helpful and unhelpful to decision processes.

vi) Level of authority

A level of authority was rarely negotiated with senior Trust personnel as was originally intended. Thus, on many occasions, members determined their own level. This goes against advice that authority must be transferred if staff are to be empowered and so responsible for decision outcomes (Morris & Smith 1993). In this study, as these authors have warned, accountability without authority led to a degree of frustration and impotence. Council members were responsible for decision outcomes but not often conferred clear authority to act. Thus, difficulty arose when members were not authorised for the action they wished to take, such as when resource issues were implicated. Lack of discussion aimed at agreeing levels of authority meant that minimal opportunities were presented to identify a focus for council issues and to agree a desired end point. As Collins (1996) points out, to be successful, teams need to have clear decision-making authority and know their boundaries. However, in seeking authority levels, members may have upheld Hess's (1994) argument that managers maintained control in this way, in this case by limiting authority levels and directing how some issues should be dealt with. This is a view shared by Morgan (1986) who suggests that decision-making can be directly influenced by communication structures, rules and procedures. In this instance, council members repeatedly failed to raise the issue of level of authority, yet when they did, managers discussed it willingly, although the final choice of level rested with the managers. Councils might be expected to become more self-directing as they become more proficient in the longer term. Until such point there is benefit to be had through the managerial guidance gained through seeking a level of authority. However, the emphasis is on 'longer term'. As Kerfoot and Uecker (1992) point out, it usually takes much longer than a year for empowered work teams to become fully self-directed. There exists a lack of longitudinal SG research that is much needed to examine the transition of council members from appointment to full decision-making competence. These findings indicate gaps in current knowledge around potential factors such as the effectiveness of council members' preparation, the time

taken for transfer of authority and subsequent withdrawal of managerial support.

vii) Background information

Having a clear aim for council issues was at times related to a focused search for background information to inform subsequent decision-making. At other times a broad search for information was instigated, but this was less valuable at informing decisions. As Schoonover-Shoffner (1989) points out, a flawed (inaccurate or incomplete) information base will lead to erroneous decisions. Valid information may be rejected if its importance is not seen. Whilst a lack of information may result in inaccurate decisions being made, too much information can cloud and so delay decision processes. As Vroom and Yetton (1973) point out, much rests on the disposition of group members to use available information appropriately in solving the problem at hand. In this study, it was established that council members gained confidence from undertaking an information searching exercise, although much time was often spent on this stage of the decision process with questionable benefit to the informing of decisions.

Yet this information searching process reflects a core element of rational decision-making, as described by Koontz and Weihrich (1990). They suggest that in seeking alternative solutions, experience, experimentation, and research and analysis are key. What it is critical is not experience *per se*, but reflection and learning from experience. Experimentation can also be costly, risking failure. Research and analysis, as has been common amongst these councils, is effective as it concerns reaching an understanding of the problem prior to trying to solve it. Arguably, the effectiveness of the information-searching element of decision-making is a balance of time spent over appropriateness of information achieved. Furthermore, there is a distinction to be made over *available* and *relevant* information, as that which is readily available may not be what is needed (Adair 1997). In the present study, the councils were at times observed not to heed Dearden and Foster's (1994) view that information should not be gathered until a clear reason for it has been identified. Instead, councils would frequently gather information in the hope of it bringing about such clarity of purpose.

viii) Key informant

Use of several key informants acting as subject specialists proved beneficial at

informing decision processes in this study. However, these informants tended to have short-lived associations with the councils. Full use was infrequently made of co-opted seats set aside for temporary membership for subject specialists to join councils working on a particular issue. Whilst other UK trusts have similarly provided co-opted seats, it is not reported whether these have been utilised fully, although their use is believed to promote objectivity and a fresh perspective, especially when co-optees originate outside of the organisation (Geoghegan & Farrington 1995).

In this study, council members had the requisite knowledge for some issues, and these could be managed within the councils without outside input. This was especially the case amongst the directorate-based MHC as its remit was to address local practice issues familiar to its members. At times, though, information was inadequate and a view of the wider Trust picture and use of informants may have been beneficial even to this council, rather than its tendency to perpetuate an insular perspective. An example is where MHC members did not seek survey advice for the Motivation Survey Issue (MH7) (see Appendix 23) and due to their lack of research skills a poor survey design was employed. Further difficulties arose when identified informants did not participate as requested. Interpretation of these situations mirrors Morgan's (1986) view that gatekeepers are often in a position to wield power by slowing down transmission of information so that it arrives too late to use.

Outer Circle Supportive Conditions

ix) Evaluation

Evaluation of the councils' progress, in this case through action research cycles, has facilitated learning and improvements to be made to the SG councils' structures and council members' capability. Thus, evaluation has elicited information to inform and support decision-making processes, which is a recognised means of improving decision-making quality (Clarke 2001). Commonly, these improvements have impacted on the structure of the SG model, catalysed away-days, problem-solving techniques, general skills development and role development such as chairing skills. Some means of evaluation is essential when an organisation is implementing such a large, complex initiative as SG, which is a view shared by several SG authors (Belcher 1998; Hess 1995; Martin 1995). Evaluation can be expected to enhance the success of an initiative,

which is especially important when it has been heavily invested in, in terms of staff commitment and finance. Having a strong evaluative element has been an important component of this study, unlike other SG initiatives where attention to evaluation has often been scant (Conrad 2003; Reis & Sturis 1995) or indeed absent (Beck *et al* 1994; Edgar *et al* 2003).

It is argued that the aforementioned improvements are less likely to have occurred if evaluation had been less substantial. The improvements indicated were prompted directly by evaluation findings. Lip service can often be paid to evaluation and in this case, the prominence of the research has demonstrated to others the Trust's commitment to achieving successful SG implementation. As achieved here, evaluation in-built at the start of an initiative is desirable and likely to promote success as feedback informs refinements (Smith 1990). Without evaluation, it is impossible to accurately attribute any improvement in decision-making to SG as opposed to any number of other organisational variables (Morris & Smith 1993). Much will depend on the means of evaluation, the time invested in it and the skills of those who undertake it.

That is not to say that evaluation of a SG initiative cannot be undertaken in-house or by council members themselves, simply that it needs to be done well. Evan *et al* (1995) emphasise the need for strong council structures and evaluation of outcomes as means of ensuring effective and timely decision-making. Organisations need to determine their own approach and this need not necessarily involve research. Facilitated reflection on progress and adequate time allocated for these processes may well be effective, as recognised in this present study. As Adair (1988) reiterates, monitoring for the effects of change is insufficient and what is needed is learning from mistakes so that further changes can be made to promote success. As experienced here, it is deemed helpful if someone within a SG initiative maintains an overview of the whole situation and wider organisational picture.

x) Skills

For rational decision-making to take place, it is accepted that people need to have the requisite skills and information to appraise alternatives to reaching their goals (Koontz and Weihrich 1990). Skills development within the councils was initially limited to the three day Leading an Empowered Organisation (LEO) course undertaken by members

prior to joining. Whilst the LEO proved valuable, skills around how to perform in a council situation were not specifically developed. Members struggled with how to chair meetings, how to address problems and divide up work and responsibilities in particular.

Skills profiles collated as part of the study indicated that most members had never even chaired a meeting before joining the councils and much of what was expected in their council roles was new to them. Once recognised, these needs were then addressed through measures such as away-days, increased facilitator support and monthly support meetings for council chairs. More skills development could have been done at the outset, especially as many council members were junior and inexperienced compared with some of their senior colleagues.

Early skills development has been recognised as a particular need by other SG authors (Davis 1992) whilst experience has been identified as a key attribute in making effective decisions (Dearlove 1998). Additionally ongoing, targeted skills development, on top of those learnt 'on the job', were indicated in this study, as experienced by others (Guidi 1995; Horstman & Zlokas 1995). As with these findings, others implementing SG identified training around agenda setting, managing meetings and dealing with group dynamics as key skills required by council members (Morris & Smith 1993). Westrope *et al* (1995) and Goode (2003) report that in their councillor SG models, workshops were held on how to chair meetings for chairs and vice chairs. Usually the requirements for council roles are determined locally and in Rochdale's case, this was not done to a great extent. Limited mention of the specific elements of council chair and member roles has been made within the SG literature (Geoghegan & Farrington 1995) and it is not until very recently that suggested role content for vice chairs and secretaries has been made widely available (Burnhope & Edmonstone 2003).

Decision-making education has been recognised as valuable, but not often implemented (Jones 1995). Whilst a small component of the LEO course considered problem-solving techniques, no specific decision-making training was undertaken with council members, until addressed by this study, and this has been a particular weakness in their preparation. Similarly, preparation for later members joining the councils was inconsistent until identified through the study and addressed, with most not having undertaken the LEO course as original members had. Thus, these individuals were at a

particular disadvantage in not being prepared for the 'LEO language' used in meetings and not having experienced the councils' development. Thus, orientation of new members became a key means of promoting commonality of skills and knowledge pertaining to council functioning.

The adoption of the LEO course as an underpinning foundation to SG implementation in Rochdale has been a successful one in terms such as creating staff perceptions of empowerment and increased change agent abilities (Williamson *et al* 2001). This need for substantive leadership development has also been the experience of others implementing SG (DeBaca *et al* 1993; Evan *et al* 1995).

xi) Coaching/support

The appointment of somebody to offer guidance and direction to the councils in a facilitator role has proved valuable within the Rochdale model of SG. In other models, this role of giving guidance and support has resided with a manager in terms of defining available resources and/or an executive level member whose role it is to maintain a strategic overview (Porter-O'Grady 1991a). In this present study, the absence of a facilitator has been noted to coincide with a lack of council progress in such terms as keeping a focus and maintaining momentum. Much of the benefit of a facilitator surrounds their grasp of the wider situation beyond the confines of the council and understanding of the organisation, its history and people within it. Other studies have found this lack of council members' organisation-wide insight to be a key concern (Doherty & Hope 2000). Thus, some kind of facilitator is deemed advantageous and has been a recommendation made in another SG study as a means of promoting inter-council co-ordination, providing advice and securing action on council requests (Ash *et al* 1998).

In this study, an empowering facilitation style was usually adopted with encouragement to make members think for themselves balanced with occasional direction. The facilitator role here resonates with that within another councillor model as being one of coaching, mentoring and cheerleading (Morris & Smith 1993). A more directing approach might have progressed council issues more speedily, despite the desire to help members develop through coaching them rather than doing things for them. This is because in this council model, many members were junior and inexperienced, struggled

and became frustrated. Looking back, there were times when a more directing approach was needed to prevent the despondency some council members reported due to lack of progress. The more empowering approach could have been worked towards at a later stage. Indeed, contrary to the advice of Kerfoot and Uecker (1992), councils had substantive decision-making responsibility from the outset instead of a gradual shift of responsibility from the manager to the group as the latter develops. Even though council members received significant support from the council facilitators, this sudden introduction of responsibility added to councils' lack of ability at times to make good progress. Correspondingly, the original intention for facilitators to withdraw from councils after several months was not possible, as councils evidently needed their continued support. Thus the empowering style of facilitation did not achieve self-managing councils, as had been expected by the project leaders. Again in retrospect, significant decision-making preparation of members might have diminished the need for a facilitator at an earlier stage.

xii) Membership

Good attendance and adequately prepared members were noted to aid council decision-making processes within this model. Conversely, vacant seats and lack of orientation for new members had a negative effect on progress. When many members were absent, meetings were cancelled or issues deferred, as there were insufficient skills and insight amongst present members to address the issues. Others have highlighted variable attendance at council meetings (Burnhope & Edmonstone 2003; Conrad 2003; Guidi 1995) and vacant council seats (Edgar *et al* 2003), to present problems to their SG processes.

