

## SHARED LEADERSHIP: The LGLDHU Leadership Model

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You are a nurse working at a busy clinic and find that the system is just not working well for you. You do not seem to have enough time to spend with each client to really intervene in the problems that they are experiencing but you cannot easily see what the root of the problem is, much less the solution. What do you do?



You are an inspector and you just cannot seem to find the time you need to spend with the proprietors of the food premises assigned to you to assure yourself that they can safely handle the food they serve. There is no obvious solution to this problem as the number of food premises assigned to you keeps rising and proprietor turnover is high. What do you do?

You are an assistant assigned to support a committee. The agenda of the committee keeps getting longer, those who attend the meetings seem to have rarely read the materials that you send out prior to the meeting and much of the agenda time is spent reviewing the materials. When action items are reviewed, many actions have not been taken because the assigned persons have not remembered to carry them out despite your circulating the action items in the minutes shortly after the last meeting. You cannot see any simple solution to these problems. What do you do?



In each of the above scenarios, staff are faced with problems they cannot solve alone.

One option is to take the problem to management and hope they can solve it. However, many supervisors are not as familiar with the day to day realities of the work environment for staff involved and may have difficulty finding solutions.

Another option is to ignore the problem and just keep working away. Unfortunately, this option leads to frustration and burnout.

A third option is to try to get staff together who can collectively develop some options, maybe identify the best option, or even try to implement the best option while keeping the supervisor informed and possibly involved. This latter model is called shared leadership – and it's for you if you want to avoid burnout, reduce frustration, increase job satisfaction and improve the efficiency and effectiveness of your work.

However, you cannot work in this way without a workplace infrastructure and culture to support you. That is why adopting a shared leadership model for the whole workplace is necessary.

## INTRODUCTION

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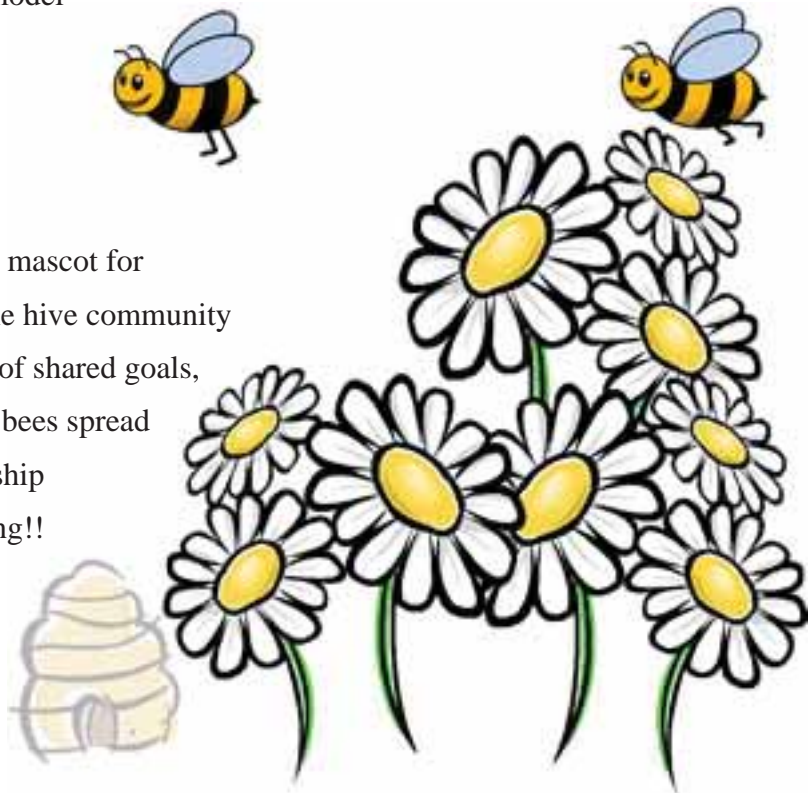
The Leeds, Grenville and Lanark District Health Unit (LGLDHU) Strategic Plan 2006-2010 lays out our vision, mission and values. Our vision is “healthy people in healthy communities”. Our mission is to work with the community to enhance, promote and protect health and our values are: integrity, respect, caring, accountability, fairness and excellence. One of the drivers identified in our strategic plan is leadership and a Leadership Task Force has been created to develop a leadership model for the health unit that will help us move forward with our vision, mission and values.



