

Strengthening group decision making within shared governance: A case study

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Abstract: Shared governance is an approach to empowering nurses and other health care workers to have authority for decisions concerning their practice. Commonly, visible definers of shared governance are groups of workers known as 'councils' whose membership works collectively to realise a shared goal. The literature is replete with rhetoric as to the benefits of shared governance yet the evidence base concerning shared governance and especially decision-making within shared governance is scant.

This paper presents a case study of group decision-making within a UK shared governance council model. The evidence which informs the case study is drawn from a doctoral action-research study to strengthen decision-making within the model.

Eight key factors affecting decision-making and four supportive conditions are presented and incorporated into a conceptual model. Within the case study, presence of these factors was found to be necessary but not sufficient to enhance decision-making. Factors included having a clear issue, clear aim, fitting issue, manageable issue, size, lead person allocated, level of authority, background information, key informant/s, a mechanism for evaluation, adequately skilled members, support/guidance and sufficient/appropriate membership.

Aspects of group decision-making processes are highlighted and compared with established management, shared governance and group dynamics theory.

Keywords: shared governance, decision-making, groupwork,

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Introduction

Health care organisations are increasingly cost-conscious and constantly having to seek ways of delivering efficient, quality care (Duncan, 1997). In response, organisations have invested in a variety of approaches to develop the leadership capability of their clinical workforce (Buchan *et al* 1998; Caldwell & MacPherson, 2000).

One leadership approach, still relatively new to the UK and with its origins in Northern America and Canada, is shared governance. One definition of shared governance is that it is a system of management (Geoghegan & Farrington, 1995) that seeks to empower healthcare workers such as nurses by placing responsibility for quality of care firmly in their hands through involvement in practice-focused decision-making groups. The international popularity of shared governance within nursing is related to the many positive outcomes it is purported to realise. These include improved recruitment and retention of nurses (DeBaca *et al*, 1993), greater staff satisfaction (Vilardo, 1993) and an empowered nursing workforce (Jenkins, 1993).

Central to shared governance is the erection of structures that facilitate staff to meaningfully contribute to their organisation's corporate agenda through a process of shared decision-making. These structures are variable, but models adopted around the globe commonly comprise committees known as 'councils' of elected or appointed groups of staff representing single or multiple disciplines (Edwards *et al*, 1994). Nursing as a profession has welcomed shared governance as a means of harnessing staff commitment and creating a sense of ownership of the decisions made (Naish, 1995). Yet little attention has been paid to understanding the decision-making element within shared governance or the group processes which operate within councils.

The aim of this paper is to present a case study of a model of shared governance developed in a hospital and community NHS Trust in northern England to illustrate barriers and drivers for effective group decision-making. The paper will draw on evidence from a doctoral level action research study which sought to explore group decision-making and develop an explanation of what works in what circumstances. The study involved over 200 hours of participant-observations of the councils at work and interviews with 38 council members and other stakeholders e.g NHS managers. Data informed development of a range

of data displays (Miles & Huberman, 1994) culminating in causal network diagrams that tracked council issues from inception to the end of fieldwork (see Figure 1). The study ended with development of a conceptual model of shared governance decision-making which is also presented (Figure 2). Findings are situated within existing management, shared governance and group dynamics theories where pertinent.

Case study

The Councillor Model of Shared Governance

In September 1997, the appointment of a new Nurse Director to a combined hospital and community NHS Trust in the North of England provided the impetus for the introduction of shared governance. The hospital served a local community of around 220,000 people and employed approximately 1,600 nurses and 160 Clinical Professional Services staff such as physiotherapists.

Over a fifteen-month development phase, a model of shared governance was designed in collaboration with senior nurses and a wide range of clinical staff. Staff were democratically elected by colleagues to have a seat within the shared governance council structure. As preparation, each staff member underwent a three-day leadership development programme to enhance their understanding of shared governance, develop their appreciation of working in teams, and foster a climate of innovation and involvement.

The shared governance model comprised a Policy Council and three practice-based councils: Human Resources, Research/Education, and Practice Development (Figure 3), each with a Trust-wide remit.

