Collaboration, Evidence Based Practice and Shared Governance: A coming together!

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Abstract

The development of a programme designed to improve BME aspirations and improve mental health services. The paper will outline the development of a government commissioned educational programme specially designed to empower Black and Minority Ethnic communities. The programme is the first of its kind in the North West. It was conceived partly as a result of a tragic death which took place in psychiatric care service and also more generally arising from inequalities in society. The programme is supported by staff from two different schools in the same Faculty. The PGC Community Development Worker BME (Mental Health) consist of 4 modules, at Masters level. The main aim is to produce a highly educated, culturally capable and diverse Community Development (BME Mental Health) workforce in response to the Government's Delivering Race Equality' agenda. It will pro-actively raise (and showcase) the professional and scholarly aspirations and achievements of the BME community and be at the vanguard of teaching, research and enterprise in this essential new specialism. Statistics show that the BME communities have similar or above achievements compared to the white population at level 7 and above (www.dfs.gov.uk)butthisisseldommadeknown. Community development is defined as "a set of values and practices which plays a special role in overcoming poverty and disadvantage, knitting society together at the grass roots and deepening democracy". (DOH, 2006). The values and principles of community development are social justice, self determination, working and learning together, sustainable communities, participation and reflective practice. The Teaching and Learning strategy underpinning the programme is in-keeping with Community Development Learning which holds that "education is for liberation and empowerment". This strategy, espoused by Paulo Freire in his seminal work: The Pedagogy of the Oppressed, (1972), also acknowledges that although we, as teachers, may have special knowledge and skills, "these do not accord privilege and are not solely our province". Mullender and Ward(1991:31). The paper describes how the programme was developed together with local service users and community groups eg. Asylum seekers, African Caribbean and Chinese community groups.

Introduction

The impetus to promote an evidence based culture within the NHS has received growing attention. Most notably, the focus on delivering high quality evidence based services which enhance patient care sits at the heart of clinical governance structures within the UK. The disparate way in which this has been implemented illustrates the need to consider *how* practice can best be supported to ensure that practitioners are empowered to provide evidence based care. One approach was adopted by a Primary Care Trust (PCT) in the North West of England. Using a unique governance structure – called 'Shared Governance', the PCT worked in collaboration with a group of lecturers in a School of Nursing in a local university to develop structures to smooth the Evidence Based process for practitioners through a study event. This paper describes the event structure, process and outcomes and provides insight for other organisations who may wish to develop practitioners using a similar format.

Shared Governance- the Impetus for Change from a UK Perspective

In the 1990's, the United Kingdom National Health Service (NHS) introduced a framework called Clinical Governance. The framework was implemented to support continuous quality improvement and assure accountability for standards of care. First noted in The New NHS, Modern and dependable (DH 1997) and later defined in A First Class Service (DH 1998) the concept of Clinical Governance has gained momentum and now influences all aspects of NHS service development and delivery. The way in which clinical governance has been operationalised within the UK has varied across organisations. Some trusts however, have opted to use a 'Shared Governance' approach.

The Concept of Shared Governance

Shared Governance was originally developed in the USA (Porter O'Grady 1991) and is considered to be synonymous with Clinical Governance. Shared Governance can be described as 'a way to provide leadership in which staff members contribute to decisions that affect the quality of their work' (Saylor 2007, p1). It has been used to promote the involvement of practitioners in decision making at all levels within an organisation (Burnhope and Edmonstone 2003, cited in Williamson (2004). Shared Governance is underpinned by three principles (HMRPCT 2007), which are responsibility, authority and accountability. Morris and Smith (1993) offer a fourth principle concerned with empowerment of practitioners.

A Shared Governance organisation empowers its employees by allocating responsibility to practitioners in order to manage the professional practice contribution to service delivery. Providing a pre-determined amount of responsibility allows a defined level of authority and accountability around decision making. It is recognised that some elements of professional practice are more appropriately developed by staff at the interface of service delivery that have the knowledge and skills to identify issues in need of addressing. For example, changes to professional practice may be required if patients or professionals identify additional needs, or need to respond to national strategy.

The Local Context of the Shared Governance Approach and its links to Evidence Based Practice

The skills that practitioners need to develop evidence based practice are best encouraged within an environment that promotes critical thinking, supports autonomous decision making, and is nurtured within an organisation that values empowerment processes that are evident in shared governance (Porter-O'Grady 2001, Zuzelo *et al* 2006). This is one of the many reasons why the concept of Shared Governance was introduced to a PCT in the North West of England. As a result, professional practice is currently developed specifically using the Shared Governance framework.