After surveying the literature on leadership, the task force identified the Shared Leadership model as the best model for the health unit, taking into account the highly skilled nature of our workforce, the type of work we do and our commitment to quality management. Therefore they have decided to recommend the implementation of this leadership model. This model has been successfully implemented in other health related settings similar to the LGLDHU. Because a conceptual model

can be difficult to grasp, the task force decided to make the process of communicating the model a bit easier and more fun by adopting a mascot

– the Leadership Bee. The bee is an ideal mascot for shared leadership for two reasons: first, the hive community represents the successful implementation of shared goals, vision, values and processes; and second, bees spread pollen as they work, just as shared leadership spreads as we work together – it’s catching!!



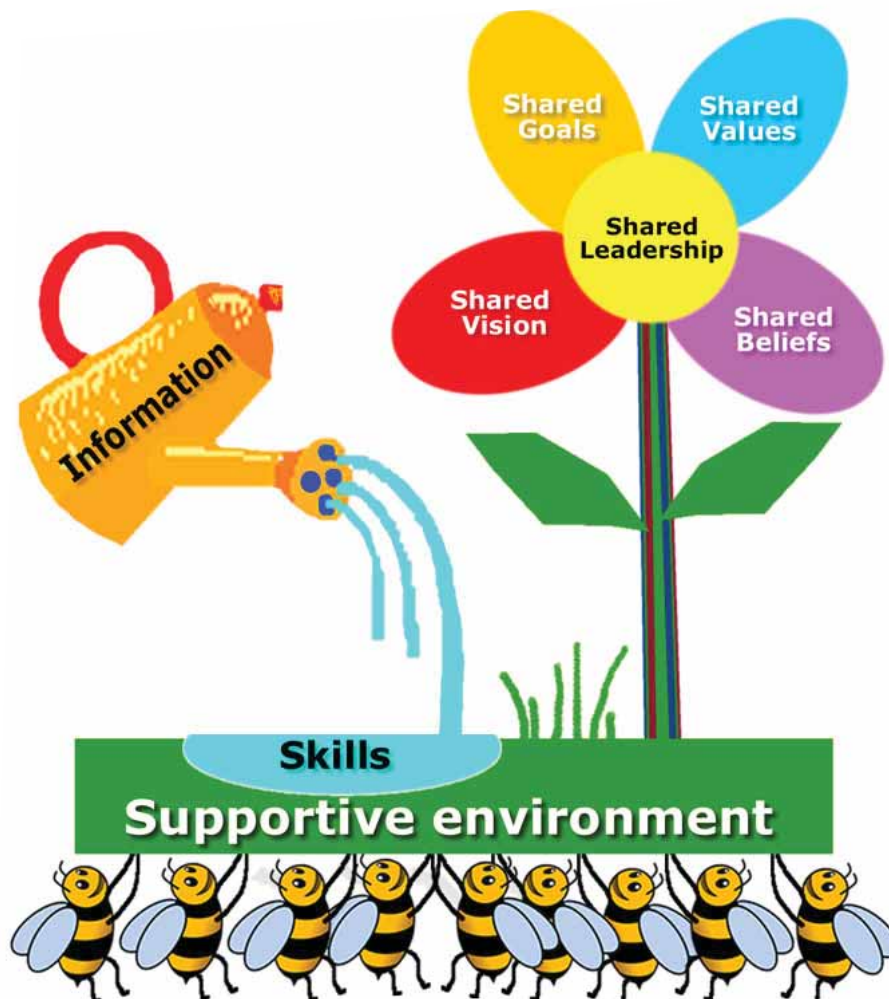
## SHARED LEADERSHIP MODEL

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The shared leadership model assumes that individuals or teams performing the work of the LGLDHU are the ones who know best how their work can be done and are in the best position to lead necessary changes to improve the work processes.

