Using shared governance to empower nurses

In this article...

- What is meant by the term ‘shared governance’
- Structures and models of shared governance
- The benefits of a shared-governance approach to care

The Francis report (Francis, 2013) identified a need for transparency and honesty in the NHS. Shared governance is a structure that places staff at the centre of the decision-making process and sees managers having a facilitative leadership role (Haines, 2013), so managers can be assured that the concerns of ward-based staff are being voiced and acted on. The approach also allows managers to hear these concerns from staff themselves (Swihart, 2006). The system empowers nurses to deliver high-quality patient care, independently and collaboratively, as equal members of the healthcare team.

In January 2012, two of Nottingham University Hospitals Trust’s (NUH) senior nurses received funding from the Foundation of Nursing Studies (FoNS) to bring together a group of frontline staff to improve acute-care skills. Box 1 outlines the group’s development.

The group’s enthusiasm and motivation to strive for better patient outcomes shone through in its first meeting. It became clear that the group was describing a system of quality improvement called ‘shared governance’.

The group became NUH’s first unit practice council (UPC), the pilot council within what would become a shared-governance structure at the trust. With support from FoNS, the facilitators expanded the opportunities for the UPC (Dinning et al, 2014).

What is shared governance?

At NUH, shared governance is defined as staff having collective ownership to develop and improve practice, to ensure patients receive caring, safe and confident care. One of the recommendations of The Shape of Caring review (Health Education England, 2015) was to “…examine the potential and implications of developing and implementing Magnet principles to improve the education of the workforce and patient outcomes”. Of the five Magnet-model components (Box 2), the shared governance structure most closely aligns with exemplary professional practice and structural empowerment.

A national NHS staff survey (Picker Institute, 2012) identified that only 29% of staff felt that their senior managers involved them in important decisions, with only 27% reporting that senior managers acted on feedback from staff (average of acute trust results). These findings are supported by the views of our own NUH
staff. An engagement survey of 2,732 out of 4,000 nurses, midwives and operating department practitioners at NUH, was conducted throughout 2012/2013; feedback identified that staff faced a number of challenges in their daily roles, with the major ones being:

» Lack of autonomy in practice: nurses and midwives felt that they could not make changes in their practice area without first consulting the hierarchy of leadership, and that the procedures or guidelines were to be followed stringently, with no regard for clinical expertise;

» Top-down nature of mandated changes and projects: staff were required to implement changes with little explanation of why, consultation about the approach, understanding of underpinning evidence-based practice or feedback about the results. This made staff resistant to change and indifferent to the benefits of future projects, leading to a lack of sustainability and embedding of projects;

» Hard work was not always noticed or rewarded: nurses felt their nurse leaders were present and critical when there had been a problem but absent when things were going well.

In recent years, the high turnover of band 5 nurses has become a concern across the NHS. The Mind the Gap report (Jones et al, 2015) focuses on the needs of nurses and midwives in the early stages of their careers. It shows that differences are generational, with different “values, expectations, perceptions and motivations” (Jones et al, 2015). Today’s student nurses are ambitious – they like to have a clear sense of purpose and career development; the shared-governance structure has the potential to offer such opportunities.

From a patient perspective, it has been suggested that “90% of decisions about patient care should be made at the point of care, with only 10% being made at an operational level” (Porter-O’Grady, 2001). This means that those providing care are in the best position to change the pathway of patients, thereby improving patient care, experience and satisfaction.

The introduction of a shared-governance structure means nurses and midwives can be directly involved in – and often lead – changes in their practice areas. This gives frontline staff a sense of empowerment, ownership and an appreciation for their expert knowledge. Staff have a shared overview of the nursing and midwifery strategy, and UPC members get a taste of leadership.

Developing shared governance
The UPC selected its own service improvement areas, which were:

» Noise at night;
» Staff morale;
» Implementation of the Malnutrition Universal Screening Tool.

The UPC recognised that noise at night was the cause of many complaints and a reduction in metrics. By working with colleagues and management teams, the UPC came up with four changes:

» Asking doctors to wear soft-soled shoes at night;
» Campaigning with all staff to keep their voices down;
» Attaching buffers to doors to prevent them slamming;
» Offering all patients earplugs on the 22:00hr drug round.

At the same time as the first UPC was being created and facilitated, Laura Hailes, staff nurse in oncology, went to the US on a scholarship, visiting more than 13 hospitals to look at their shared-governance models at different stages.

As the first UPC became more successful, it met with the trust board and the project lead to present its work and achievements. It was important at this stage to ensure buy-in from the board to be able to develop a structure of shared governance beyond a single UPC. NUH’s former director of nursing was supportive and drove the initiative within nursing. In 2013, the trust board decided to implement shared governance trust-wide and the structure began to be defined. In addition to the UPC, ward-based and specialty councils, and themed councils, were set up to meet the needs of different areas of the trust (Fig 1). To assess the implementation of shared governance, the trust created a number of projects, leading to a lack of sustainability and embedding of projects.