In the present study, release time to attend meetings presented considerable difficulty, as had been the experience elsewhere within SG models (Ash *et al* 1998; Buchan 1999; Joiner 1996; Mitchell *et al* 1999). Staged stepping down processes did not happen as expected either. Members left at various times and with variable periods of notice if any, making the appointment of their replacements challenging. Related to this was that the twelve-month tenures originally anticipated were found by members to be insufficient, as they were just getting settled within their roles at this time. Geoghegan and Farrington (1995) similarly view twelve-month tenures as a minimum, whilst in another council model, tenure of one council was extended to four years, as two years

was found to be insufficient for new members to fully grasp their roles (Frenn & Schuh 1995).

The recruitment process displayed its own problems. Due to being time-consuming, councils that originally recruited members through a formal voting system later changed to adopt the more informal approach of seeking volunteers. This shift is reflected in Ash *et al*'s (1998) study whereby appointment to council seats following interview was challenged by the expressed preference for self-nomination as a means of minimising hierarchy. A further UK model's approach was to self-nominate from the outset of SG, which is believed to be a measure that promotes motivation and ensures commitment (Geoghegan & Farrington 1995).

In the Rochdale model, councils had multi-disciplinary membership from the outset. This is counter to the advice of Porter-O'Grady (1994b) who warns that models may be better established within nursing first before incorporating other professional groups. Merit can be seen in establishing SG in one professional group before moving to embrace another in view of the potential professional issues and language difficulties to be faced. Professional differences were noted as a problem in this present study. For example, physiotherapists displayed and expressed difficulty in contributing to discussions that had a predominant nursing focus and their interest levels suffered over many months of discussing nursing oriented issues. This has been the experience of Prince (1997) who also found council members to have concerns about their lack of input at council meetings. Similarly in Ash *et al*'s (1998) study, there was a view that not all areas were adequately represented, and midwife council members experienced some difficulty in working on nurse oriented issues.

In Evan *et al*'s (1995) experience, a major communication problem arose when they failed to engage the necessary professional groups, in this case physicians, in the process of a decision that affected them. Much effort was expended in making amends. Where other clinical disciplines were incorporated into council membership, the experience was one of "...improved problem-solving, increased consensus, resolution of long-standing issues, and new respect between disciplines" (Jenkins 1993:103). In summary, there would appear to be no wrong or right approach to membership, simply that it should be appropriate for that setting. A council should either be representative of all stakeholders or good use made of co-opted seats, as it is important to ensure that all

who are affected by a decision have a say (Porter-O'Grady 1995b).

Work was not always done away from council meetings as agreed. This again goes against Porter-O'Grady's (1998) mandate that within SG, staff must take responsibility for the part they play in achieving shared objectives. This lack of work on the part of individuals often incurred delays in the meetings as this work was caught up on. The MHC was more likely to engage non-council members in its work to foster their involvement and to reduce the work for them as individuals. This has been a successful strategy in other council models whereby work groups were set up comprising the person making the referral, a council member and other staff (Culpepper-Richards *et al* 1999). Similarly, models with a longer standing experience of SG developed in such a way as to engage non-council staff much more fully in council work and decisions, as a means of sharing out these responsibilities (Shadley & Gossett 1997).

Conceptual Model of SG Decision-Making

The culmination of this study has been the development of a conceptual model comprising eight elements and four supportive conditions for effective SG decision-making. The relationships of the components within the conceptual model have been demonstrated in the earlier causal networks and preceding discussion of each of the model's twelve factors. No strict order has been proposed for each stage of the SG decision-making process, only a common-sensical order (see page 187). This reflects recognition of the debate around 'coherent' versus 'chaotic' action dimensions within decision-making theory (Miller *et al* 1999). As these authors explain, a coherent approach is one where decision processes are believed to be sequenced and linear. However, this has not been the understanding gained in this study. Care has been taken not to inadvertently impose such logic, not least because decisions are future-oriented and "...the future almost invariably involves uncertainties" (Koontz & Weihrich 1990:109). No claims are made that any factors are necessary or sufficient for effective decision-making, and so prediction or assurances about decision-making outcomes with use of the model cannot be made. The appropriate claim is that these factors have been found to be the most significant in affecting SG decision-making within this case study and that to address these will promote the likelihood of effective SG decision-making, but will not guarantee it. As a single case only, this case does not represent a 'sample' (Yin 1994); thus, findings are generalisable at a theoretical level only. Any cross-case

conclusions can only be arrived at by testing out the findings from this case in other UK SG settings.

A possible comparator model is that of Caramanica and Rosenbecker's (1991) decision tree (see Appendix 2 - Decision Tree) yet this is more of a structural model than a conceptual model. Their similarity is that the act of defining council issues is highlighted and both reflect the need to establish the fit of a proposed issue with a council remit to effect an appropriate referral. In the decision tree, level of authority is implicit in that decision types requiring council or managers' attention are differentiated. The decision tree is limited in that it is focused on the *initial* decision-making stages and goes no further in modelling decision-making processes, unlike the conceptual model.

In comparing the elements of the conceptual model with management theory of normative decision-making, there are a number of congruencies. These are evident in Pheysey's (1993) description of how decisions can be maximised to get the most benefit out of them, although he is clear to point out that most is not always best (see Table 4 – Maximising Decision-Making).

Table 4 – Maximising Decision-Making

Search

1) Ascertain the limits within which you are working – what authority you have, what others expect, and so on.
2) Define the problem.
3) Collect data.

Analysis

4) Analyse the data.
5) Consider all the solutions that are possible.

Evaluation

6) Use an appropriate rule to rank the solutions so that you can choose the one which gives greatest net benefit.
7) Implement the solution of your choice, and check the results.

Pheysey (1993:104)

Similarities of the conceptual model with accepted management models of decision-making tend to pertain to the *early* stages of decision-making. These are depicted as

identification of the problem/issue, clarification of a goal, level of authority and information gathering. The *later* stages of decision-making models have tended to be dissimilar to the conceptual model, apart from recognition of the need for evaluation. The elements of these models have generally focused on generation of options, appraisal of these and evaluation of decision outcomes (Dearlove 1998) which have not been found to be key factors affecting SG decision-making.

Typically, discussions within the decision-making literature bypass identification of the stimulus for decisions and skip to issues around appraisal of options. This tendency misses out the important early stages concerning how the decision stimulus became apparent, the actual problem and initial responses to it unlike the conceptual model presented here. In a seminal paper on strategic decision-making, Mintzberg *et al* (1976) track and flowchart twenty-five strategic decisions within a variety of organisations. In these cases, the researchers suggest that initial diagnosis, which generally influences subsequent actions, is paid little attention, unlike later activities concerning selection of solutions. Diagnostic activity was found to mostly centre on easily accessible, familiar areas of the organisation prior to resorting to searches of less familiar, more remote areas. This finding resonates with this present study in that seeking further information was done in council members' own areas first, with consideration of alternatives, such as key informants being brought in, undertaken latterly.

A further, little-explored area within the decision-making literature pertains to the tendency of management models of decision-making to present the ideal or rational approach to decision-making which do not allow for the influence of human factors such as intuition, moral or ethical judgements (Dearlove 1998). Whilst not identified in the present study either, the conceptual model does highlight the importance of decision-makers' skills and support as adjuncts to effective decision-making.

Other potential decision-making factors not noted within the conceptual model but prevalent in the wider literature include group members' motivation to make a decision and their commitment to it (Vroom & Yetton 1973). Whilst not sufficiently evidenced to include in the conceptual model, these lesser factors have been inferred to have been at play during some council decision processes. A simple example is when members have not completed work tasks for no good reason, having agreed with the initial decision and accepted responsibility for the work.

Another potential factor that has not been greatly apparent through this study pertains to the effect of personality on decision-making. Personality as an issue has been illuminated in Paden's (1998) study of the Myers-Briggs Personality Type Indicator in relation to SG decision-making preferences. She argues that effects due to non-contribution, non-attendance, abstract thinkers and dominating members are due in part to personality types and the mix of these in meetings. Other researchers have made reference to personality difficulties amongst key participants but not in any detail (Burnhope & Edmonstone 2003). It was evident on a minority of occasions in the present study that personality might have been an issue, such as individuals dominating decision-making. To appraise individuals' personality types has been beyond the confines of this study. It remains a subject for future research.

The conceptual model of SG decision-making has communicated the study findings in a simple format for others to follow. What remains is for other organisations considering adoption of a SG framework to consider these findings in relation to their own situations to determine their applicability. An important step in this process will be comparison of organisational contexts with that of the Rochdale Healthcare NHS Trust during SG implementation.

Summary

This section has examined the summative study findings. The findings have been compared with SG literature where it exists, and where it has not, decision-making and management literature has been especially targeted as a means of seeking corroboration and disconfirmation. The twelve factors affecting SG decision-making as represented in the conceptual model of SG decision-making have been examined in turn. Whilst there was a lack of existing SG research evidence for comparison, findings from other studies and anecdotal evidence located, generally supported the findings from this present study. Results from contrasts made with alternative literature were favourable, although this evidence source tended to be focused on less comparable business settings. The section concluded with consideration of the conceptual model as a whole and comparison of this with existing decision-making theory. It was asserted that the model gave a truthful representation of factors affecting SG decision-making and relayed the summative findings in a concise, communicative way. The limits to claims made about the findings and the relationships between components of the conceptual model were

made clear.

PART 4 - Conclusions & Implications for Policy and Practice

Conclusions

The investigation of the study case generated a view of SG decision-making which survived vigorous attempts to disconfirm it, first by later action research cycles, then data displays and finally the literature.

It is the researcher's responsibility to ensure that the story of the case is reported sufficiently and in such a way as to convey to the reader the learning that has taken place (Stake 1998). In this case study, the process of strengthening SG decision-making has been illuminated. Sufficient description has been provided to avoid superficiality and to enable adequate interpretation of the meaning and context of what has been researched (Popay *et al* 1998). Action research has been demonstrated to have utility at contributing to theory development whilst initiating evidence-based changes in practice. The underlying principles of action research, in particular participation and empowerment, have served to reinforce the corresponding attributes exemplified by SG. The single-embedded case study design has supported the use of a mixed method approach to data collection. These methods have permitted collation and comparison of numerous data sets from which emergent findings have been drawn. Testing of formative findings against existing and subsequent data have led to rigorous efforts to test the fit of findings with the reality of SG decision-making practice. The use of data displays within action research has been a novel use of an accepted qualitative data analysis approach. In addition to the study findings, a substantive contribution has therefore been made to understanding the application of this methodology, especially the more advanced data displays, in health services research.

Examination of the merits of a programme's components is in itself valuable, and does not automatically mean that insight into the relationship amongst these components is required (Scriven 1994). However, in this study, a degree of explanation has been required and achieved. Full explanation of the relationships between SG decision-making components has not been possible, as is to be expected in such a complex

programme situation comprising numerous components. The approach used has met the requirements of this study to identify and act upon factors that may subsequently improve SG decision-making. As Gore *et al* (1992:19) remark:

> *"Once a complex decision is broken into stages it is easier to suggest specific improvements at particular points or stages."*

In addition to considerable local relevance, there is potential for the study findings to have external validity; that is, generalisability at a theoretical level to other councillor SG models in the UK. This view is supported by the similarities to these findings identified within the SG and decision-making literature and consideration of the contradictions to these findings within the literature. Together, this research and findings from other studies provide a developing evidence base to underpin future endeavours aimed at sharing governance within health care settings.

Epistemology is about whether something we believe to be the case is something we can be certain of, as opposed to something that remains a belief or opinion. Whilst complete certainty cannot be sought in any study, what has been achieved in this study is the realisation of an accurate representation of decision-making within SG to inform the understanding of others. Such accuracy has been promoted by the democratic involvement of others to develop a consensus view, where possible, on which action has been based. Thus, a commitment to participatory elements within this study has been central to its success at achieving the study aims. As Argyris *et al* (1985:13) eloquently point out:

> *"The test of truth is rather that a community of investigators, beginning with different assumptions and free to criticize any aspect of each other's work, converge on a set of beliefs. They can never be certain that their beliefs are true, but they can approach truth through a self-corrective process of rational criticism in a community of inquiry."*

Implications for Policy and Practice

Implications centre on two main areas: the utility of action research in health care and the enhancement of SG decision-making.