The goal of improving work processes is to provide better (more efficient and effective) service to the community. All members of the Health Unit would be accountable, not only to complete their work, but also to participate actively in improving work processes so that maximal efficiency and effectiveness is achieved. In this model, staff approach problems in collaborative ways, engaging each other in defining the work to be done, facilitating interaction so that goals can be realized. Staff focus on the work itself and how it can be improved, rather than on authority or whose job it is to do the work or lead the change. This requires a decentralized structure with individual and team autonomy and accountability in a supportive environment based on a shared mission, vision and values as articulated in the strategic plan.

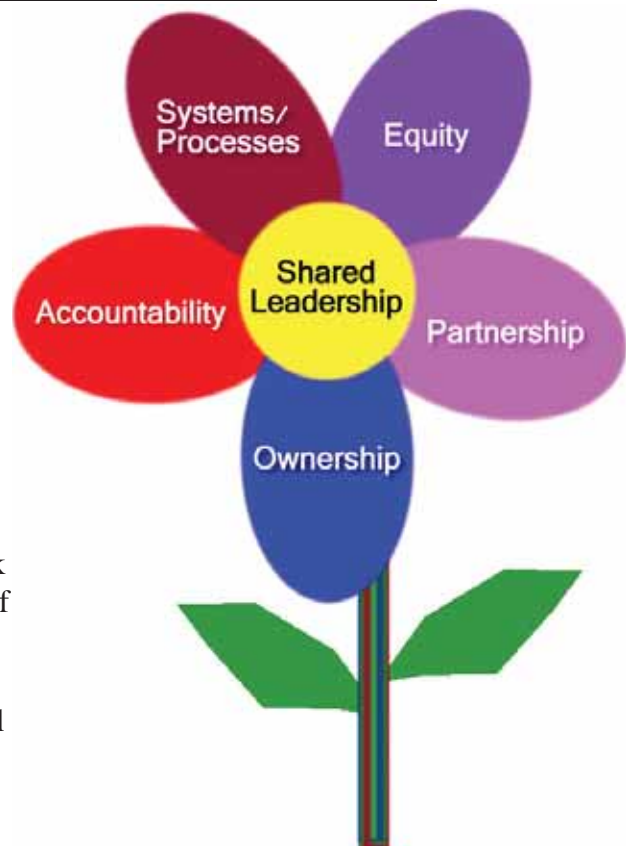
Given the right goals, information, skills and mutually agreed upon vision and values and a supportive environment, all individuals in the organization lead the organization forward.



## Key Concepts of Shared Leadership:

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- **Accountability:** for problem identification, solutions and action intrinsic to the role the person has, responsibility can be delegated but accountability cannot.
- **Partnership:** collaborative relationship of individuals striving toward a common goal, usually in teams, based on honest communication.
- **Equity:** mutual respect and recognition for every person's unique contribution.
- **Ownership:** commitment to the outcomes of their work and the mission of the organization, which arises out of feeling valued and included in a shared vision.
- **Systems focus** (as opposed to a hierarchical, individual focus): establishing functional systems and processes to enable partnerships/teams to be effective.



The shared leadership model incorporates the principles of Continuous Quality Improvement (CQI). LGLDHU is striving to become a quality organization. Therefore the adoption of a shared leadership model for the Health Unit would contribute to this goal. Specifically, the important principles of CQI which are incorporated into the shared leadership model are:

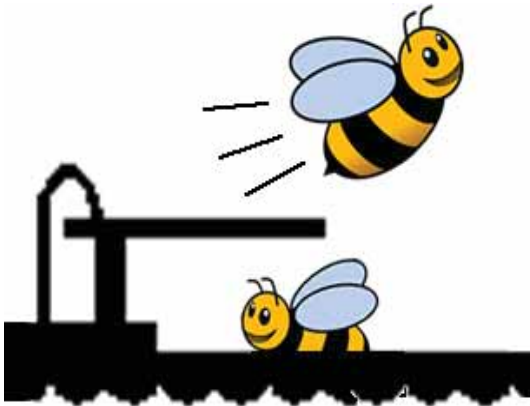
- Enabling staff to use evidence, skills and creativity to make decisions and changes
- Focus on systems and processes
- Innovation oriented
- Challenging the status quo
- Investing in people
- Continuous feedback to improve performance
- Evidence based
- Focus on learning
- Customer service