Each council had twelve seats to allow for professional representation of clinical staff working in Medicine, Surgery, Community, Mental Health, Maternal and Child Health and Clinical Professional Services (e.g. physiotherapy). Each council had a Chair and Vice-Chair and was supported by a council facilitator (one of the shared governance project leaders). The councils fed into and were supported by a Policy Council that comprised the Nurse Director, Senior Nurses, Directorate and Service Managers and Chairs of the three practice-based councils.

Fig.1. Example of a causal network

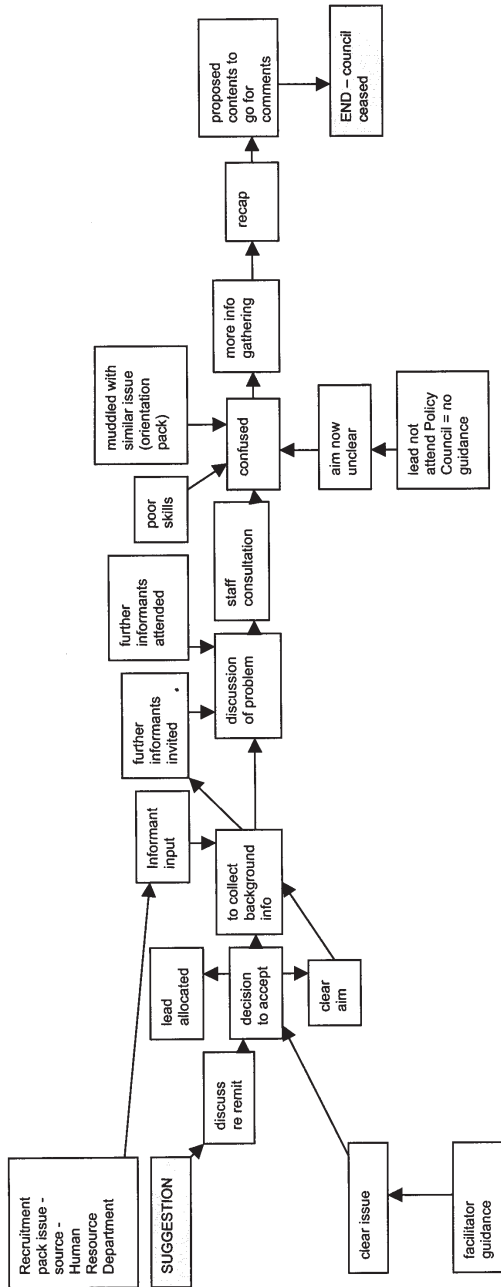
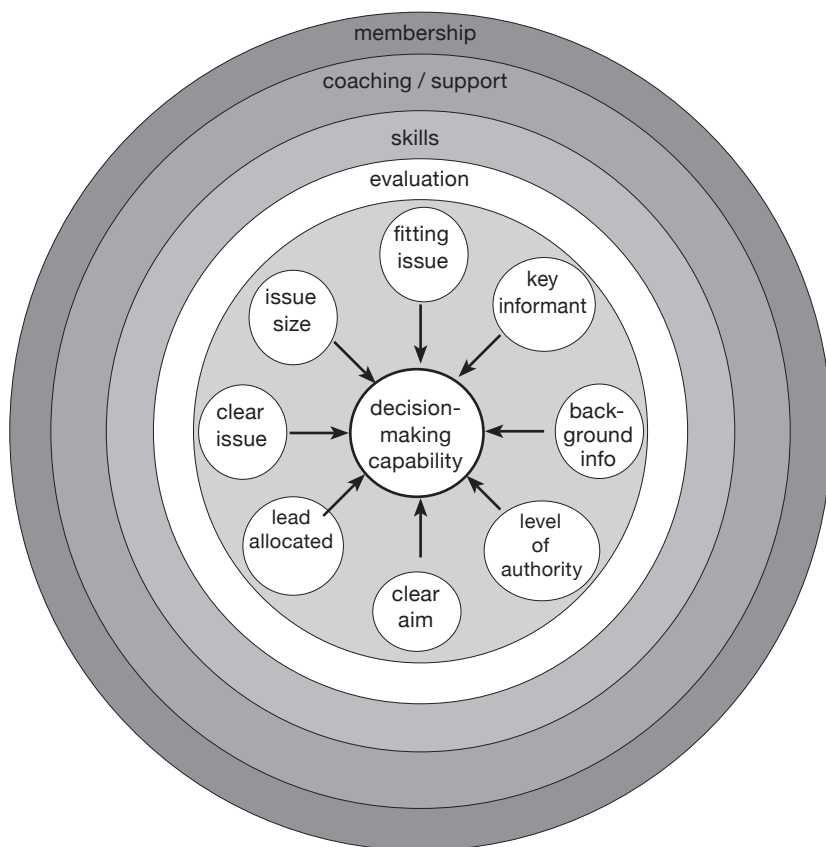