Action research is a well-established research tradition that is increasingly being utilised in health care settings in recent decades. Recognition of action research as a valuable means of promoting change and organisational learning in the NHS is growing (National Co-ordinating Centre for NHS Service Delivery and Organisation Research & Development 2001). Its emphasis on evaluation, practice and theory development, and their integration, offers a valuable means of response to the current NHS climate of improvement and involvement. In a climate of rapid change and finite resources, such methods of evaluation are needed in order to identify what works in practice so that continual improvements can be made (Clarke 2001). Action research demands involvement of stakeholders, including professionals, patients and the public as appropriate. As such, action research is an appropriate means of meeting government aspirations for consumer involvement in health care decisions. Yet for improvements to be made, learning must occur, as Lewin (1946:202) states:

> *"In a field that lacks objective standards of achievement, no learning can take place. If we cannot judge whether an action has led forward or backward, if we have no criteria for evaluating the relation between effort and achievement, there is nothing to prevent us from making the wrong conclusions and to encourage the wrong work habits."*

In terms of its usage, action research has particular appeal within nursing, as it resonates with the familiar elements of the nursing process. Furthermore, it provides a means of inquiry that can be undertaken in the workplace in day-to-day practice by and with practitioners. Health care is subject to a number of drivers to promote evidence-based practice and the potential for action research to help reduce practice-theory gaps is marked. As UK health care research and education policy continues to encourage practitioner-academic and practitioner-public research relationships, action research presents as a particularly appropriate vehicle for the achievement of such partnerships.

Resulting from this study, a considerable contribution to action research knowledge has been made in three areas, pertaining to the enhancement of action research in practice due to explicit collaborations, the complementarity between action research and SG and similar reciprocity between action research and data display development.

Firstly, the development of explicit collaborations has been demonstrated to promote the sustainability of an action research project. Such collaborations serve to establish

and strengthen relationships with the leaders or gatekeepers of the project being investigated. One example of this strategy is the appointment of a Research Advisory Group that comprises representatives of these stakeholders and agreeing with them such things as:

- Terms of reference (including an appropriate membership).
- Members' commitment to address organisational blocks to the research process.
- How and with whom problems are to be addressed.
- Mechanisms for feeding back sensitive or controversial formative findings.
- Members' willingness to review the progress of the research study and offer feedback, including how the study may be strengthened and any weaknesses addressed.
- Members' availability for support between Advisory Group meetings and on an individual basis.

A further example of a collaboration strategy is the joint development of an Access to Site and Data Agreement. This would address such issues as:

- What organisational data are and are not accessible to the researcher.
- Mechanisms for locating and obtaining relevant organisational data.
- Who is responsible for assisting the researcher to access organisational data.
- Ownership of data generated by the research process.
- The giving of assurances concerning the ethical conduct of the study.
- Two-way communication and feedback mechanisms throughout the study.
- What material to disseminate and through which media.
- Written permissions for all agreements made.

The potential for these measures relates to the prevention of problems or their optimum handling should they arise within a study. The measures focus on the fostering of an optimum rapport and clear communication channels with project leaders. Through establishment of an Advisory Group, responsibility for any problems that arise is shared with members rather than being the researchers' sole responsibility. Thus, problems may either be avoided completely or prevented from escalating into much bigger problems. Explicit agreement over access to data and resources can further reduce the

likelihood of problems arising from unclear boundaries once a study is underway. Having such clear lines of communication and explicit authority to act further promotes the likelihood that problems will be identified in good time and resolved promptly.

Secondly, the relationship between SG and action research has been established as complementary. A number of similarities exist between the principles of action research and those underpinning SG. These include participation, empowerment, involvement in decisions, ownership and democracy. Rather than operating alongside each other, integration of action research and SG is made possible by incorporation of these shared principles into the design of the study. In this way integration is achieved whereby, the researcher reinforces the tenets of both approaches by ensuring that there are substantial elements of each evident in the research design and processes, and that these principles are exemplified in the researcher's own behaviour. This may be demonstrated by:

- Participants' freedom of choice as to whether to participate.
- Meaningful involvement of participants in the study design.
- Participants' deciding whether or not to act on findings.
- Participants' determining what action to take in response to feedback.
- Involving participants in verification processes and acting upon feedback.
- Involving participants in dissemination of shared findings.
- Ensuring that all participants have a 'voice' and an opportunity to be heard.
- Encouraging learning from mistakes without blame.
- Adopting a facilitative approach as opposed to directing.

This integration of action research and SG has impact beyond the immediate study setting. The authorisation by an organisation to adopt an action research approach is indicative of its intent to support the involvement of its staff in decision-making and subsequent change. When an organisation contributes its own resources in terms of finance and people's time, this gives testimony to the value it places on the project. This is important because SG will affect systems beyond the study setting and the wider organisation needs to receive the message that staff empowerment is a major goal of SG. This will be reinforced by the purposeful and subliminal messages present in all research activities, in particular dissemination of findings within the organisation. Responding to staff's views and concerns pertaining to a project is a powerful way of

demonstrating where values lie.

Thirdly, the combined use of action research and data displays has been demonstrated to be a valuable approach to qualitative data analysis. A range of similarities exists between the analysis processes intrinsic to these approaches. These include:

- Constant comparison of emergent data.
- Cyclical processes between data collection and interpretation.
- Careful selection of what variables to include and what to exclude.
- Commitment to seeking disconfirming data and alternative explanations.
- The researcher as a key research tool.
- Commitment to verifying emergent findings with stakeholders/participants.

Thus, development of data displays is undertaken in tandem with action research fieldwork that similarly involves observing, planning, acting, and reflecting. Display development extends the analytical processes of identifying what variables are important and proposes the relationships between them. Through action research, these are then tested out in the field so that refinements are made to displays as understanding evolves. Display development adds a further element of rigour by making transparent which variables are considered most significant and why. Being explicit in this way creates opportunities for the researcher and others to interrogate the displays for accuracy and trustworthiness. The writing of display narratives adds to the theoretical memo writing that is usual practice in action research. Conversely, the writing of theoretical memos, emerging interpretations and tentative conclusions has further aided the development of accurate narratives used with data displays.

Action research studies necessitate the generation of large quantities of largely text-based data. Data displays are an alternative means of organising and analysing data and will appeal to researchers who prefer to develop their analyses on paper as opposed to computers. However, the main purpose is not to enable researchers to work within the confines of their technical expertise, but to enhance analyses by being able to visually examine a range of displays simultaneously. Utilisation of displays is a more effective means of communicating condensed data to participants for verification purposes than could be achieved by sharing large quantities of text-bound data. The meaningfulness of

verification processes is enhanced, thus adding to the accuracy of findings. This is particularly important when the intention is for policy makers to base substantive decisions on a study's findings. Ultimately, arrival at unsupported or biased findings has been countered by the combined use of action research and data displays and together these approaches substantially strengthen analytical processes.

The evidence base for SG is still very much in early development, especially in the UK. The move to embrace SG in the UK in recent years has been based on scant evidence and a belief that it is suited to application in the British health care system. The substantive contribution to SG knowledge made by this study concerns the factors affecting decision-making within a UK councillor model. The findings give insight into decision-making processes that have received limited attention in the existing SG research literature. Steps to be taken during council processes and strategies to support those processes have been identified as key factors that are required in order to strengthen decision-making. Through an action research approach, the knowledge gained through this study has had immediacy of impact at a local level within Rochdale Healthcare NHS Trust. Development of the first known conceptual model of SG presents this new knowledge in a format for others to consider for application to their own SG endeavours.

Of note is the importance of empowerment as a prerequisite for meaningful involvement in decision-making. The design and execution of SG decision-making processes are key to its success. True involvement requires participants that are genuinely empowered. Through their own actions, empowering behaviours will be reinforced. For this to happen participants need to be engaged in issues and decisions that concern them and to which they can contribute. They need to be conferred the authority to act and then be accountable for the outcomes of their actions and make improvements as required. The value of training for empowerment has been established through comparison of staff who have undertaken Leading an Empowered Organisation (LEO) training and those who have not. Highly statistical differences were noted in responses from these two groups with those who had undergone the LEO reporting greater impact of SG at a Trust level in relation to perceived empowerment, involvement in Trust decisions and influencing of change (Williamson *et al* 2001). Similarly, positive effects of SG on staff as individuals were identified in more than twice as many LEO than non-LEO staff. Examples of these include changes in personal practice, having a say and personal

development. Conclusions drawn from interviews with council members indicated negligible perceived impact of LEO on their authority, responsibility and accountability.

This knowledge goes some way towards adding a new dimension to existing decision-making theory, which is not known to have focused specifically on SG decision-making previously. It provides a much needed and complementary addition to the small UK SG evidence base. Hence, the development of understanding as to how outcomes were arrived at by examining preceding decision processes is proposed as a welcome addition to what is already known.

Further Research

As an additional UK longitudinal study, this study has been valuable in terms of the extent to which it has investigated SG. It remains, however, a study of a single case. To assess the broader application of these findings to other health care organisations, it is necessary for health care colleagues to consider the study findings in relation to their own contexts and determine their applicability. Until the findings from this case are tested out elsewhere, their wider merits will not be known. A number of areas have been identified as being in need of future research:

1. *Testing of the Case.* The primary area in need of further research is the application of the conceptual model of SG to other UK SG council models. Ideally, if sufficient numbers were available, a multi-site study would allow valuable comparisons to be made and a greater insight into the generalisability of these findings. Testing of these findings in single sites remains valuable and others may well adapt the model to their own situations, prompting even further research to test those refinements.

2. *SG Structures.* More understanding is needed about how SG models can be designed and evolved to be most effective as a framework to support staff engagement in decision-making. More comparison is needed to establish whether there are any advantages of one SG model type over another, e.g. councillor models and congressional models.

3. *SG Processes.* Research is limited concerning the process of SG. Whilst attention to impact is valuable, what is needed is a better grasp of how outcomes were arrived at, so that as well as the 'what', we better understand the 'how':

- The decision-making processes of SG are particularly under-researched. The study of decision-making is important, as it is essential for modern organisations to understand what they need to do to function effectively (Miller *et al* 1999). So that effective decision processes may be promoted, insight is needed into how participants within SG models can be helped to be productive. This may be in terms of support mechanisms, skills development, selection of members, climate and so on. The difference made by council members' varying personal attributes and personality types may also be useful in determining what constitutes an effective council composition. The origins and nature of council issues and the use of leads for items, sub-groups, co-opted seats and key informants could be particularly explored. The effectiveness of different council member preparation approaches, and whether these affect the transition to decision-making competence or the degree of support needed, could also be examined.

- Issues related to time are a further area for exploration, especially time-scales for decision processes and for the achievement of outputs. Ideally, sufficient baseline data concerning how decisions were arrived at prior to SG implementation would enable comparison with previous ways of doing things. Delays in decision processes could be particularly investigated so that the effectiveness of processes could be maximised.

4. *SG Outcomes.* In the wider SG field, there is a recognised lack of research into the outcomes of SG:

   - Longer-term evaluation research would be particularly valuable and would address the limitations of one-off, snapshot evaluations. This is especially so because studies to date have concentrated on the early years of SG implementation, whilst the impact and sustainability of SG is little understood five or more years after implementation. Broad evaluation can establish the impact of SG throughout organisations and not be confined to its sub-parts or structures. Furthermore, the characteristics required of organisations to best implement SG can be identified.

   - Existing outcomes research has tended to focus on staff perceptions of outcomes

in terms of their impact on them at a personal level and outputs from councils such as policies developed. Research into the impact of SG at the organisational level and the relationship of SG to quality of patient care is especially needed.

- The financial implications of SG, in terms of release time, training costs and long-term cost savings in relation to outputs of SG, have been little researched and require further attention.

- In focusing on outcomes, the need is highlighted for accurate definition of SG and adequate identification of its components, in order to be sure that it is SG, and not some other phenomenon, that is being researched.

As this thesis is now brought to an end, the last word is left to that most prolific writer in the SG field, Porter-O'Grady, who at a conference in 1999, left the audience with the following thought, which, it is believed, reflects the essence of the study:

> "The task is not so much to see what no one yet has seen, but to think what no one else has thought about that which everybody sees."

