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Shared governance: A vehicle for engagement and change

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Introduction

After 3 decades of strength and stability, our nursing school experienced successive changes in leadership between 1999 and 2005 at a time when nursing was transitioning from polytechnic to university status. Previously a "school" in its own right, the discipline of nursing became part of a Division of Health Care Practice, along with midwifery, paramedicine, and emergency management. Prompted by feelings of loss and recognition that old structures and processes were not functioning as well as they could, in August 2006, we decided to review our ways of working. In my previous role as Director of Nursing for a tertiary health provider, I had introduced a shared governance model which is value based and had provided an effective vehicle for change in a healthcare setting. I believed the model also had potential in an academic setting.

Working with the principles/values requires that processes dynamically give form and direction to the structure of an organisation. It is difficult to determine where the journey will lead but identifying principles at the outset of a change programme provides guidance for the evolution of structures and processes over time (Bamford 2003).

By sharing my experiences of working with shared governance, others were enabled to see the potential of the model and how it might work for us. And so through processes similar to those articulated by Drenkard (2001) a cross functional steering committee was formed to: in the following points

- assess the current situation;
- acknowledge the past by telling the important stories;
- create a vision;
- undertake a SWOT (strengths, weaknesses, opportunities and threats) analysis between the current situation and the vision
- arrange forums to engage the staff in development of the vision and values and the planning process
- refine processes on receiving feedback from staff
- receive validation of the overall plan and processes for moving forward

Beginning Steps

With this framework as a guide, beginning steps were made by the steering committee of approximately 20 academic and allied staff. Weekly meetings were scheduled on Mondays at 7.30 am and were well attended. Wheatley (2001) suggests that when people engage with each other to learn more about their collective identity and purpose, they are affected in surprising ways. It was clear that many staff appreciated the opportunity to participate in a process whereby they could reshape and further strengthen the School. By September 2006, a vision had been articulated and reads as follows:

> *The Division of Health Care Practice is an academic centre of excellence that safeguards and supports the growth of healthy communities by preparing students to be competent health professionals, through scholarship, innovation and passion, in partnership with key stakeholders in nursing, midwifery, paramedicine and emergency management.*

Senge (1999, p. 530) argues that "a compelling vision that connects what people care about is a powerful ingredient for change". An extensive SWOT (strengths, weaknesses, opportunities and threats) analysis then provided a platform for commencing the change process. It included an overall consideration of the School of Health Care Practice in relation to the Faculty of Health and Environmental Sciences, the university strategic plan, stakeholders (the healthcare industry, professional groups), students, the Tertiary Education Commission (as national funder of tertiary education in New Zealand) and other universities.

Staff recognised that a paradigm shift was required if they were to successfully lead the institution in new directions while continuing to effectively manage its current operations. Further analysis was then undertaken to assist planning, priority setting and allocation of the resources required to narrow the gap between the current situation and the newly articulated vision.

Aligning Vision and Values

The role of leadership in a knowledge-based environment is one that is broad and overarching. It includes being visionary, able to interpret the 'big picture', being a coach, educator, facilitator and integrator. Leadership at the School level must integrate the broad visions of the university with the goals of the School and its disciplines. Leaders serve in a facilitatory capacity by ensuring that resources and information are available for staff. This also means negotiating for resources, providing opportunities and supporting implementation of the vision and goals underpinning the culture change (Bamford 2003).

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A sustainable culture change process requires both a vision and shared values. The values guide decision making and the identification of behaviours appropriate for the new culture. This aligns with Senge's belief that *profound change* requires the "inner shifts in peoples values, aspirations and behaviours, with "outer" shifts in processes, strategies, practices and systems" (1999, p.15). The values adopted for the new School environment were: respect, equity, accountability and responsibility, innovation and celebration (Fig. 1). Each value is accompanied by attributes and/or behaviours congruent with the value. The six values are highly visible. They are depicted in a series of "sails" which hang in the foyer of our School. Sails have particular relevance as our city is known as "The City of Sails".

Another key leadership function is the development of resilient individuals and teams able to embrace an ever evolving growth in autonomy, control, responsibility, accountability and participation for the nursing discipline. It takes transformational leadership engaging the four "Is" essential to transformational leadership to achieve these attributes. These are applicable to individuals and teams and provide a timeless framework for encouraging ongoing development.

Idealised influence: Trusted to make the right decisions, respected, walking the talk.
Inspirational motivation: Articulate the desired future state and encourage a team spirit to achieve it.
Intellectual stimulation: Question the status quo, encourage critical thinking, innovation and creativity to improve the organisation.
Individual consideration: Demonstrate a genuine concern for individuals and energise people to develop and achieve their full potential and performance.