BOX 1. SETTING UP THE PILOT COUNCIL

A poster was displayed in the staff room, asking three questions:

● Passionate about good patient care?
● Enthusiastic about what happens in your area?
● Feel like you want a voice?

Staff were asked to respond via email and invited to attend a study day, the purpose of which was to encourage them to improve their acute-care skills. But the enthusiasm of those who attended inspired much more; not only did they want to improve their skills, they were also eager for their ward to provide the best patient care and have the happiest staff.

The group, which was comprised of healthcare assistants, band 5 nurses, one band 6 nurse, one receptionist and an advanced nurse practitioner, evolved over the next six months into a unit practice council (UPC). Its focus was to improve patient experience, patient satisfaction, staff satisfaction and the working environment, using evidence-based practice to ensure sound grounding to their work.

The UPC defined its purpose as ‘listen, act and improve’:

● Listen to the voices of patients, colleagues and managers;
● Act: use research, do research and come up with a strategy for improvement. Implement change;
● Improve: improve what you identified that needs to be developed. Share best practice with other areas.

This is now the mantra for shared governance at NUH.

The UPC launched its new identity during a three-day event in October 2012. Members of the trust board attended, as well as ward sisters and other frontline staff.

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BOX 2. COMPONENTS OF THE MAGNET MODEL

● Transformational leadership
● Structural empowerment
● Exemplary professional practice
● New knowledge, innovations and improvements
● Empirical quality outcomes

TABLE 1. COMPLAINTS ABOUT NOISE AT NIGHT

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of patient complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>38</td>
</tr>
<tr>
<td>2012</td>
<td>34</td>
</tr>
<tr>
<td>2013</td>
<td>18</td>
</tr>
<tr>
<td>2014</td>
<td>15</td>
</tr>
<tr>
<td>2015 (to September)</td>
<td>7</td>
</tr>
</tbody>
</table>
governance over the course of 2013-14, staff engagement was measured by surveying 2,732 out of 4,000 nurses and midwives. The results in Table 2 highlight that nurses were largely proud of their roles, but fewer felt they contributed to decision making.

The trust began to recognise the benefits the four UPCs set up by then, and in June 2014 it increased the funding for shared-governance project leads to two whole-time equivalents. Two staff nurses, Anna Edwards and myself, were employed to develop the model.

Structure
The council model promotes shared leadership and is one of the shared-governance structures most commonly used in healthcare. Swihart (2011) advocates that direct-care nurses should make up 90% of the councils in this model. Twenty-three frontline staff councils have been formed across the trust; each has at least five members and meets for six hours a month. Members can come from any role in the ward team – for example, a council might comprise two band 5 nurses, one band 6 leader, one band 6 HCA and one receptionist. It is important that all key stakeholders in the patient journey from that area are represented. The councils:

- Identify issues;
- Undertake audits where required;
- Look for funding;
- Manage colleagues’ expectations;
- Implement their improvement strategies;
- Undertake re-audits where required.

Ward leaders have an advisory capacity and may or may not directly sit on their councils. Shared governance therefore involves a culture change, allowing staff to become involved in decision making by sharing it with managers of all levels, having ownership of practice and sharing accountability. A key concern of ward sisters has been the accountability of the councils, so it is crucial that each council’s chairperson – who may be a staff nurse or HCA – has excellent communication with their ward sister.

Leadership council
The leadership council coordinates all the frontline councils; it meets for 1.5 hours a month and is chaired by the chief nurse. Key stakeholders attend this meeting, such as clinical lead nurses, matrons, the head of nursing and midwifery research, and a learning and organisational development representative. The chairperson of each frontline council presents a short report to the leadership council on:

- What they are working on;
- What is going well;
- What they need support with.

This allows the leadership council to support and advise where required.

The meeting also includes a brief talk from a key speaker; this may be the chairman of the trust board, Care Quality Commission lead, or the head of learning and organisational development. The aim is to improve leadership council members’ understanding of the issues discussed and allows key messages to be passed on. The meeting is not only where successes are celebrated, but also where challenges and blockers are addressed (Box 3).

Frontline councils
Each frontline council has a chairperson, a co-chairperson and a secretary to take minutes. The chairperson represents the council at the leadership council and other senior nurse meetings. This can be quite daunting for some but is, at the same time, character building and informative.

Benefits of shared governance
Haines (2013) suggested that shared governance enables healthcare leaders to ‘talent manage’ frontline staff to prepare them for future leadership positions. This is a major benefit as many senior nurse managers are approaching retirement age.