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

II Volumes

Volume II of II

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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

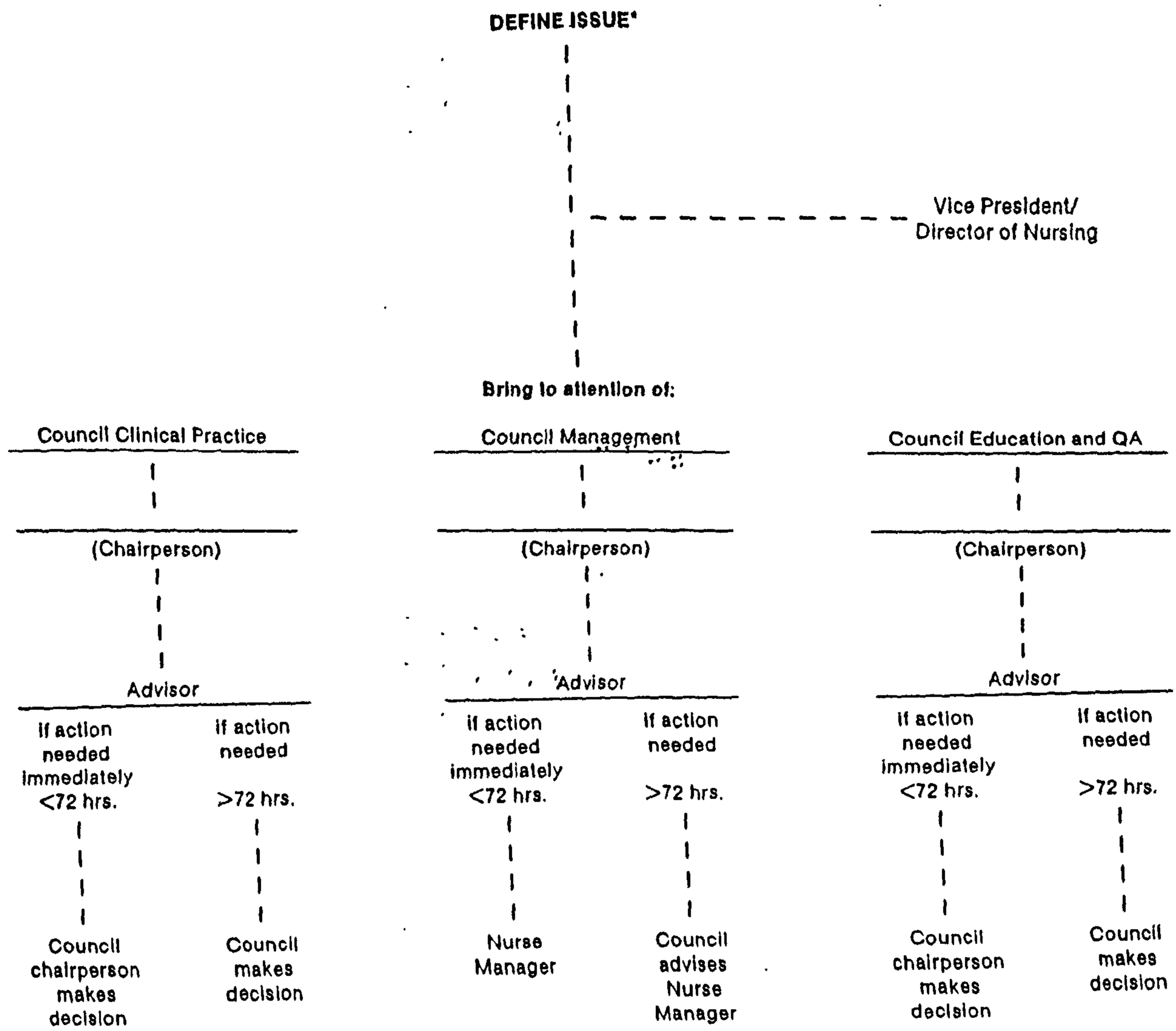
The functions, processes, and systems that will be needed to fulfil our Governance responsibilities have been defined and are listed in the following table: -

GOVERNANCE FUNCTION	SYSTEM / OTHER REQUIREMENTS
Whole Systems Approach to Governance	♦ 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	♦ 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	♦ 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	♦ 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	♦ 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	♦ 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	♦ Appraisal systems for all clinical staff to be implemented in 2001 ♦ Review of system re poor performance management needed
Education and professional development	♦ 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	♦ 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	♦ 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

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

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

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

Colette Mullins

Ian Buchanan pp.
Chairman
Bury & Rochdale Local Research Ethics Committee

Bury &
Rochdale
HEALTH AUTHORITY

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

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

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)l, 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

C. Mullins.

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

<u>Council Comparison</u> – *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	• Millennium issues • Recruitment & retention • Support Worker role • Communication • Personal Development Plans • Canteen hours • Shift patterns	• 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*								
Council member (pseudonyms):	Council	Gender	Discipline	Seniority	Chair?	Prior meetings experience	Knowledge of subject area	Tenure to-date
Nicky Walkden	***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***
Jan Glossop	***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***
Lucy Whitefield	***HR***	***F***	***Nurse – acute Surgery***	***D grade Staff Nurse***	***Yes – is 5/12***	***Own department meetings only***	***Non***	***15/12***
Ria Huddersfield	***HR***	***F***	***OT***	***Junior grade***	***No***	***Departmental only***	***Non***	***12/12***
Isaac Bolton	***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***
Alice Clayton	***PD***	***F***	***District Nurse - Community***	***G grade Sister***	***No***	***Rep on course committee and support group***	***District nurse documentation group***	***3/12***
Zeta Manchester	***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***
Gwen Worsley	***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	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

Fieldwork CM/DM HR 10-00 (ANONYMISED EXTRACT)

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).

B – we're meeting as a sub group so bring next time.
A reiterating again to collect prior to next meeting so November 3rd agreed. (Need to watch how many do the work as usually only one and this is first time they have set a clear deadline for Council Member work I think).

Orientation Pack
B – **still waiting for bits from other councils (unbelievable as was requested in June)**. This could have been completed last month if the other councils were responsive).
A – can you update me as missed last few meetings. Have all looked at the draft pack.
B – No, will send a copy out once have other councils bit.
A – so to others for comments prior to finalising it? (**advice** posed as a question)
B – anything else needed in it?
F – might when seen the draft first
A agreed
B asking x to send it out when ready

Recruitment Pack
D – where up to on this?
B – F to do bits (not accurate and checked with x). Need bus time tables etc (Why this is not an orientation pack)
B asking for mind map A has to go in while.
B – where get bus timetable from?
G – I can ring up bus stations – YES
A – Royal Infirmary has some info
B – said last time that we'd ask Directorate Managers to nominate people to write a piece about own areas. Still want to do this? Will ask at PC.
A nodded. (DIDN'T ASK AT PC)
B – can you remember anything else to put in? (Not referring to any notes)
F – is this only an overseas pack?
A – no is a general one to supplement the existing one. Limited due to new development.
A explained how new nurses had come to the council to inform this item previously.
B – we mentioned entertainment info too. If there's anything else, send it to me and I will bring it to the next meeting.
F – will look around HR dept. (Good source of info)

.....

Communication
B – **this problem came up in Tracey's feedback** and our own discussion
D – to advertise stuff?
B – partly
D – could ask Training to send out things. Would be nice to have someone from training here. Said we'd use the Trustee last time

Chatty finish at 3 40pm.

THOUGHTS

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

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

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

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

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

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

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

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

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

info in Recruitment Pack.

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

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

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

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 ONEMPOWERMENT	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 ONEMPOWERMENT	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 ONEMPOWERMENT	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 ONEMPOWERMENT	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

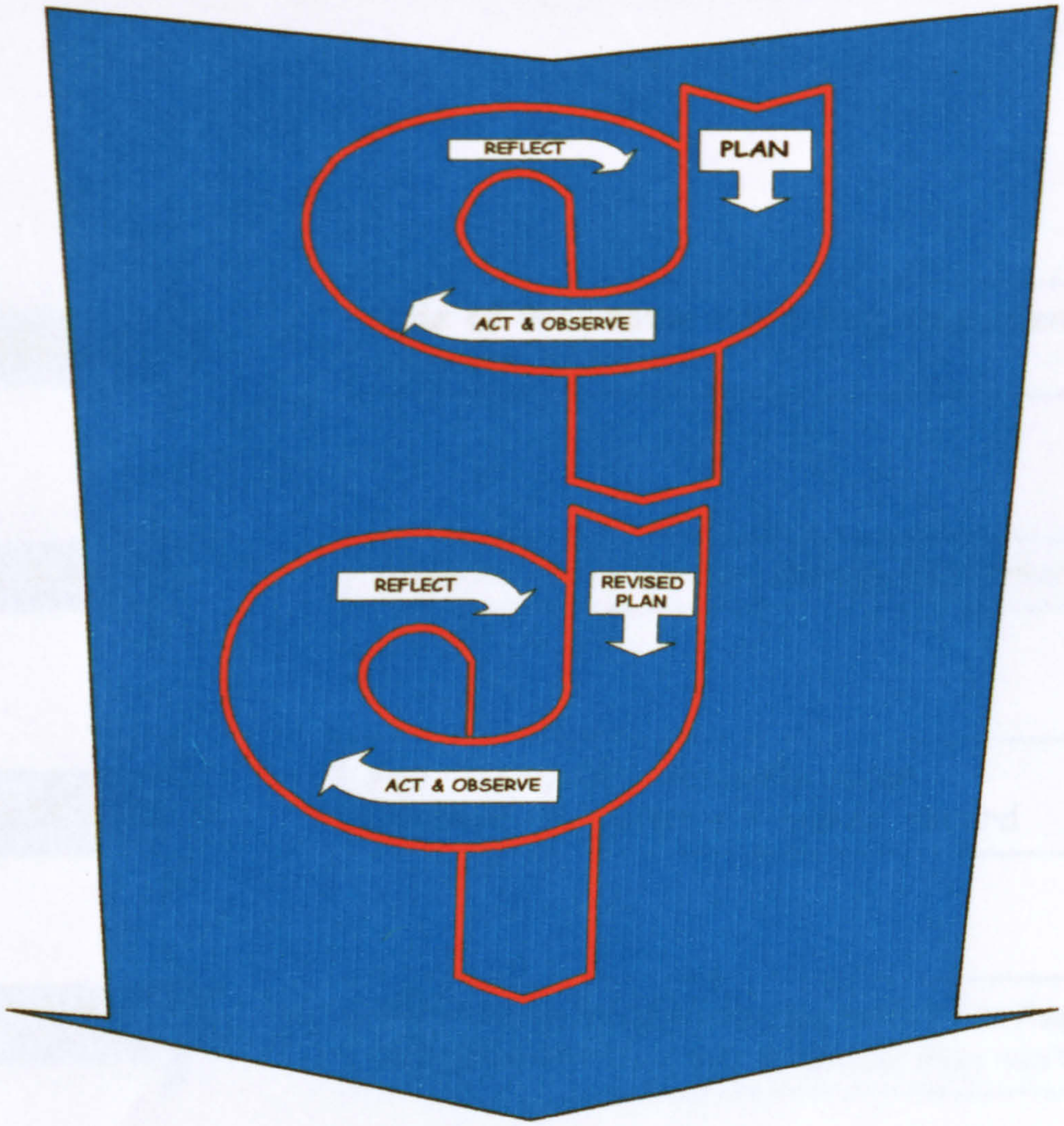
Amendments from January: Merged decision making Acts and Processes, deleted Context, and merged Personal and Professional Development