(Riggio, 2009; Hall et al., 2011).

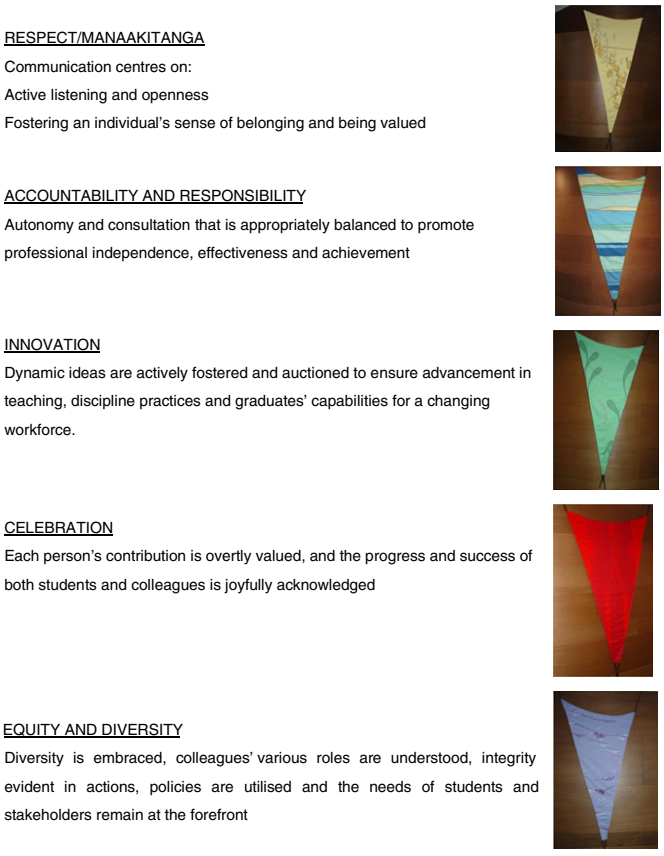

Fig. 1. Values, attributes and behaviours.

With the vision and values identified, they now formed a framework to underpin the operationalisation of the change process in a way that incorporated the four "Is". Consideration was given to the areas that needed development if the vision and values were to become tangible within the culture. This required the formation of four cross functional teams and a workable definition of shared governance. Porter-O'Grady (2010) defines shared governance as:

> "a professional practice model founded on the cornerstone principles of partnership, equity, accountability and ownership that form a culturally sensitive and empowering framework, enabling sustainable and accountability-based decisions to support and interdisciplinary design for excellent patient care".

A Structural Model: Giving Shape to Shared Governance

The following five areas of core business were identified: Quality/Operational Processes and Systems; Staff and Professional Development; Pedagogy and Practice; Research; and Innovations and Projects. Cross functional teams were formed to lead in these areas. The leadership roles for each team were advertised internally and appointments were made for 2 years with a 0.4 full time equivalent allocation. The Team Leaders were responsible for working with self selected team members to develop terms of reference and implement activities through collaborative and participatory processes. Membership within the teams assisted capacity building through a process of active learning which, in turn, has encouraged growth in confidence, competence and commitment to shared governance.

Another significant change occurred with the re-advertising and contestable appointment of discipline leaders in nursing, midwifery and paramedicine/emergency management. In the spirit of shared governance, nursing, the largest discipline, selected 2 people with complementary skills to this position.

The Leadership team for the School of Health Care Practice now comprises the Head of Health Care Practice, the heads of discipline, team leaders for research, pedagogy and practice, staff and professional development, quality operational processes and systems, innovations and projects, the postgraduate leader and representation from the Kawa Whakaruruhau Komiti (which advises on Treaty of Waitangi matters).

Nursing Leadership in a Shared Governance Model

Having created a vision and values for the School as a whole, nursing worked further to identify and implement a style of leadership congruent with the shared governance model. According to Senge (1999 p.16) leadership is "the capacity of the human community to shape its future and specifically to sustain the processes of change required to do so". Nursing had appointed 2 people to jointly lead the discipline, one being myself who brought experience in leadership and culture change within a hospital setting and a colleague who had experience in education. A flattened structure of nursing leadership was developed. Thus the nursing leadership team was formed consisting of the heads of nursing (2), year leaders (3), programme leader, clinical leader and the post graduate co-ordinator (Fig. 2).

Recognising the need to build capacity in order to respond to the challenge to be 'change capable' the nursing leadership team developed structures and processes to encourage and support growth. Individual development plans identified ways to energise staff to achieve their potential. Formal opportunities to enhance academic writing and IT skills, and extending clinical competence were offered. The benefits became evident, as staff grew in confidence, more able to articulate the values of the new culture, their own