Shared leadership is not a novel concept at LGLDHU and, especially with the move towards becoming a quality organization, many parts of the concept are already in place. However, shared leadership has not previously been articulated as a unified concept and, therefore, no specific attempt has been made, until now, to implement the concept as a whole or to examine the organization's ability to maintain and grow it. This is now being proposed. The most common structure currently used to achieve shared leadership is collaborative decision-making, often in a team environment. Other structures and processes need to be developed.

One concept of shared leadership that may help in developing facilitating structures is the concept of servant leadership: the leader is there to serve those who are led and those served should grow as persons and professionals. This is congruent with our organizational role to serve the community by leading it to better health. Another aspect of shared leadership that must be considered is the need for the organization to supply tools to all staff to assist them in making decisions and implementing changes: information, training, policies and procedures, the right forums and a culture that is supportive.

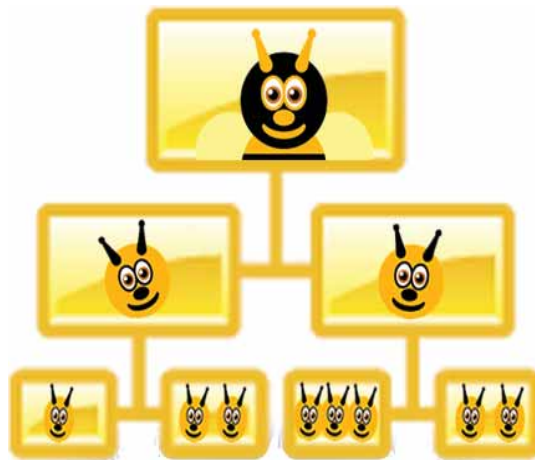
An organization's vision and values create an organizational culture that shapes how work gets done. Shared leadership works best in an organization that:



- Shows respect for all
- Gives staff the responsibility for their actions and use of resources
- Shows a willingness to take risks
- Rewards and recognizes superior performance
- Trusts staff
- Mentors staff
- Strives for continuous improvement

The structures within an organization must be adapted to support a shared leadership culture. These include:

- Strategic Plan
- The organizational chart (a matrix rather than a pyramid, use of teams)
- Performance appraisal process
- Governance
- Professional development processes
- Orientation and mentoring process
- Recruitment process
- Union contracts



In general, an organization must make shared leadership systemic and expected throughout all of its structures and its culture if it is to successfully adopt the model.

## How do leaders lead?

- They challenge the status quo to enable the organization to become better.
- They inspire a shared vision and excite others about the work to be done.
- They enable others to act and to make changes using the vision and values of the organization as a framework.
- They model the way, set an example, and deliver what they say they will.
- They encourage the heart by having passion for the mission and vision.

Every person, with the right infrastructure to support them, can do these things and be a leader.

## DEFINITIONS

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**Leadership:** a dynamic relationship based on mutual influence and common purpose between leaders and collaborators in which both are moved to higher levels of motivation and moral development as they affect real, intended change. It is a process that can be learned. It involves power by influence.

**Management:** the process of setting and achieving the goals of the organization through the functions of management: planning, organizing, directing and controlling. It involves power by position.



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Leadership deals with change, inspiration, motivation and influence.

Management deals more with carrying out the organization's goals and maintaining equilibrium.

The key point in differentiating between leadership and management is the idea that staff willingly follow leaders because they want to, not because they have to. Leaders may not possess the formal power to reward or sanction performance. However, staff give the leader power by complying with what he or she requests. On the other hand, managers may have to rely on formal authority to get staff to accomplish goals.