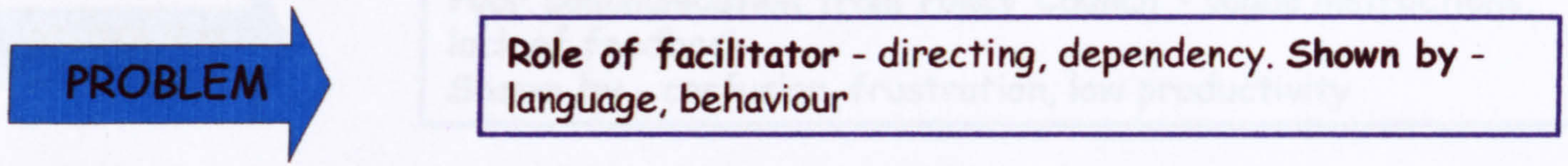
CODING SCHEME 3 – May 2001

MAJOR CATEGORIES, SUB-CATEGORIES & *Labels*	**ASSIGNED CODE**	**SOURCE RESEARCH QUESTION**
SHARED GOVERNANCE SYSTEM	**SYST**	
MODEL	SYST-MOD	1, 2
REMIT – *Other's View, Own View, How Deliver Remit*	SYST-REM	7, 8
COUNCIL RELATIONSHIPS	**REL**	
INTRA COUNCIL – *Influential Members, Roles*	REL-INTRA	4
INTER COUNCIL	REL-INTER	5
INTRA ORGANISATION – *Common Language, Engagement, Insular, Other Groups*	REL-ORG	6
DECISIONS	**DEC**	
ISSUE IDENTIFICATION – *Constituents, Managers, Types*	DEC-ID	9
ISSUE SELECTION – *Clarify problem, Gain Further Info, Fit Remit, Issue Size, Subjective Selection*	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	**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 ONEMPOWERMENT	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 ONEMPOWERMENT	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

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

PROBLEM

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

PLAN

Discuss with participants - identify possible solution

ACT/OBSERVE

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

REFLECT

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)*

CM - Council Meeting

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
A D – 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 liasing 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 *eg info, decision, discussion*	ACHIEVED OUTCOME & ACTION
		Total needed:		

OARRRS:

O = Outcomes	What is desired for each item. (eg *a decision, for information, discussion*)
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

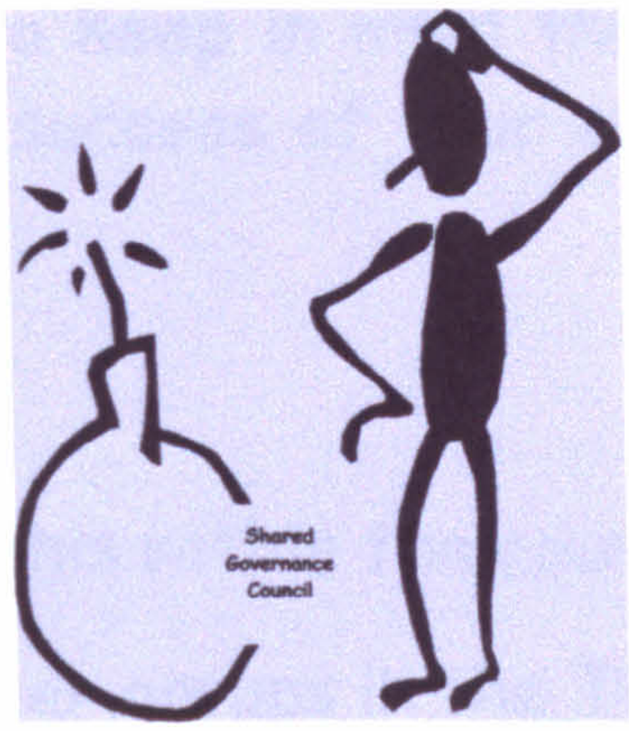
Process Facilitator role:

- 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)

Rochdale Healthcare NHS
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

362 362 362 362

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 sub-group 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 Millenniu m work												No meaningful objective – just to check out if any role for council. Just resulted in frustration.
Lead Person	NO – fell to Chair												Chair copping 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 Millenniu m lead if needed in Month 4	Awaiting PC feedback in Month 4	Brainstorm ed 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)

368 368 368 368

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 2nd	2nd 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)

369 369 369 369.

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 Recruitmen t 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/Man y apologies Council ceased to meet from here on				
Approval Sought													
Completed													

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

370 370 370 370

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)

371 371 371

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 constrying 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)

372 372 372 372

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)

373 373 373 373

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 ed 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)

374 374 374 374

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 involveme nt generaly												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 involveme nt	Info shared. Brainstorm ed 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 involveme nt. Sub group to carry on	Update from sub group. List to be sent out of all user involveme nt 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. Vice 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)

375 375 375 375

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 deigned 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)

376 376 376 376

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 acccept 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)

377 377 377 377

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 member												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)

379 379 379 379

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 discus 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)

380 380 380 380

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							Members fact finding						Not sought
Consultation													
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)

381 381 381 381

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 of Authority				Level 2									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 **END OF FIELD WOR K**					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

382 382 382 382

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 of 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 meting 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 fell 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.

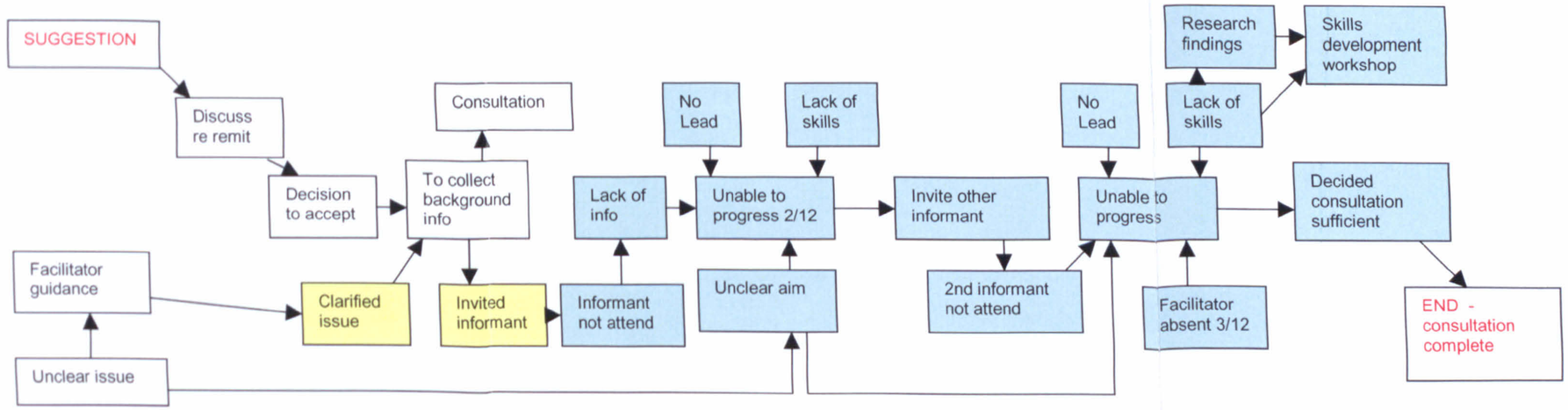
- **LEO.** Are noticeably influenced by the LEO eg OARRRS model and 90-minute model. Also language used and principles adopted ie aiming for consensus decision making (covered elsewhere in the data).

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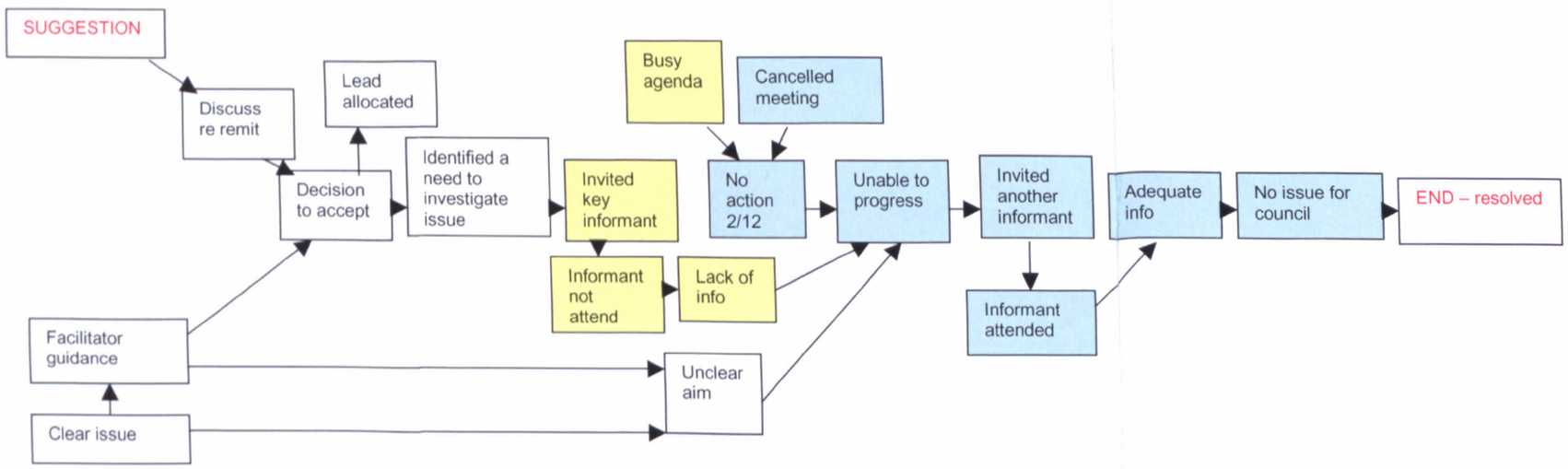
Causal Network Diagram 3 - Human Resources Council Personal Development Plan Issue (HR3)



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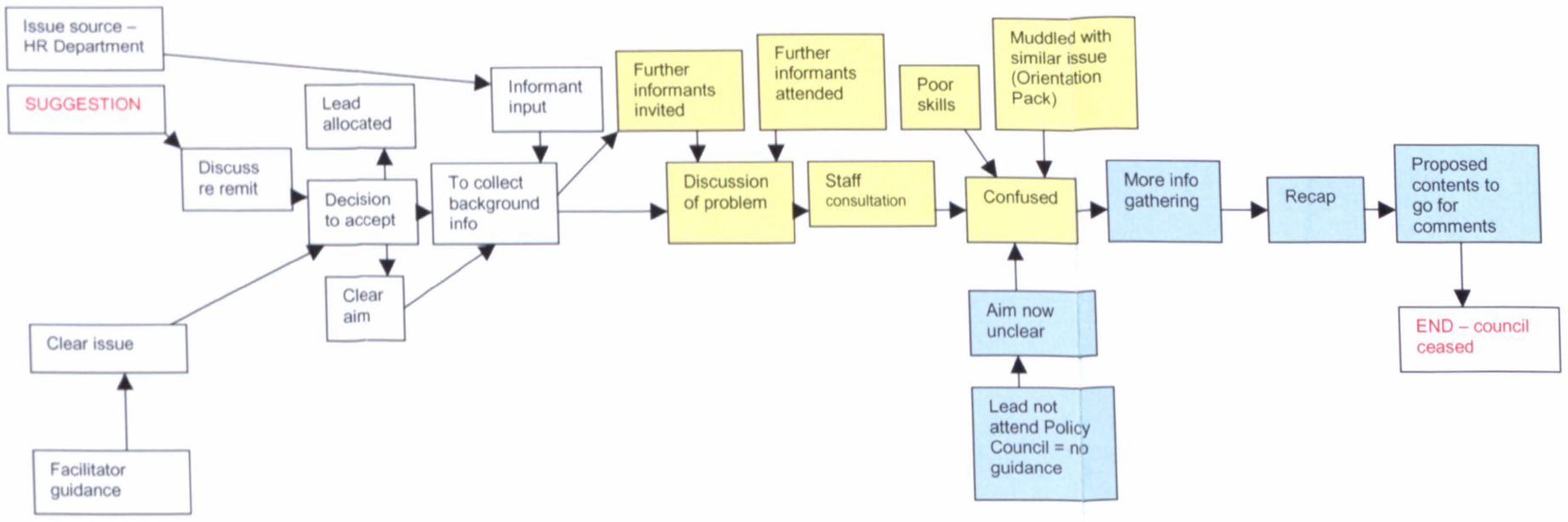
Causal Network Diagram 4 - Human Resources Council Recruitment Pack Issue (HR4)