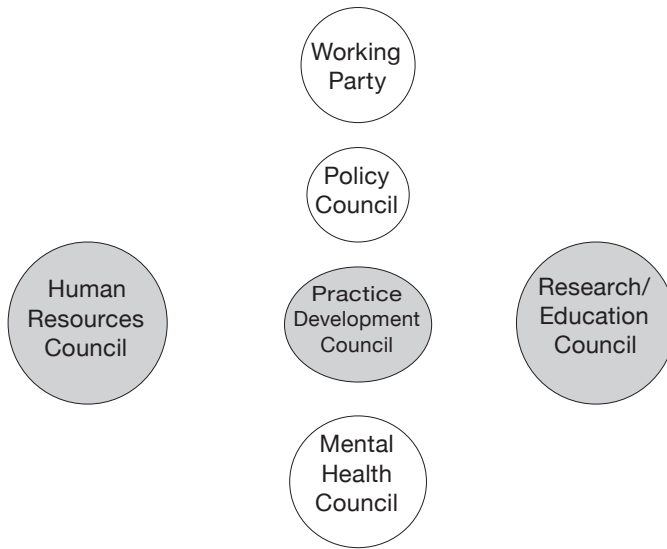
Fig. 2. Conceptual model of shared governance decision-making



The role of the Policy Council was to give the councils advice and direction. All councils met monthly for between 2 to 3 hours. Issues for the practice-based councils to address were self-generated by members, identified through a Trust-wide suggestion form system or proposed by the Policy Council.

As the model developed, a further practice-based council evolved unexpectedly in the Mental Health Directorate. This council addressed directorate-specific practice issues only, unlike the other councils' Trust-wide remit and sphere of influence. This council comprised thirteen seats occupied by Mental Health nurses from the acute hospital

Fig. 3. Shared governance council model



and community settings, an administrator, a psychiatric consultant and nursing assistants. Being a directorate-based council, the Mental Health Council reported to and linked with the Psychiatric Services Management Team as opposed to the Policy Council. This group comprised Mental Health Directorate service heads, the Directorate Manager and psychiatric consultants.

Examples of issues addressed by the councils included development of a Trust recruitment pack, interdisciplinary patient case notes, a staff motivation survey and a Trust journals repository.

Factors affecting decision-making within groups

In-depth examination of 12 council issues from inception to end of fieldwork permitted a wide variety of council decision-making processes and associated group dynamics to be interrogated. Issues were worked on by council members over periods lasting between six and twenty-four

months. Causal network diagrams (Figure 1) evidenced tangible factors that were considered to help or hinder effective decision-making within the groups. Through these processes, 12 core factors were identified that had a significant impact on group decision-making processes and outcomes which have been incorporated into a Conceptual Model of Shared Governance Decision Making presented later. An overview of these factors is given here and for ease of presentation these have been grouped under three headings: Problem Focus, Empowerment and Information Requirements.