## Leadership

## Management

People	Processes
Emotional	Intellectual
Persuasion power	Position power
Commitment	Control
Possibility thinking	Problem solving
Proactive	Reactive
Doing the right thing	Doing things right
Values	Rules
Vision	Goals
Verbal communications	Written communications
Innovation	Standardization

**Framework:** a basic conceptual structure used to solve a complex issue.

**Mentoring:** a developmental, empowering and nurturing relationship that extends over time. It involves mutual sharing, learning and growth occurring in an atmosphere of respect and affirmation. A voluntary, mutually beneficial and long-term relationship where an experienced and knowledgeable mentor supports the maturation of a less experienced mentee.

**Model:** a representation of a set of components of a process, system, or subject generally developed for understanding, analysis, improvement and/or replacement of the process, system or subject. A representation of information, activities, relationships and constraints.

**Partner:** an associate who works with others toward a common goal, voluntarily cooperates, has mutual dependency and is willing to formalize the relationship that benefits both parties.

**Self-directed:** being independent, autonomous, but within the boundaries of the mission, vision and parameters of the organization.

**Staff:** includes all those who work for the Health Unit, both those who manage and those who carry out frontline duties.

**Work Team:** a group that works in collaboration to achieve an objective or goal.



The role of the Board of Health in a shared leadership model is to support the organization in implementing and maintaining the model. The major role of management is to support individuals and teams to exercise their autonomy to make good decisions and changes. This primarily consists of building the supportive environment for such activity.

The correct tools must be provided, including:

- information about the processes and outcomes of the work, including policy and procedure manuals, evaluations and resources;
- training in participating in teams, collecting and analysing information and coming to good decisions;
- forums for teams or partners to meet, exchange ideas and make decisions;
- an atmosphere that focuses on systems rather than individuals;
- a culture that accepts risk taking and moves forward to resolve issues;
- an organizational structure that is non-hierarchical;
- a communication system that is open and supports all of the required activities and interactions;
- a system that recognizes those who take on a shared leadership role;
- resources necessary to carry out the processes, including the staff time required to carry out the processes;
- accessibility of management to staff;
- policies and procedures that support shared leadership.

Management must also walk the talk by modeling the required behaviour, sharing power and information with individuals and teams, supporting individuals and teams in the leadership process, creating a culture of respect and autonomy and behaving with integrity by keeping promises and commitments.

The role of individuals is to be accountable and actively participate in improving work processes to improve service to the community. This involves committing to learning the skills needed to do so, modeling the required behaviours and attitudes and sharing wholeheartedly the mission, vision and values of LGLDHU.

## Shared Leadership Ladder:

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As individuals become accustomed to participating in a shared leadership environment and more experienced in doing their work, they gradually move up the shared leadership ladder. At the bottom rung they expect to be told what to do. As they move up, they participate more and more in the responsibility of solving problems and improving work processes.



It is not always possible, or even ideal, for staff to be at the top of the ladder in all situations. The situation dictates the most appropriate rung of the ladder (sometimes called situational leadership). The ideal is to be at the most appropriate rung, not necessarily the highest rung. For example, legislation or policy may prevent specific staff from making a final decision about a situation. Or, a staff member may not be sufficiently experienced to make a final decision in a certain situation whereas another staff member might be.



Deciding on a program issue:

Issues requiring decisions arise in the course of a working day for almost all staff. Because of their competence in their field of work, staff members make the required decisions, record the decisions they have made and carry on with their work. This “decide and inform” process represents the top rung of the leadership ladder. Management will always set certain parameters such as policies and procedures and there may also be legislation that guides decision-making. However, staff members can make all the decisions within these parameters and need only inform management of their decisions under full, shared leadership practice. If staff members are inexperienced or if the situation is so unusual that the staff members do not feel competent to make the decision, they may contact a colleague or management for assistance with the decision-making. This would be part way up the leadership ladder and is to be encouraged in the appropriate circumstances. It is to be discouraged if the situation is routine and the staff member is fully competent to make the decision alone. Practicing shared leadership means ascending the ladder as high as you feel competent, comfortable and able under policies, procedures and legislation to go, in any particular circumstance.