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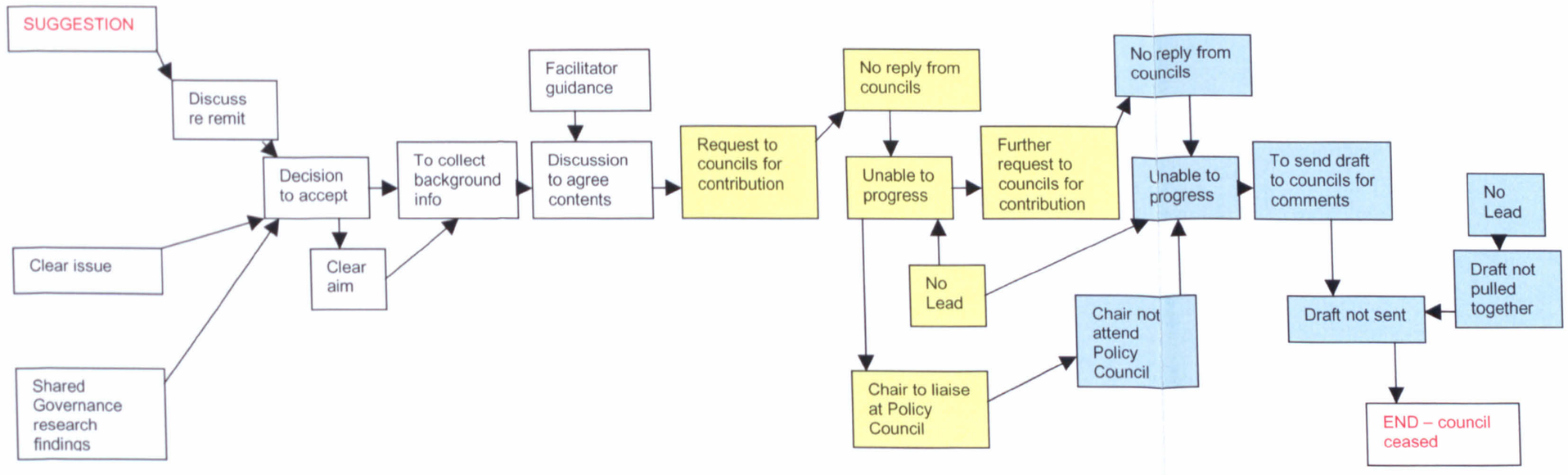
Causal Network Diagram 5 – Human Resources Council Orientation Pack Issue (HR5)



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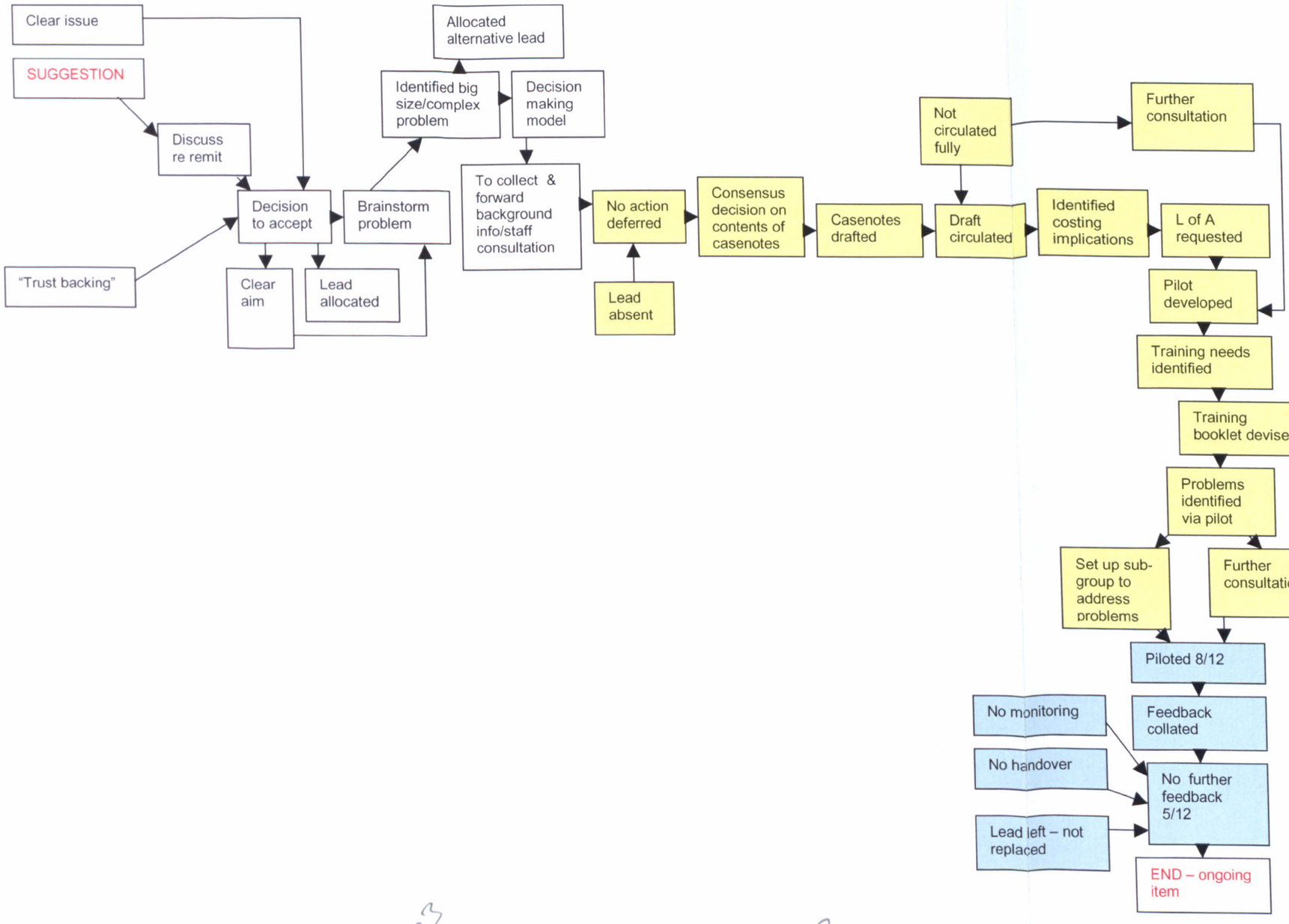
Causal Network Diagram 7 - Mental Health Council Case Notes Issue (MH2)



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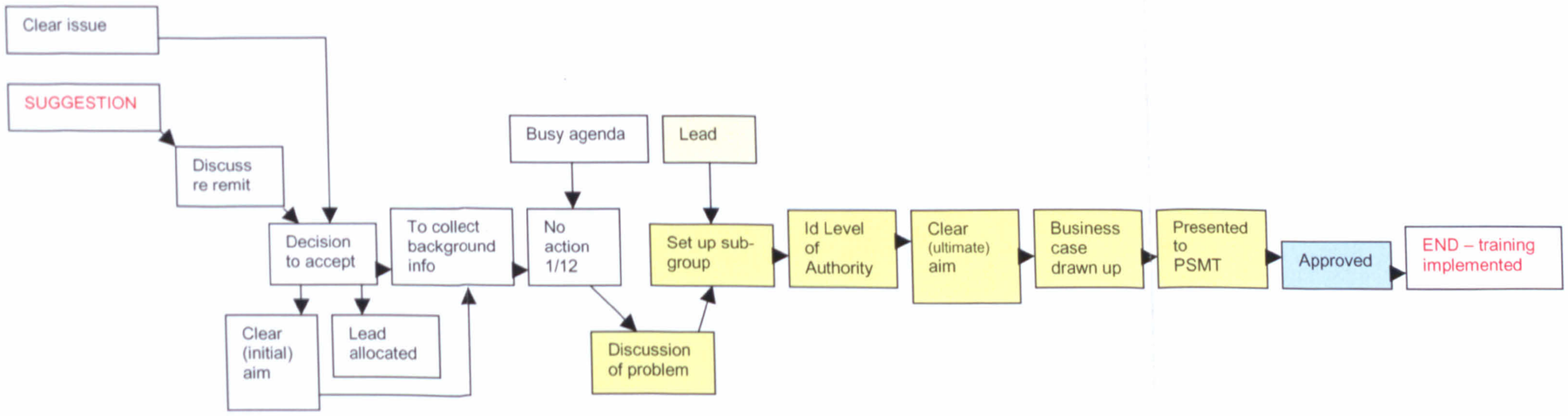
Causal Network Diagram 8 - Mental Health Council Bank Nurse Training Issue (MH3)



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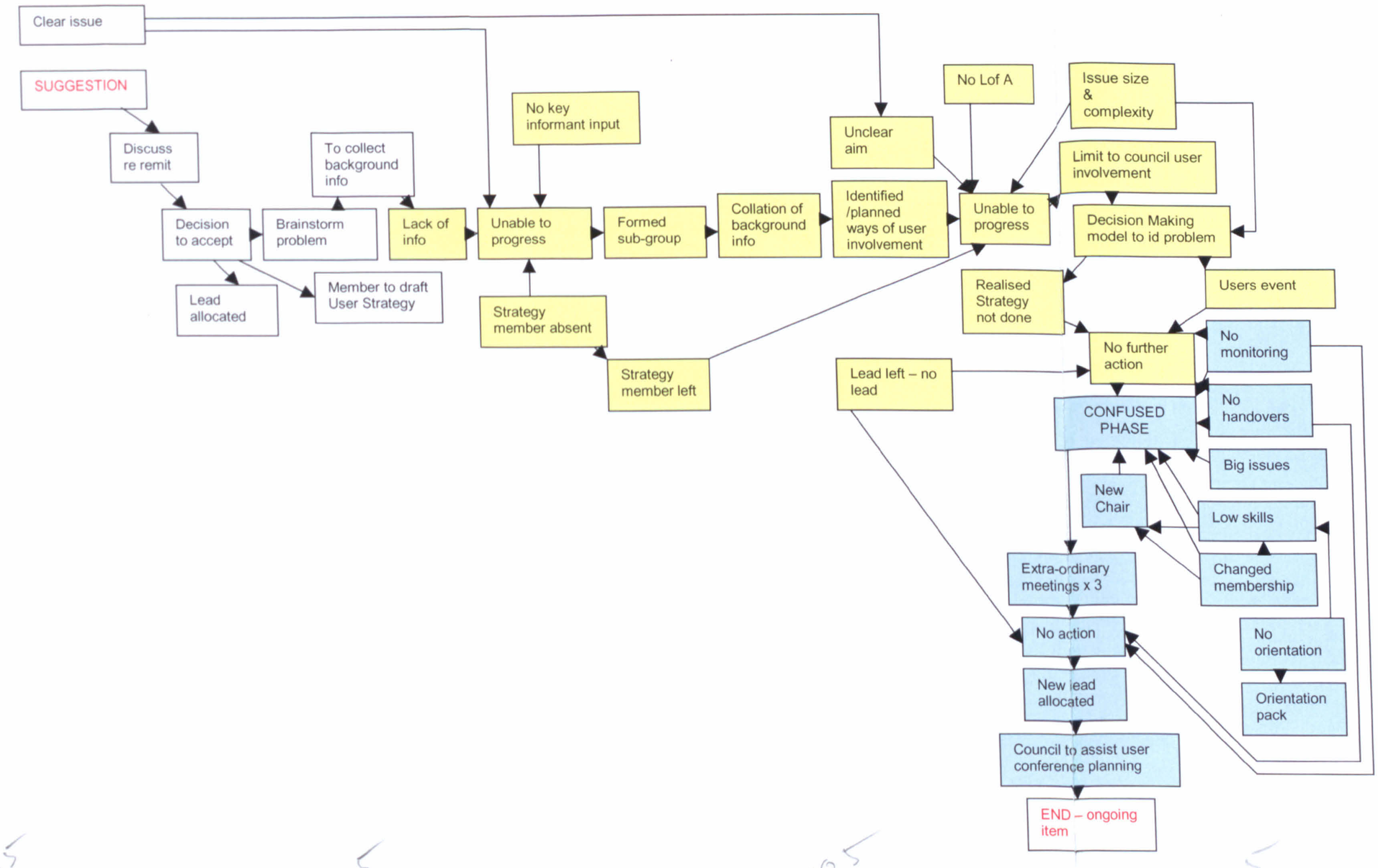
Causal Network Diagram 9 - Mental Health Council User Involvement Issue (MH4)