Shared governance also encourages linear career development. While not all staff nurses want to become managers in the conventional sense, this does not mean they do not want the opportunity to have a say in the way they provide care. In essence, with shared governance they become managers of their care, or ‘bedside leaders’. The system can give nurses greater autonomy in practice and is therefore attractive to those looking for professional and personal career development. Box 4 illustrates how shared governance has enhanced my own career.

Barriers to shared governance
The duty rota has, at times, made the implementation of shared governance challenging. The national nursing shortage, combined with day-to-day staff engagement, has made it difficult to find time and resources to continue the project. Staff have been asked to take on new roles and responsibilities and have not always been willing to do so. However, despite these challenges, the project has continued to develop and expand.
sickness, can adversely affect the protected time given to council members; patient safety is the first priority, so staff can be removed from council meetings to cover ward staffing. However, through advance planning of dates and by negotiating with ward sisters, regular council meetings can be achieved.

Although they involve increased upfront costs, particularly if they are preventative rather than curative, staff initiatives such as shared governance can increase long-term cost-effectiveness.

Initiatives with higher engagement are more sustainable, and sustainable initiatives are cost effective.

Overenthusiasm can be a hindrance to shared governance, as implementation of improvements must be planned carefully. If they are rushed and not carefully thought through, there is a great risk of reduced understanding and failure.

Shared-governance councils need careful leadership and access to coaching and training. Ballard (2010) suggested the implementation and breakdown of shared governance in a healthcare setting can be detrimental to morale and future engagement, so it is vital that each council can easily access resources and has a manager who is willing to support the process.

The future at NUH

The trust aims to introduce divisional councils that focus on topics such as safety and quality or professional development, and which can be used as sources of advice by the shared-governance councils. Membership will consist of individuals with managerial roles.

At present, shared governance at NUH is very much led by nursing and midwifery. Although this works well, it is important to ensure that all voices in the multidisciplinary team are heard, so the aim is to encourage allied health professionals and medical staff to join the councils.

There is now also a health-education council that focuses on the needs of early career nurses and midwives in the evolving structure that depends on the professionals who are closest to the patient. It gives back to nurses their sense of worth and allows them to voice why they believe in projects. It also instills passion and a need to improve the environment in which they work, not only for themselves, but also for their patients.

BOX 4. PERSONAL AND PROFESSIONAL DEVELOPMENT

As chairperson of the trust’s first unit practice council (UPC), I felt excited and slightly daunted by expectations. However, the experiences this role gave me as a junior staff nurse allowed me to progress to the role of shared-governance lead and facilitator. I have been leading the project with a colleague for more than a year and have seen changes. Progressing from only one council more than three years ago to four councils in August 2014, and now 25 councils, is incredible. I am proud to have had the opportunity to give about 200 staff members the experiences I had as a council member.

There have been challenges with culture change. Sometimes I find myself reminding colleagues of the existence of the councils and what they do, but they will continue to embed. I have learned that conflict is a symptom of changing culture. The need to adapt my communication style has never been more apparent, from teaching frontline staff council members to managing an autocratic leadership style, and I have acquired skills I would only have developed as a ward sister.

Sadly, some nurses still resist change and the implementation of shared governance, although they are the minority. Initially, I felt personally affected by the conflict this created but I have learnt that it is not directed towards me, but the expectations of change. I have been able to work with those colleagues who have created conflict and understand their feelings – it is often due to misunderstanding.

When I took on the role, I was told by a number of people that I lacked self-belief and confidence in my abilities. However, I have received some incredible feedback about my leadership style from frontline colleagues and senior nursing and midwifery leaders. This has boosted my confidence and I am now more assertive. My self-awareness has increased, as has my perception of the potential impact of the things I do or say.

Shared governance has developed my career in ways I could never have imagined. When I replied to the call of the poster on the staff room wall, I never dreamed where it would lead. Even with all the challenges I have faced, I would do it all again. Service improvement and culture change is not easy, but it is worth it.

Kerry Taylor, shared governance facilitator and Health Education East Midlands clinical leadership fellow. Nottingham University Hospitals Trust

TABLE 2 STAFF SURVEY

<table>
<thead>
<tr>
<th>Comment</th>
<th>Staff in agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses on my ward (or in my department) take an active role in contributing to decisions that affect our work</td>
<td>51.4%</td>
</tr>
<tr>
<td>Organisational management follows through on nurse suggestions for improving performance</td>
<td>41%</td>
</tr>
<tr>
<td>I am proud to be a nurse</td>
<td>87.4%</td>
</tr>
</tbody>
</table>

References


Dinning A et al (2014) Knowing Why We Do

What We Do: establishing a unit practice council to improve evidence based nursing practice in acute medicine using appreciative inquiry. Nottingham University Hospitals Trust.


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