Within the PCT, a Professional Executive Committee (PEC) plays a key role in the continuing development of the professional practice agenda and in maintaining the overall responsibility for driving the national and local agenda. The PEC confers authority via a councillor model of Shared Governance to empower practitioners. To enable this, a number of councils have been established, which include a Professional Practice Council (PPC) and a 'Evidence into Practice' Council (EIPC). These two councils have a range of members within and external to the PCT. The PPC is the more senior council; one of its responsibilities is to approve and subsequently ratify proposals for clinical development. The EIPC is made up of front-line practitioners and a representative from Higher Education School of Nursing. The EIPC in particular is responsible for guiding practitioners to develop evidence based practice by supporting them through the ten stages of a Developing Practice Framework (see figure 1).

Figure 1, Ten stages of the Developing Practice Framework

1. Identify the need
2. Review of evidence
3. Action plan
4. Develop guideline
5. Peer review
6. Ratification process
7. Implementation
8. Evaluation
9. Dissemination
10. Review

EBP and the Developing Practice Framework

Shared Governance is a process which is integrally linked to the evidence based practice cycle. Evidence based practice is described as a five step process which encourages practitioners to 'ask

a clinical question, collect the most relevant and best evidence, critically appraise the evidence, integrate all evidence with one's clinical expertise, patient preferences and values in making a practice decision or change and evaluate the practice decision or change' (Melnyk and Fineout-Overholt, 2005:9). These progressional steps of evidence based practice are reciprocated (see table 1) within the Developing Practice Framework. Therefore, when a practitioner first identifies a clinical issue, they are then guided by the stages of the framework thus ultimately ensuring that the practice development is evidence based.

Table1.The alignment of the Developing Practice Framework to Evidence Based Practice

Evidence Based Practice	Framework for Developing Practice
ask the clinical question	1.Identify the need
collect the most relevant and best evidence	Implicit in the Framework
critically appraise the evidence	2.Review of Evidence and 5 Peer Review
integrate all evidence with one's clinical expertise, patient preferences and values in making a practice decision or change	3. Action Plan. 4.Develop Guideline 6. Ratification process 7. Implementation
evaluate the practice decision or change	8. Evaluation 9. Dissemination

Constraints of EBP and Developing Practice Framework

Despite the work undertaken to develop a Shared Governance framework within the PCT it became evident that the Developing Practice Framework was not consistently being utilised. Particular difficulties arose from the limited guidance available for practitioners in relation to the expectations of evidence that they should use to support practice development and the peer review process needed to ensure robust developments. Also there was limited understanding of Shared Governance across the organisation, compounded by inconsistent communication between the Shared Governance, Research and Development and Audit groups who's functions should be interrelated.

Purpose of Event/Rationale

Recognising the extent of this problem, the Shared Governance committees addressed the shortfall through the development of a full day workshop in collaboration with a local Higher Education Institution (HEI) School of Nursing Academic in Practice Team. The workshop was designed to resolve the problems identified relating to the application of the Shared Governance process and the Developing Practice Framework. The workshop sought to demystify the shared governance process and explore how practitioners can influence practice through use of the Developing Practice Framework. To achieve this, a number of aims and objectives were used. These helped to structure the day and ensure that it remained focussed and participatory. In total there were three main aims. These were;

1. To facilitate communication between shared governance councils and other individuals.
2. To produce a check list making explicit to practitioners what is expected in terms of the evidence they should use and the peer review that they should obtain.
3. To help strengthen the shared governance process.

To achieve the aims, a number of objectives were designed which provided the opportunity for participants to explore how the Developing Practice Framework links to the process of EBP. This included methods to find, appraise and use evidence.

Structure of the Workshop

Health care practitioners, managers and other staff from a range of professions (see table 2.) including members of the Professional Practice Council and Evidence into Practice Council were invited to attend the workshop. This multi professional approach to the day provided an

opportunity for networking with staff from diverse roles, working at different levels both within and outside the organisation. In addition, a collaborative approach was thought to be synonymous with meeting the government's clinical governance agenda (Dewar 2000) and emphasised the need for substantial working between clinical and professional personnel.