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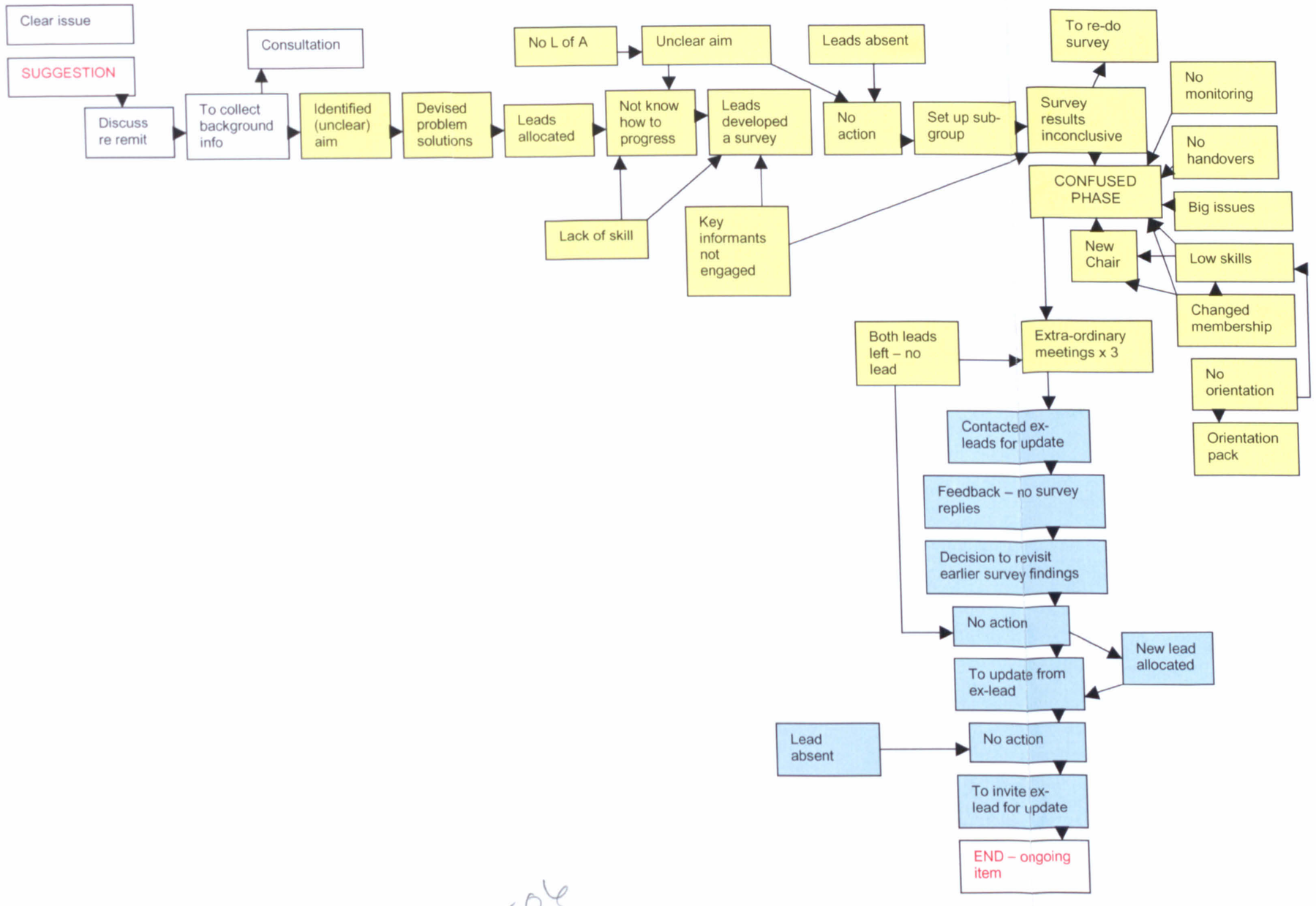
Causal Network Diagram 10 – Mental Health Council Face-to-Face Contact Issue (MH5)



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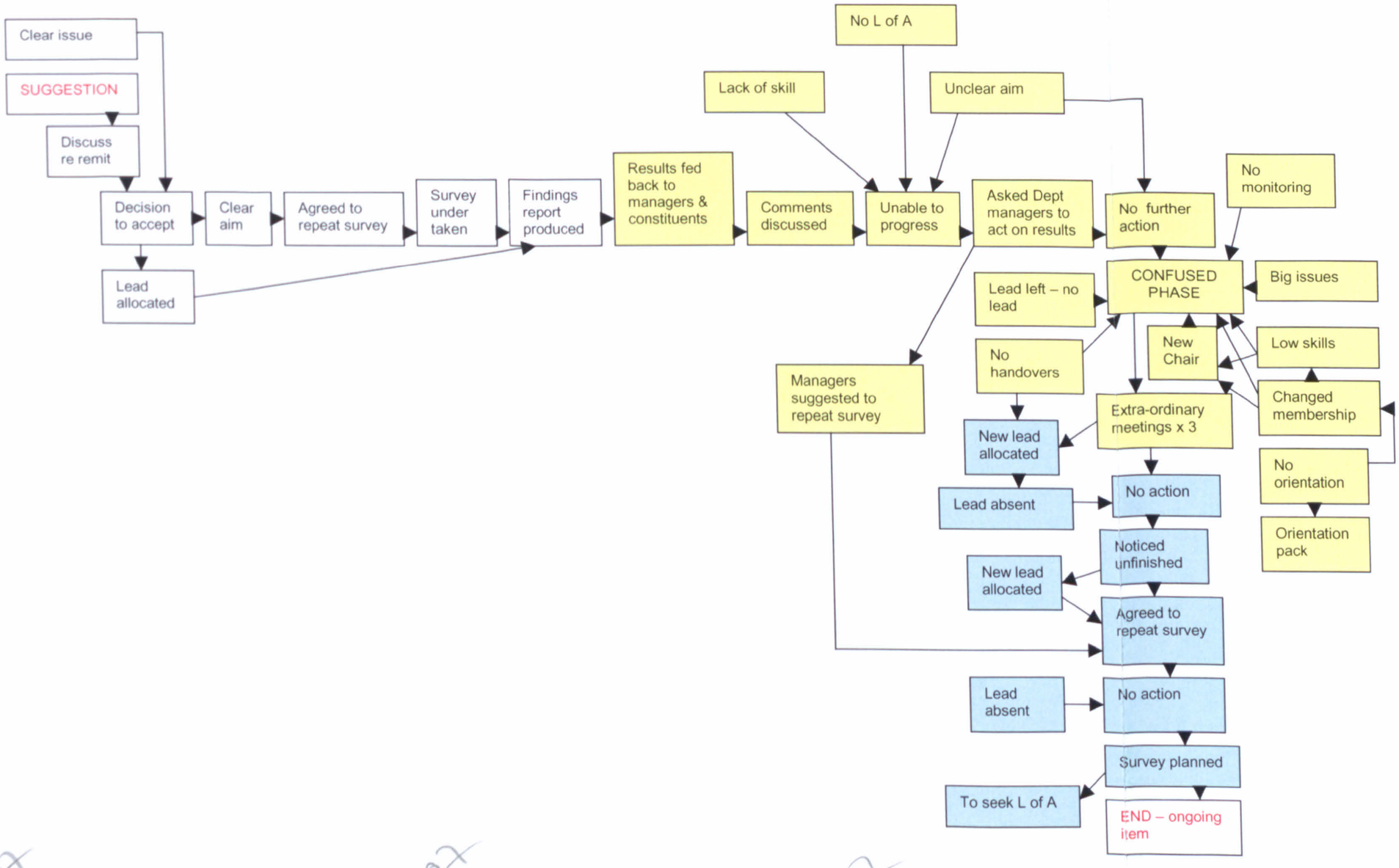
Causal Network Diagram 11 – Mental Health Council Motivation Survey Issue (MH6)



Causal Network Diagram 12 – Mental Health Council Ethnic Minorities Issue (MH7)

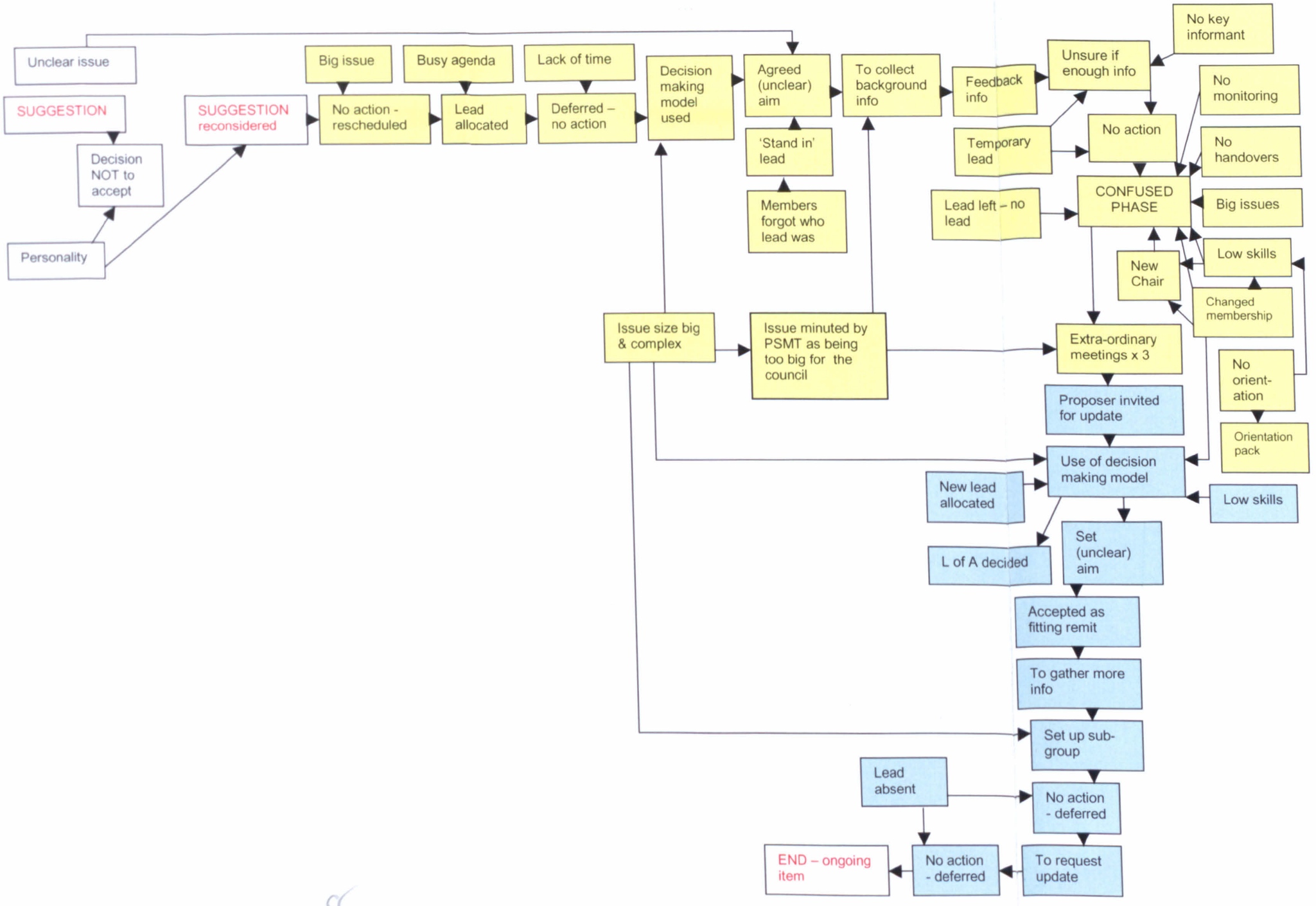


Diagram 2 - HR2 – Millennium Issue

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 - HR3 – 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.