Problem focus

When addressing issues presented to their councils for them to address, group members were seen to struggle in the absence of a clear aim. Whilst not all issues themselves were clear on presentation, there would usually be some activity aimed at seeking clarification of the issue itself and what the goal of the council was with it. Once these had been made clear, group members would generally have a discussion to establish if the issue fitted their council's remit. Where it did not, members would pass the issue to another group or individual in the organisation for consideration. Only on one occasion was a systematic approach used to determine whether an issue was accepted and on this occasion the council used a decision-making model they had been introduced to when undergoing leadership training for their role. Subjective influences were noted to be at play when some issues were accepted or rejected such as who was leading the discussion at the time or who the issue had been suggested to in the first instance and whether they brought it to the rest of the council members' attention at all.

In the absence of a clear aim, group processes tended to be one of 'work it out as we go along'. This approach was sometimes successful whilst at other times it was not and issues never gained a clear focus. Despite this, some positive outcomes were achieved such as the prompting of a conference when the opportunity presented although that had never been an intention. Group members congratulated themselves on a job well done without realising that the good outcome was despite their actions and not because of them.

When deciding the fit of an issue, its size was sometimes noted. However this was not always the case and even when several issues

were observed to be particularly sizeable and so challenging, this was disregarded and the issues accepted. This meant that at times of overload, councils still accepted further large issues which had the anticipated effect of overloading them further. One council nearly folded at one such acceptance of new work when already struggling. Members did appraise whether they could cope with newly presented issues yet then bowed to pressure from themselves to accept all issues that fitted their remit. Encouragingly they did realise at a later date that their actions were detrimental to their successful management of issues. Whilst they realised that others outside of the council were perhaps better placed to deal with some of these issues, help from groups such as other councils was not sought.

The origin of a suggested issue was a further determining factor, as those from Policy Council appeared to be accepted by one council in particular without question. Issue acceptance also depended on the councils themselves being clear about their own remits and this too was not always the case.

To illustrate, the average time that issues remained on the Human Resources Council agenda was 10 months and average time on the Mental Health Council agenda was 19 months, with meetings lasting 2 to 3 hours per month, most months of the year.

Empowerment

Having had authority to act conferred by the Policy Council, it was viewed that Council members would be empowered to address each issue they were presented with and reach a resolution such as a new policy, a changed practice or a recommendation for change or further action. How they arrived at this was up to them.

Council members would sometimes allocate a lead person for issues who would then co-ordinate work on the issue and drive it forward. What was unhelpful was the frequent practice of allowing the responsibility for leading issues to be absorbed by the council chairs who already had ambitious workloads. 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. Secondly, issues fared differently, due at least in part to who the lead was. Some issues were found to be less effectively co-ordinated whilst others were particularly well driven. Thirdly, issues were not always shared out equally with some members having no issues at all whilst others had several, which at times meant that these leads also dominated the council agendas and discussions quite heavily. Sharing issues, and hence workload, amongst leads appeared to work well.

At the outset of shared governance implementation, there had been discussion that councils may wish to negotiate a specific level of authority to act with the Policy Council or Psychiatric Services Management Team in the case of the Mental Health Council. Yet this was rarely done. When one council opted to assign its own level of authority, this did nothing to help it gain clarity over what was already an unclear issue. Overall, less clarity of purpose existed where a level of authority had not been gained and on several occasions members' actions were not endorsed by the Policy Council.

With regards to sufficient resources to act, effective processes were observed to occur when there was adequate membership present. Attendance levels at meetings and the degree of orientation of new members also noticeably affected council momentum. At one council, due to its lack of popularity and initial poor recruitment, there could be 30-60% of its ideal membership present at any one meeting. 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. When attendance was too low meetings were no longer quorate to permit decisions to be made. At other times the membership was under-representative of certain professions so that there was insufficient knowledge to inform decisions. On occasions meetings were cancelled altogether due to lack of attendance on the day. Council members were often frustrated as rarely were any updates on progress made forwarded by members who knew they were going to be absent.

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. This work away was not always done by

all members, and would typically be done by one or two enthusiastic members e.g. commenting on draft documents.