Table 2.Range of professionals attending the study day

• Learning disability nurses
• District nurses
• Occupational therapists
• Health Visitors
• Specialist Nurses
• Infection Control Nurse
• Medicines Management
• Clinical Governance Staff
• Clinical Audit Staff
• Physiotherapist
• Audiologist
• Lifelong Learning Staff

In order to engage with all participants during the day and to address participants individual learning styles there was a need to provide a variety of teaching and learning strategies (Reece and Walker 2001). The workshop began with an introduction to the Shared Governance concept. This was presented by a member of the Evidence into Practice Council who had been involved in shaping the Shared Governance model and who had a thorough understanding of the subject matter being taught (Quinn 2000). At this point, participants were introduced to the Developing Practice Framework. This contextual information helped clarify how the model and framework can assist practitioners develop evidence based guidelines in practice.

The facilitators initially encouraged participants to consider whether they considered themselves to be 'evidence based practitioners'. Specificically, the questions asked sought to promote discussion about the nature of EBP and how the participants would be able to recognise and determine whether a guideline was evidence based. This promoted some discussion about the concept of 'evidence' and the different types and levels of evidence used in health care. This approach is particularly useful for groups of participants who learn if the subject matter can be applied directly to them via a group activity (Reece and Walker 2001). To illustrate this, a case study based on the different available treatments of head lice was provided (see Box 1).

Box1 Case Study Scenario

A health care professional has been asked by a client about the best treatment for their child's head lice. There has been some debate between parents about the best choice! They have concerns about the current range of treatments available, the chemicals that are often involved and their overall effectiveness. One particular parent is adamant that combing the hair is the best option! Because the parents are concerned about using chemicals, they are reluctant to use them. A number of schools are concerned about the increased prevalence of head lice.

To address this, the health care professional decides to explore the evidence base
Q: What evidence could the health care professional look at?

To address this case study, the participants were divided into small groups to discuss the different types of evidence available to support practice. This small group approach aimed to help participants to share ideas with other group members (Brown 1996, cited in Quinn 2000). In

reality a range of evidence could be accessed to support a decision. In this instance, the participants considered Trust policy/guidelines, professional opinion, Department of Health guidance, NICE, user and carer opinion, grey literature and Local Education Authority guidance coupled with relevant research evidence. The case study helped to illustrate the conflicting nature of some research findings. Participants were also asked to think about what strategies are in place to help practitioners evaluate the quality of such 'conflicting' evidence. This prompted some dialogue about the quality of evidence and the potential appraisal techniques. As a result, some participants raised concerns about their own [and others] abilities to critically appraise evidence. To address this, the participants were asked to reflect on a range of questions which could help them determine the relevance, quality and applicability of evidence.

The head lice case study was discussed in small groups. This empowered the participants to think about the key issues, problems and advantages of evidence based practice. This discussion was related to the PCT's Shared Governance model and Developing Practice Framework, which helped to contextualise the framework for the participants. Facilitators from both HEI and practice were able to answer queries and use examples of the Developing Practice Framework to illustrate its utility. Feedback within the larger group provided an ideal learning opportunity which then enabled work to start on the development of a checklist. In particular, the aim of the checklist was to guide practitioners and peer reviewers when making decisions about the quality of evidence they should use. The completed check list would then be submitted with the proposal to provide some assurance for the Professional Practice Council that the guideline was based on the most appropriate evidence when making decisions about ratification.

Armed with this theory base, participants were then asked to think about what questions should be included in the checklist. The facilitators helped generate debate about potential checklist questions. Similar appraisal tools are available (Milton Keynes PCT 2003, Crombie 1996). However, the development of this tool by the practitioners that would be using it reflected the Shared Governance approach. This approach also contributed to developing a support system for evidence based practice that addresses the importance of the infrastructure of an organisation in terms of systems, roles, processes, relations, alignments and capabilities (Stetler et al, 2007).The check list was specifically designed to accompany the different stages of the Developing Practice Framework (see Figure 2 for example of content of the checklist).

Figure 2, Example of content of the checklist

Where
Where was the evidence found?
E.g. was it found in a professional journal/ Trust or NICE guidelines?
Where was the research undertaken?
Was it with a similar population to the Trust population?

What
What type of evidence was found?
E.g. systematic review/ randomised control trial/ user/carer opinion, professional opinion.
What is the relevance of the evidence to the care issue?
What was the quality of the evidence? E.g. can obvious flaws be identified?