**I have identified these options. I have chosen this one:** A staff member assesses a situation and, based on competency, experience, policies and procedures and legislative authority, makes a decision as to how to proceed. The staff member presents the final decision to their manager for information by recording his/her decision as required by policy, procedures or legislation. If the situation is unusual, the staff member would bring the decision to their manager. ....

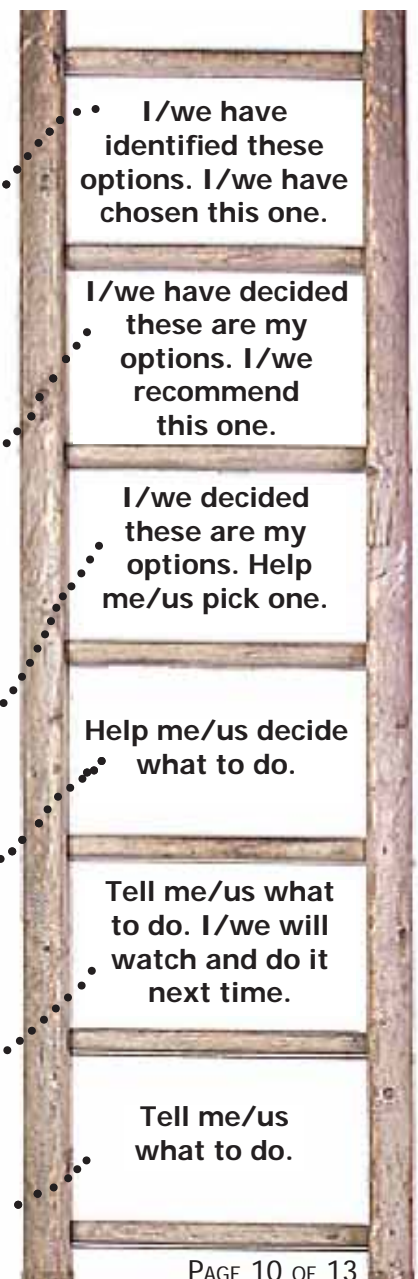
**I have decided that these are my options. I recommend this one:** A staff member assesses a situation and realizes that his/her competency is not sufficient to make a final decision alone. However, the staff member can develop all of the options available in the situation and believes that one is best. The staff member then consults with an experienced colleague (mentor), or their manager for direction as to whether that option should be chosen. ....

**I have decided these are my options. Help me pick one:** A staff member assesses a situation and realizes that his/her competency is not sufficient to make a final decision or to even choose the best option. However, the staff member can develop all the options available. The staff member then presents the list of options to an experienced colleague (mentor) or their manager who make the final decision. ....

**Help me decide what to do:** A staff member assesses a situation and, realizing they are not competent to recognize all the options, contacts an experienced colleague (mentor) or their manager describing the situation and asks for direction. ....

**Tell me what to do. I will watch and do it next time:** A staff member asks an experienced colleague (mentor) or their manager to show him/her how to assess the situation, develop options and choose an option. The staff member understands how the decisions were made so that he/she can proceed further up the ladder next time. ....

**Tell me what to do:** The staff member asks a colleague (mentor) or their manager to make all decisions and does not learn how the decisions were made or how to proceed further up the ladder in future. ....





Changing Policy or Standards:

Many areas of work involve policies or standards that cannot be changed without senior management or board approval. In these cases, it is not possible to reach the top rung of the shared leadership ladder but staff can climb as high as the standards and experience will allow. For example, due to scope of practice regulations, nurses do certain tasks under medical directives. In this case, shared leadership is still an excellent principle to follow when staff feel that a medical directive does not meet the needs of their clients.

**I have identified these options. I have chosen this one:**

This would not be appropriate in this situation as staff cannot change the medical directive without MOH approval. ....

I/we have identified these options. I/we have chosen this one.

**I have decided that these are my options. I recommend this one:**

Staff review the evidence behind the medical directive. Staff review the options for the directive. They pick a recommended option that is evidence based and most meets the needs of their clients. Staff then present it to the MOH for a decision. ....