Amongst the first appointed council members, personal qualities, experiences, backgrounds and capability varied considerably which were noted to impact negatively on decision-making processes. Preparation for council roles could have been more substantive and it was chairs and vice chairs who appeared to struggle the most in being clear about their roles within this new and complex initiative.

Subsequent members and those taking over from existing chairs and vice chairs 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 and three months later admitted to still having no idea what the remit was or what was expected from them.

Professional backgrounds of members were also an issue especially when working on uni-discipline issues and trying to make sense of the professional issues and language of other professionals.

Also affecting sense of empowerment was the presence and supportive input of a facilitator at some council meetings. This was associated with good progress being made on occasions that the facilitator was present. Unfortunately there were occasions, including a three-month period of absence of one council's facilitator, which had a marked negative impact on that council's progress. When absent, the facilitator could not signpost members to key informants or tease out the best ways of approaching issues. This particular council needed its facilitator to be quite directing as opposed to being facilitative and whilst this approach was intended to be short-term, the council never gained sufficient self-management for the facilitator to withdraw. Some disempowerment was evident during facilitator absences as council members believed they could not act independently and chose to await the facilitator's return, resulting in delays.

Information requirements

A further aid to clarifying and informing each council issue was to seek background information. This was done for the majority of council issues. 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. 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 councils was avoided.

Key informants were a valuable source of expert knowledge for the councils. An example is when a Human Resources staff member attended to help with development of a Trust induction pack for new staff. Conversely non-attendance of a key informant was unhelpful as issues could not progress without their involvement. Recognition of the need to invite a key informant was often done late into the lifetime of an issue in response to difficulties, as opposed to being a proactive activity. As a directorate-based council, the Mental Health Council utilised a specialist informant only once as members tended to believe they had the requisite knowledge amongst themselves, which was not always the case. 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 appropriate colleagues drawn from their practice areas to address a particular task.

The activities of council members were supported by regular feedback from the action research study this case study is drawn from. Whilst emerging findings were fed back three-monthly, these were often repeat findings as no action had been taken despite much agreement with the findings. The findings impacted positively in a number of ways including improved council members' preparation, decision-making processes, team building, support for council chairs and increased presence of facilitators, to name but a few.

Conceptual model summary

To aid multi-professional groups of healthcare staff make decisions in the future, especially within a shared governance framework, the 12 key factors associated with effective decision making have been represented in a 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.

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.

In summary, this model proposes that effective shared governance 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.

Discussion

A range of inter-related factors affecting group decision-making within shared governance groups has been presented. These have further been translated into a conceptual model of shared governance which is in no way intended to suggest that decision-making processes should be viewed as sequenced and linear. Instead, the model demonstrates

recognition of the debate within management literature around 'coherent' versus 'chaotic' action dimensions within decision-making processes (Miller *et al*, 1999). Decisions are future-oriented and "the future almost invariably involves uncertainties" (Koontz & Weihrich, 1990, p.109).

The group processes described here have a number of congruencies with management theory of normative decision-making. 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. Examples include ascertaining level of authority, defining the problem and collecting data. Yet similarities of this case study with accepted management models of decision-making tend to pertain to the *early* stages of group 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 tend to be dissimilar to this case study, apart from recognition of the need for evaluation. The elements of these management theory-based 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 shared governance group decision-making.

Discussions within the management literature typically bypass the stimulus for decisions and skip to issues around appraisal of options. 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. This finding resonates with factors presented here in that poorly-focused information gathering was done hastily by council members early on, with consideration of alternatives, such as key informants being brought in, undertaken at a later stage.

On many occasions, council members determined their own level of authority. This goes against advice that truly empowered staff need authority to act conferring to them (Morris & Smith, 1993). In this case 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. Allocation of issue leads was often helpful and such 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).