Who
Who are the authors?
Do they have expertise in this area?

When
When were the articles written?
When was the research undertaken?

Contradictory evidence
What evidence was found that contradicts the evidence used to develop the guideline/proposal?
Why was it appropriate to disregard it?

Appraisal
Summary of findings
Based on the above criteria should this evidence be used to guide practice?
The peer reviewer would make the decision as to the appropriateness of the evidence

This collaborative approach re-enforced the key principles of shared governance and established a visual partnership between practice and education. It could be argued that this is one method to help reduce the 'theory practice gap' which is especially pertinent given the health care climate and the drive to promote quality evidence based care. Also this collaborative approach and active involvement by practitioners which is synonymous with Kolbs experiential learning theory (Kolb 1984) was used to break down fears that are often associated with research and evidence based practice. Indeed, work undertaken since the development of the checklist was used in collaboration with a practitioner from the Primary Care Trust and a lecturer from the University, continuing the ethos of integration of the theory and practice of EBP. The criteria were further moulded into a format that has enhanced the usefulness of the check list when being used in conjunction with the Developing Practice Framework.

The environment was friendly and supportive but importantly, flexible enough to allow an opportunity for participants to ask questions or make comments about the shared governance structures. General discussion ensued which helped promote further debate around the issues associated with using evidence to inform practice.

Evaluation of the Study Day

The study day was evaluated by asking participants to identify the strengths of the day; what they had enjoyed most and the weaknesses of the event. This type of evaluation helps to determine whether the aims and objectives of the event have been achieved and can also be used to inform the facilitators of the effectiveness of their teaching strategies (Reece and walker 2001). In addition the participants were encouraged to recommend how the event might be improved and outline whether they felt that any future events were required. This final approach is synonymous

in providing a culture of lifelong learning (DOH 2001) by recognising and addressing participants educational and development needs.

In total, 22 people attended the event, and 14 completed an evaluation. A thematic analysis on the written comments revealed four emergent themes. These themes reflected the commitment of the staff to promote EBP through shared governance and inter-professional working. The themes were; the contextualisation of evidence based practice to the 'real world'; the contextualisation of evidence based practice to the PCT Shared Governance and Developing Practice Framework; inter-professional working and networking and PCT stakeholder interest and involvement.

Theme 1 Contextualisation of Evidence Based Practice to the 'Real World'

One particular advantage with the workshop event suggested that participants thought that discussing the concept of evidence based practice and its links to the research process was useful. Participants predominantly enjoyed the session on 'how to find the evidence'. This session used a structured literature search strategy based on the head lice case study and highlighted the different types of evidence that practitioners could locate. These evaluations also identified the value of using a pertinent yet generic topic area to demonstrate how evidence can be located, appraised and then incorporated into a clinical guideline or protocol.

The evaluations demonstrate that the concept of evidence based practice was new to some of the participants, especially those from a non NHS or health care background. These participants found that evidence base practice was clearly explained and ultimately led to an increased knowledge base. One participant commented;

> *"I have gained further insight into evidence based practice and how its use is a vital part of patient care" (P1).*

Other participants echoed similar views…

> *"EBP is a completely new subject to me (as a non-clinician, also new to the health economy!). However the concepts involved were clearly explained and have increased my knowledge in a way that has built on my previous experience of quality management in public service provision. Well presented, a well planned workshop which facilitates practitioners capacity to improve outcomes for patients in their specialities" (P2)*

Theme2. Contextualisation of Evidence Based Practice to the PCT Shared Governance and Developing Practice Framework

A number of strengths were identified about the workshop. Generally, most respondents felt that they had gained insight into the contextualisation of evidence based practice to the PCT's Shared Governance and Developing Practice Framework. For example the day commenced with the clarification of the Shared Governance and Developing Practice Framework in simple terms. The evaluations demonstrated how this assisted practitioners understanding of the processes involved and helped strengthen the link between the different councils. The day also stimulated participants to submit a protocol or guideline to the Professional Practice Council for ratification, utilising the Developing Practice Framework to guide them through the overall process. Participants also felt that they could now act as a resource for colleagues regarding the processes involved. The following quote illustrates how the workshop helped reduce ambiguity and promote practitioners to submit proposals:

> '*the process within the PCT Developing Practice Framework is clearer and now I will be submitting a proposal that I am currently working on. It is clear that many clinicians are not aware of the Shared Governance policy/procedure and hopefully I can help to signpost colleagues when I return to the workplace' (P3)*

By working in small groups the development of a checklist for practitioners and members of the different councils to utilise when moving through the Developing Practice Framework was debated and ideas were generated. Participants wanted the checklist to act as a learning tool to guide practitioners wanting to develop practice, for example when writing a clinical guideline. The duality of the checklist could also ensure the tools practicability at both strategic and practice level.