Narratives - Causal Networks - MH – *revised October 2001*

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

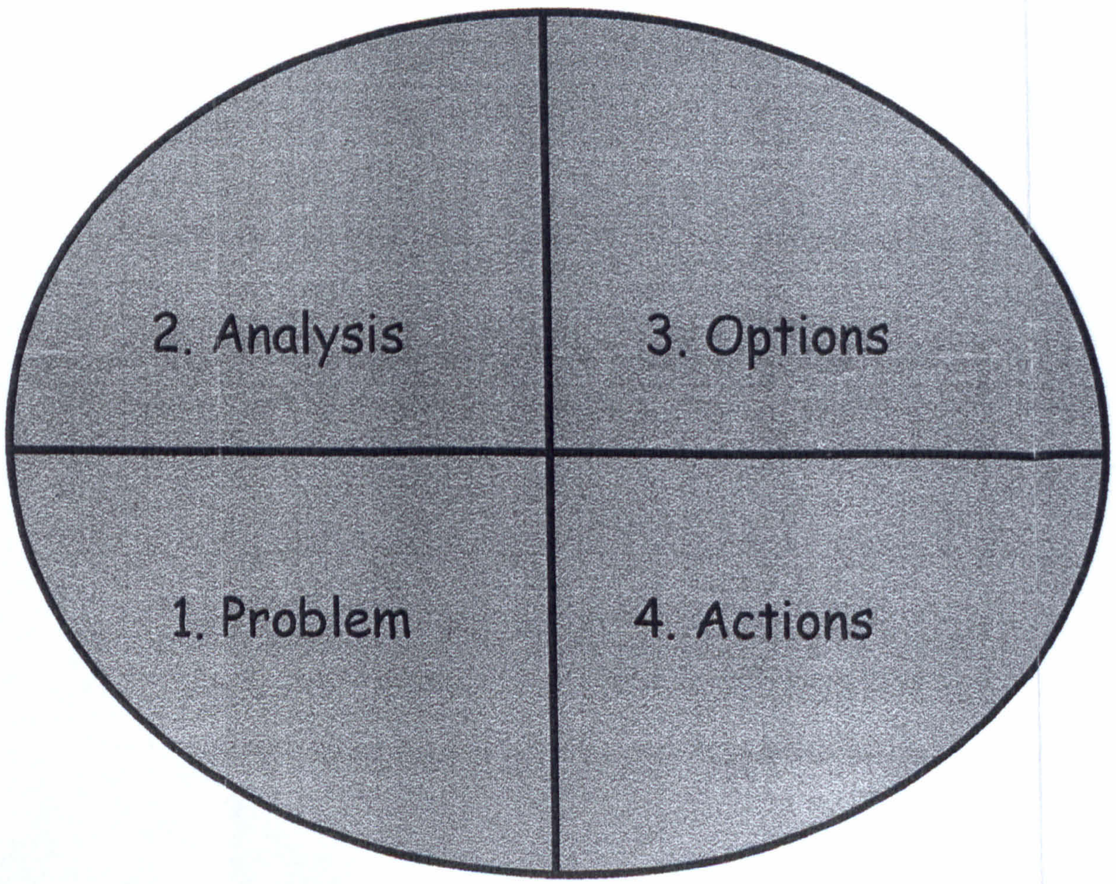
This suggestion from a staff member was unclear at the outset and with very little discussion was refused. By far the most significant factor causing this was the personality and views of a particular council member. However a few months later

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

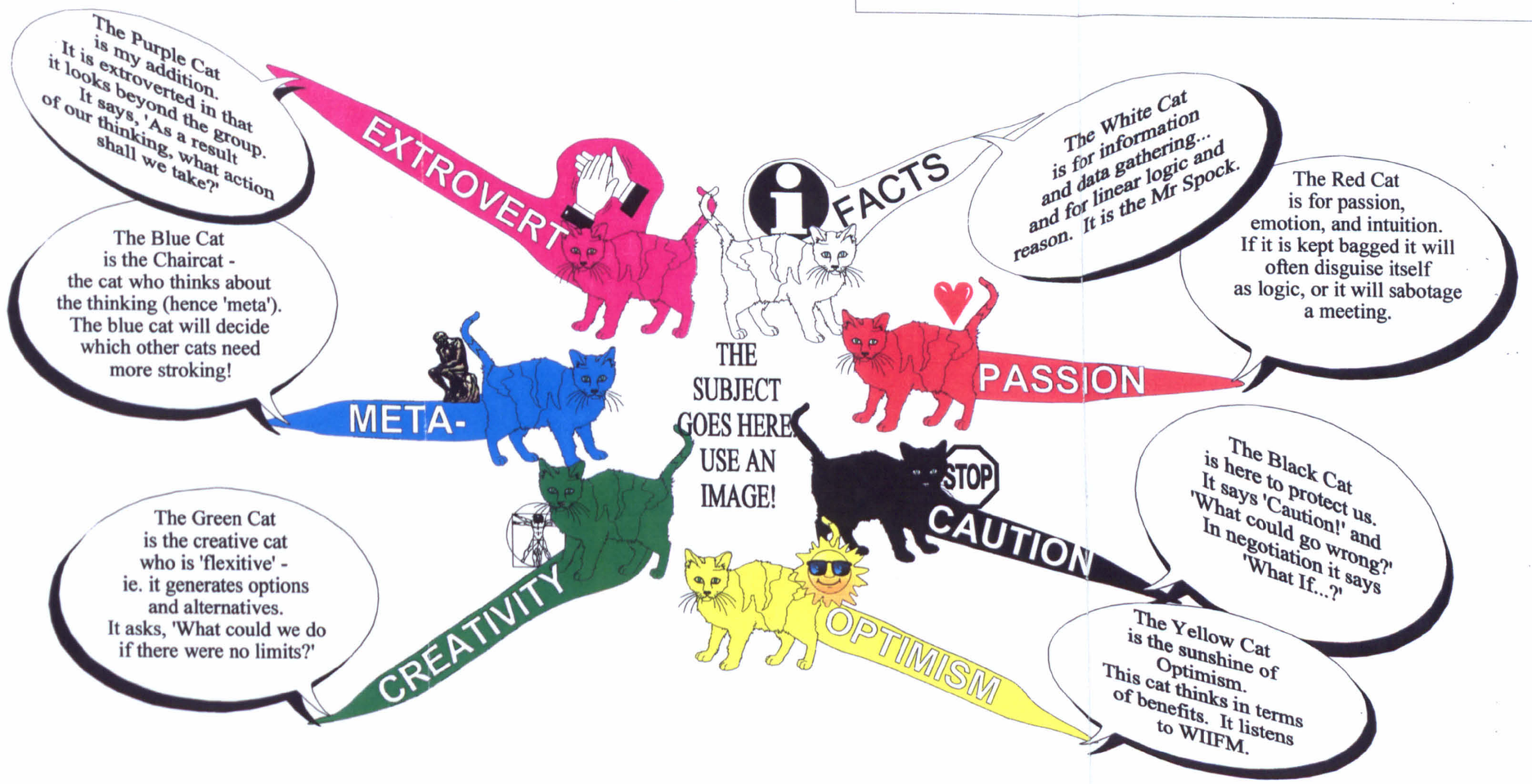
LEO Problem Solving Model



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?'

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.

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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!

Shared Governance Decision Making Workshop 2001

Evaluation Forms Summary

1. How enjoyable did you find the workshop?
   Very × 5
   Very enjoyable
   Extremely × 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 × 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 × 5
   Yes – motivating me ++
   Yes – it refreshed, revisited and re-motivated me
   Definitely

6. Would you recommend the workshop to a colleague?
   Yes × 5
   Definitely × 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

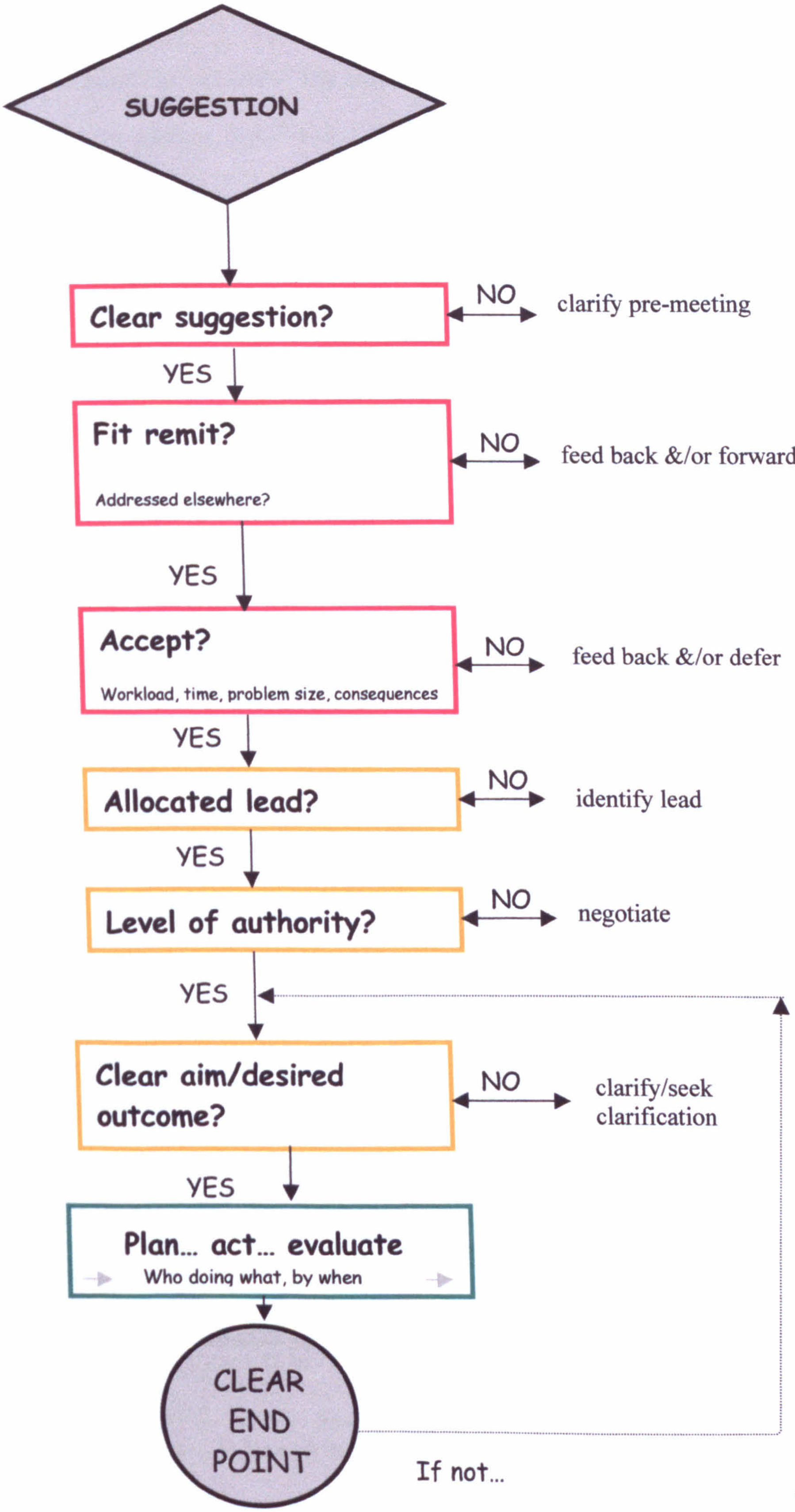
Williamson T *Survey to identify the outcomes of shared governance (poster)*, Salford Royal Hospitals Symposium, University of Salford, 5 July 2001

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



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