I/we have decided these are my options. I/we recommend this one.

**I have decided these are my options. Help me pick one:** Staff review the evidence behind the medical directive. Staff develop several options for the MOH to consider for the directive. ....

I/we decided these are my options. Help me/us pick one.

**Help me decide what to do:** Staff indicate to management that they feel that the medical directive does not meet the needs of their clients. Staff ask the MOH to review it. ....

Help me/us decide what to do.

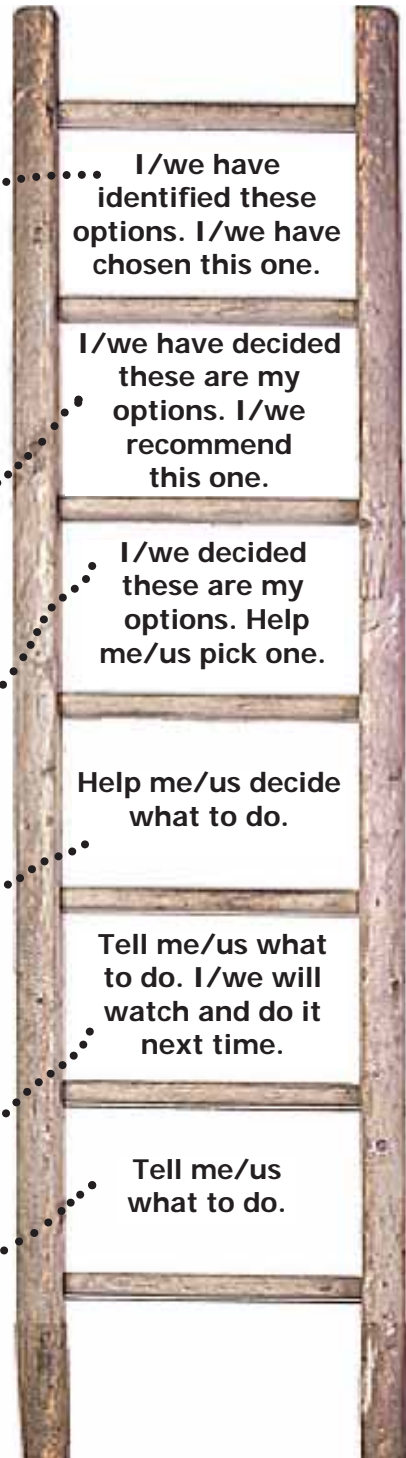
**Tell me what to do. I will watch and do it next time:**

Staff ask to meet with the MOH to outline the medical directive without requesting any changes. Staff determine that it will not allow them any flexibility to meet client needs but do not raise this with the MOH. ....

Tell me/us what to do. I/we will watch and do it next time.

**Tell me what to do:** Staff follow medical directive despite feeling that it does not meet the needs of clients. ....

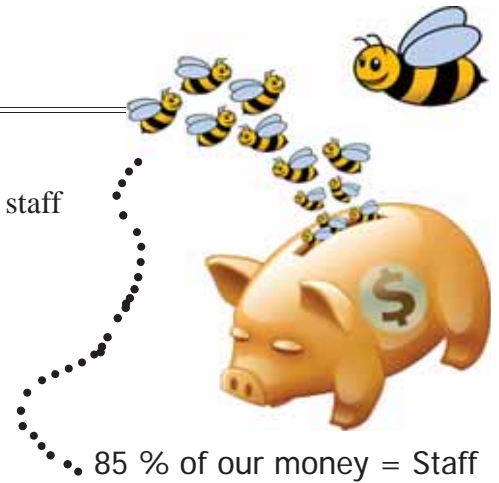
Tell me/us what to do.