Theme 3. Inter-professional Working and Networking

A strong theme emerged from the data which indicated that the participants valued the inter-professional context of the workshop. A range of health care practitioners for example health visitors, district nurses, clinical audit personnel and lifelong learning practitioners were deliberately invited to attend the workshop. Networking took place between individuals involved in the EIPC and PPC and other groups integral to the Shared Governance and Developing Practice Framework. This facilitated communication at all levels of the organisation which fulfilled one of the main objectives of the event. Participants also used the day to network both formally and informally and stated that ….

'it was good that contacts were given' (P4)

For example an appropriate person to contact if they wanted to develop a guideline for clinical practice. They also enjoyed the debate generated through the inter-professional workshops and group work. As part of the day participants were introduced to the Health RandD NOW initiative. The aim of this initiative is to "contribute to the development of sustainable capacity for high quality relevant research in health and social care and public health by providing training and support for individuals and institutions and collaborating with others in the development/ conduct of research" (http://www.lancs.ac.uk) Here the availability of training for health care practitioners to promote the implementation of evidence based practice was discussed. Participants were also made aware of modules relating to Evidence Based Practice that can be accessed by the range of health care practitioners. Again evaluations demonstrate the usefulness of contacts given.

Theme 4. PCT Stakeholder Interest and Involvement

The fact that key stakeholders within the Shared Governance and Developing Practice Framework were visible and participated in the day was identified as being of great value. This demonstrated the Trusts commitment to the overall processes involved and in widening participant's knowledge base. Participants identify how stakeholders were able……

'to clarify points which they were unsure of and felt it reassuring that they actually knew more than they realised' (P3)

Overall the evaluations suggest that the study day was well timed and organised, covered a diverse range of areas and was thought provoking. Areas of improvement included the need to reduce the time spent discussing the different research methodologies and increasing the detail about the Health RandD NOW initiative... Suggested further events included the need to focus on implementation and dissemination of evidence and the role of practitioners within the process.

Win, Win?

The collaboration between the staff of the Lifelong Learning Department of the PCT and a University School of Nursing resulted in the educational event to develop the capability of multi-disciplinary staff to work with the Shared Governance and Developing Practice Frameworks. This collaboration demonstrates a creative approach to the role of the nurse lecturer in practice settings (Humphries et al 2000). This approach involved nurse lecturers who link with practitioners in terms of students' placement experience also sitting on Evidence into Practice and Professional Practice councils in the Primary Care Trust. A practice development element of

the lecturer's clinical role was identified in a systematic review (Grant et al 2007) which identified the activities of the lecturer's clinical role.

This approach facilitated the sharing of theoretical and practical knowledge of evidence based practice for the Primary Care Trust and the University. The staff development event was facilitated jointly by the Primary Care Trust Lifelong Learning Facilitator and nurse lecturers. The Primary Care Trust benefited from the perspective of academics who taught evidence based practice and the lecturers were able to incorporate the experience gained into subsequent teaching sessions on evidence based practice.

Conclusion and Implications for practice

This event illustrated the potential advantages for HEI and the NHS to work in partnership on a pre-determined concept. In one sense, the win-win situation was never anticipated at the outset. The evaluations of the workshop highlighted many of the strengths and was viewed as a positive way to take forward HEI and PCT relationships. With the ever increasing demand on HEI's to secure work based learning and the increasing pressures on the NHS workforce, this collaborative event highlights how an evidence based culture can still be promoted through shared arrangements and agreements.

Ultimately the need to address the continuing professional development needs of the NHS workforce is synonymous with the UK government's vision to modernise the NHS (DH 1997, 2000, 2001a, 2001b, 2004a, 2004b, 2006). A highly trained workforce in the field of evidenced based practice can be linked to service improvement and positive patient outcomes, ultimately impacting on the health and well-being of the population.

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