John Edmonstone describes the implementation of shared governance at the Edinburgh Sick Children's NHS Trust and focuses on the type of support necessary to ensure effective implementation.

**SHARED GOVERNANCE** is a structure or framework for decision-making within the nursing profession. The philosophy on which it is based moves away from the traditional hierarchical 'command and control' style of nursing management where managers lead and control development. Instead, nurses are empowered to become more involved in decision-making and managers have a facilitative rather than a controlling role (Geoghegan and Earrington 1995).

Empowerment can be defined as 'responsible autonomy' or 'freedom within a framework'. It is a decentralised approach which allows nurses to retain (and enhance) influence over the decisions that affect their practice, professional development, self-fulfilment and work environment. At the same time it increases their participation in, and ownership of, problem-solving strategies and policies (Motz and Lewis 1994).

While shared governance has been implemented widely in the USA, it is a comparatively new concept in the UK. Among the first sites to use it in the UK are:

- St George's Healthcare NHS Trust (London)
- Leicester General Hospital NHS Trust
- Pontefract and Wakefield NHS Trust
- Central Manchester Hospitals NHS Trust.

In 1996 the director of nursing at the Edinburgh Sick Children's NHS Trust introduced the concept of shared governance to the senior nurse forum (a grouping of all senior nurses within the trust), which was organised on a clinical directorate system. A workshop was held early in 1997, facilitated by the author, which reviewed the existing system and explored the implications of developing shared governance.

It was seen as a move towards more collegiate decision-making and likely to be stressful for nurse managers in terms of both demands on their time and role ambiguity. There was also a paradox in that it was necessary to use the existing hierarchical structure in order to develop a more participatory approach. The anticipated benefits of developing shared governance are shown in Box 1.

As a result of the workshop, an implementation steering group was set up, comprising: the nursing director (the school nurse); the surgery theatre services manager; the medicine nurse manager; staff nurse (respite unit); senior nurse (community and family mental health); the residential unit shared governance co-ordinator; staff nurse (ITU); and charge nurse (day care unit).
Box 1. The anticipated benefits of shared governance

- Increased professionalism and accountability
- Increased direction and focus for nursing across the trust
- Increased self-esteem for nurses
- Improved team spirit, staff relations and mutual respect
- Improved recruitment and retention
- Increased professional and personal development
- Reduced duplication of effort

Box 2. Clinical practice council remit

- To resolve identified nursing practice issues and problems
- To function as a resource regarding nursing practice
- To define the scope of responsibilities of nurses within the trust
- To develop and approve nursing documentation standards
- To refer education needs based on practice decisions
- To assist in the development of clinical policies and guidelines
- To develop, review, implement and direct nursing standards and competencies, including care, practice and performance
- To incorporate research findings into nursing practice

Box 3. Co-ordinating council remit

- To formulate, co-ordinate, disseminate and evaluate yearly goals
- To recommend nurses to other committees within and outside the trust
- To co-ordinate the work of the primary councils, including mediation of any disputes
- To implement the shared governance structure and evaluate its effectiveness
- To produce and distribute the shared governance newsletter

An early decision made by the group was to opt for the ‘council’ model of shared governance, in common with most other UK sites. This model consists of three ‘primary’ councils, which reflect the parameters of professional practice, together with a co-ordinating council. The primary councils are predominantly composed of staff nurses, each representing a ward or department. In addition, each council has a senior nurse, the trust’s shared governance co-ordinator and one or two other representatives with relevant experience. Each primary council is chaired by a staff nurse. The co-ordinating council includes the chair of each primary council, the nurse director, and the shared governance co-ordinator. Its purpose is to oversee the shared governance system as a whole.

The steering group ensured that all nurses in the trust were aware of what shared governance was and, just as importantly, produced a vision statement, a mission statement, some basic ground-rules, detailed remits for the councils and a planned approach to implementation.

The framework

A vision statement was adopted by the implementation steering group: ‘shared governance – giving each nurse the power to make a difference’. There was also a more detailed mission statement: ‘Shared governance is based on the belief that nursing staff who are closest to the patient are in the best position to make decisions relating to nursing practice. Shared governance provides a framework whereby clinical staff and managers can work collaboratively to develop nursing and where clinical staff are empowered to lead the decision-making process.’

Detailed remits for the three primary councils were developed. The remit for the clinical practice council is shown in Box 2 and that for the co-ordinating council in Box 3.

Among other features of the shared governance system are: six-monthly open meetings of each council; orientation of new staff to the system; a newsletter; and the use of a referral form by which nurses can contribute to the agenda of each council.

Training support

Training support has been provided throughout the development of these arrangements. In addition to the workshop for the senior nurse forum, a one-day team-building session has been held off-site prior to the formal first meetings of each council. The objectives of this session are detailed in Box 4.

Each of these events involved the use of the ‘unfinished sentence exercise’ (Edmonstone and Havergal 1998). This is designed to expose any
anxieties and concerns about shared governance in general and the operation of each council in particular. Responses and assurances over such issues as time and secretarial support were given by the shared governance co-ordinator. Sub-groups then worked on such matters as what the council's remit would mean in practice, creating an agenda for the first formal meeting and identifying areas for early tangible success.

On each of these team-building events council members were able to informally identify the proposed council chairs and deputy chairs prior to formal endorsement at the first council meeting. Each event ended with action planning so that it was clear who had to do what prior to the first council meetings.

Further training support is likely to focus on:

- The role of the co-ordinating council
- Those trusts which have pioneered shared governance in nursing should be well-placed to contribute to, and benefit from, its development
- The tensions experienced by G-grade nurses at the point where the executive and representative systems meet
- Meeting the learning and development needs of council chairs and deputy chairs in such areas as chairing meetings, presentation skills and negotiation.

### Evaluation

In a review of early experience of shared governance in the USA, Kirshbaum (1998) notes that there were anecdotal reports of dramatic improvements in areas such as staff costs, labour turnover, absenteeism and morale over periods of about five years. This is in addition to reported qualitative changes, such as increased creativity, greater co-operation and trust, and improved self-confidence.

In the case of the Edinburgh Sick Children's Trust, implementation is ongoing and the councils are only beginning to develop their role and status within the Trust. Nonetheless, evaluation is seen as being important and administration of a questionnaire prior to the establishment of the first council has produced baseline information. The questionnaire will be administered again after a year, at which point the first council established will have been in existence for one year and the third for about six months.

It is anticipated that other qualitative evaluation methods will also be used and that the questionnaire will be used again at regular intervals to check the progress and development of shared governance within the trust.

### Conclusion

The 1997 White Paper (Department of Health 1997) states that the Government will require every NHS trust to embrace the concept of clinical governance so that quality is at the core of service, both of the organisation as a whole and of individual professionals. Those trusts which have pioneered the work of shared governance in nursing should be well placed to contribute to, and benefit from, its development.

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### References