Whilst wanting to be empowered, it was notable how some council members did not then fulfil their obligations such as when they avoided their responsibility to undertake tasks on behalf of the group. Such factors have been identified in the management literature as being ones of lack of motivation to make a decision and commitment to it (Vroom & Yetton, 1973). Yet in some groupwork studies such practices have been conceptualised as 'loafing' (Hart *et al*, 2001). Groupwork authors Karau and Williams (1993) suggest that in response, other group members have been known to act in such a way as to 'socially compensate' for those individuals whose performance is expected to be weaker in order to get the task done successfully. Arguably engagement/non-engagement in a group's activities to achieve a common goal is not just an issue of motivation or social compensation, but one of personality. Personality as an issue has been illuminated in Paden's (1998) study of the Myers-Briggs Personality Type Indicator in relation to shared governance 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 group meetings.

It is generally accepted that devolvement of decision-making can be risky (Doherty & Hope, 2000). The source of suggestions of issues for councils 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 shared governance project leaders and the expectation that they would know what issues were appropriate. Empowering staff does not negate the need for some managerial control to be maintained. From a participative management perspective, it is suggested that whilst promulgating empowerment, some managers may implement measures to support decision-making including use of a level of authority framework (Yamauchi, 1994), although Hess (1994) warns that managers may still retain control over who is involved in decisions and to what extent. Shared governance requires managers to confer authority and many may not be comfortable with this participative way

of working (Hibberd *et al*, 1992). In this case study, any council decisions that had resource implications e.g. a locum nurse training programme, had to have a business case prepared and presented before being ratified by managers. In reality, 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.

Within this shared governance model, council member numbers never exceeded thirteen per council and represented a good cross-section of clinical professions. Evan *et al* (1995) suggest that broad, multi-disciplinary decision-making is preferable to uni-disciplinary approaches as it is more effective. Furthermore, 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). However, too large a group can become unwieldy. Trying to reach agreement over decisions can be particularly time-consuming especially if a consensus decision is sought, as has been the experience here. A successful strategy here and in other councillor models is where work groups have been set up comprising the person making the referral, a council member and other staff (Culpepper-Richards *et al*, 1999) as a means of sharing the workload of councils.

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 shared governance, supports these suggestions. She comments that during team development, members often get stuck in early stages of development, these being forming and storming, because members want to get on with matters rather than prepare adequately. 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 shared governance project leaders, this was limited and goes against the advice of Frusti (1996) and Miller (1997) who suggest such clarification is essential if team members are to work together effectively. From a managing organisations position, identification of a focus and clear

objectives should be the priority before embarking on any decision-making process (Dearden & Foster, 1994).

Decision outcomes are an area commonly discussed within management literature. As in this case study, positive outcomes have been known to arise by chance rather than good planning (Pauker & Pauker, 1999). 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). As Schoonover-Shoffner (1989) points out, decision-making will be erroneous if based on inadequate information. 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. Vroom and Yetton (1973) suggest that it is up to individual team members to make best use of available information in their problem-solving activities. Within the shared governance councils, frequent and extensive information gathering exercises were employed and although time-consuming, these activities produced questionable benefit to the informing of decisions.

A significant constraint to decision-making in any situation is time (Dearden & Foster, 1994). Other shared governance models have succeeded in part by focusing on smaller more achievable issues at first (Frenn & Schuh, 1995), which might have been beneficial here in terms of seeing what works and learning from early successes and failures. From a groupwork point of view, 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 group process can be slow and somewhat draining, it is very worthwhile in the long run. Importantly, as Kerfoot and Uecker (1992) note, it usually takes much longer than a year for empowered work teams to become fully self-directed.

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, thus risking a waning of interest amongst Trust staff not

directly involved in shared governance. This time-consuming nature of shared governance decision-making has been the experience of other councillor 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).

Conclusions

This paper has presented factors affecting group decision-making within shared governance and examined these in relation to shared governance, management and group dynamics theory as a basis for further exploration and discussion. It is concluded that these theories offer a range of valid possible explanations for observations made of council members engaged in group task activities. The conceptual model offers organisational leaders an evidence-based framework to enhance the implementation of future shared governance models and optimise the likelihood of their success. Practitioners will benefit from being able to identify pre-requisites for effective shared decision-making roles within a groupwork environment. Where shared governance initiatives are already established, the conceptual model may be used as a tool to appraise existing decision-making processes as a means of identifying areas for improvement.

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