## POSSIBLE BENEFITS OF IMPLEMENTING THE SHARED LEADERSHIP MODEL

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- Increase in job satisfaction for all staff
- Sense of ownership, pride and control of the work environment for all staff
- Increased commitment of staff to the organization and their work
- Improved work processes, effectiveness, efficiency and service to the community
- Improved community satisfaction with LGLDHU
- Reduced staff turnover



## POSSIBLE RISKS AND BARRIERS TO IMPLEMENTING THE SHARED LEADERSHIP MODEL

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Changing the organizational culture is not easy. It has been found that it can take up to six years to fully implement the model. Even after implementation, shared leadership, like CQI, is a dynamic, ever-changing, never-ending journey rather than a destination. Particularly during the implementation phase, all involved will experience uncertainty, confusion and anxiety and stress levels will rise, possibly influencing workplace health.

Good leadership from senior management, good communication and good planning can reduce these negative outcomes but they cannot be eliminated. They are intrinsic to all change.

### **Barriers to successful implementation include:**

- Inability of some individuals to make the required changes. How does the organization cope with those who cannot cope?
- Inability to secure the required tools, particularly the information systems, training and/or resources. Staff forced to work without the required tools become very frustrated and cynical.
- Inability to change the culture of the organization, particularly the mental mindset of the individuals involved.

### **Methods for overcoming the barriers:**

- Strong organizational commitment to the principles, starting with the Board of Health and permeating through all departments, sites and levels including both unions. This can be achieved by marrying the shared leadership model to the current CQI initiative that has already successfully obtained the commitment of the Board and staff.
- Strong lines of communication and dialogue from the very first efforts to consider implementation of the model.
- Provision of multiple forums for addressing issues to ensure that the vision filters throughout the organization.
- Development of a supportive infrastructure in advance of implementing the model built upon the current CQI infrastructure.
- Focus on an outcome that all can support: better service to the community.
- Regular evaluation of the progress of implementation to identify and solve problems before they affect morale and reduce buy-in to the model. This began with a pre-implementation consultation with staff to determine if this leadership model is really what is needed by LGLDHU at this time.

## ILLUSTRATIVE EXAMPLES OF SHARED LEADERSHIP

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The performance appraisal system is a valuable contributor to the implementation of a shared leadership model. It must reward activities and attitudes among staff that are compatible with and supportive of shared leadership while discouraging activities and attitudes that are not supportive. The current performance appraisal system will be reviewed by the People Committee in the future. Meanwhile, senior management has identified the 360-Degree Performance Appraisal (PA) process as a potentially valuable one that could contribute to the implementation of a shared leadership model.

The essence of this PA process is that it involves staff that surround the staff member being appraised;

- those who report to that person;
- those who are peers of that person;
- and those to whom that person reports.

Since all senior managers are due for a performance appraisal, it has been decided to implement a 360-degree PA for senior managers in 2008 as a pilot project. In order to fully benefit from this new appraisal process, the current appraisal forms will need to be revised to reflect the knowledge, attitudes and skills required to function well in a shared leadership environment.

### **Development of Program Operational Plans by Teams**

Each year, staff participate in the development of the program operational plans for the year for the programs for which they are accountable. These plans are developed by the teams that will carry out the program. The teams develop the plans autonomously in a shared leadership model. Once the plans are developed, they are passed through the department's Director to ensure that the plans fit with overall organizational goals and resources. The plans are sent to the Program Co-ordinating Committee (PCC) for information and discussion on how to co-ordinate the delivery of program activities. Therefore, although the development of the plans is carried out on a shared leadership model, the approval of the plans is based on a hierarchical model. A fully developed shared leadership model would see the teams given their own finite resources and, being fully imbued with the organization's goals, make the final decisions as to their own operational plans after co-ordination with other programs at PCC. Senior management would provide overview (through PLC and SMC) in order to identify problems such as duplication of effort and the necessary infrastructure.

### **Evaluation Community of Practice**

The current efforts to develop an evaluation community of practice at LGLDHU would see staff in each program develop their own evaluation plan for the program, carry it out with assistance from the QI department, and then make decisions based on the results of the evaluation as to how to improve the program in the future. Senior management would provide the resources and infrastructure needed to carry out the evaluations, the skills training to staff and would be apprised of the results of the evaluation and decisions made but would not intervene in the decisions.

This would be a fully developed shared leadership model once it has been implemented.