Government of **Western Australia**
Department of **Health**

Executive Summary Report and Recommendations

Clinician Engagement in the Brave New World – Health Service Boards

Clinical Senate of Western Australia

2 September 2016

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Executive Summary

The third meeting of the Clinical Senate of Western Australia for 2016 was held on 2 September at the University Club of WA.

The topic for debate was “Clinician Engagement in the Brave New World- Health Service Boards”.

The specific focus for debate was to provide an opportunity for two-way discussion on clinician engagement between clinicians and health service boards in Western Australia. Clinicians considered strategies to influence health service agreements in the provision of quality and safety of care.

The sponsor for the debate was Dr David Russell-Weisz, Director General WA Health.

A broad range of experts were invited to the debate. Invited guests included the chairs of the clinical service associations and medical advisory committees as well as the heads of department for both nursing and allied health. Experts also included both public and private clinicians.

The opening session

Mr Brett Collard, Yelakitj Moort Nyungar Association Inc., opened the session and offered a Welcome to Country. He shared his personal experience working over fifteen years in mental health in Narrogin. He emphasised the importance of speaking with people, visiting them, having tea with them and establishing relationships. Mr Collard stated, “Mental health doesn’t discriminate, doesn’t care who you are and can destroy you if you are not strong. Health is not a discriminate person either, it will take you on so work in your spheres in a more productive manner, not only in your job but in the community then people will know your name”.

Professor Julie Quinlivan, Chair of the Clinical Senate, introduced the debate by emphasising the importance of clinician engagement. She gave an overview of how the Clinical Senate could influence health policy in the setting of the WA Health Department as System Manager and the associated operational Health Service Boards.

Professor Quinlivan cited numerous studies that linked clinical engagement as a lead indicator of health service efficiency, quality and safety outcomes. She stated: “Where engagement is poor, disaster follows. Likewise, where clinical engagement is high, hospitals are efficient and quality and safety outcomes improve”.

She asked Clinical Senate members to consider how we could ensure clinicians who worked at the coal face of health services, and who had valuable collective knowledge of local systems, could engage with management. Likewise, she asked how health service boards and hospital management could bring coal face clinicians on their journey of health service reform.

Professor Quinlivan stressed the importance of a shared understanding of clinician engagement and offered the following definition adopted from Queensland Health:

Clinical Engagement is the manner in which the health service involves the people who provide direct patient care in the planning, delivery, improvement and evaluation of health services.

Director General, Dr Russell-Weisz, stated that the debate was the first Clinical Senate since the passage of the Health Service Act 2016. The new legislation had transformed the landscape of how we govern the delivery of healthcare in Western Australia.

In setting the scene for debate, Dr Russell-Weisz spoke of the need for a culture of genuine clinical engagement. He emphasised the need to invest in skills that deliver better engagement directed towards greater/organisational good not individuals. He spoke of the importance of engaging genuinely with all clinician stakeholders. This required partnerships.

Dr Russell-Weisz shared his experience from Fiona Stanley Hospital where the four clinical commissioning leads came on board as near full timers to lead clinical commissioning and "walk the floor" with other clinicians. This was a key to success. The response was that staff at all levels rolled up their sleeves and brought colleagues along ensuring broad engagement. He stated that clinical leadership was critical to commissioning of the hospital and it remains critical in all health services.

He outlined priorities for the first year as safe quality care and clinical and financial performance.

Dr Russell-Weisz called on senators to consider how they should work with Boards to make decisions that support better service delivery and patient care as well as how the Boards should engage with clinicians. Dr Russell-Weisz closed his talk challenging clinicians to set him a vision for the future, to speak openly and freely under Chatham House Rules and to move the discussion towards solutions.

The guest speakers for the day, Mr Danny O'Connor, Chief Executive and Dr Michael Datyner, Visiting Medical Officer (VMO) and Medical Director, Acute Medicine Division, Blacktown and Mount Druitt Hospitals, Western Sydney Local Health District (WSLHD) provided experiential insights to facilitate discussion. Providing a chief executive and clinician's perspective, they shared their five year journey illustrating changes undergone within their organisation, the impact of the changes they faced under a new government regime and lessons learnt.

The Western Sydney Health District covers 780 square kilometres; there are five local government areas, five hospitals, and a total of 120 health facilities and over 11,000 staff. It is also one of the fastest growing areas and is multicultural. In describing "where we were" Mr O'Connor stated that in 2010 there was major disunity. There was a breakdown of working relationships between clinicians and management and disengagement of clinicians. It was a fractious and unproductive environment. There was a significant decline in performance metrics and major conflict with the NSW Health Department and because of these factors there was a significant loss of talent succession and major deterioration in financial performance.

Dr Datyner, in offering the clinician's perspective, explained that staff had given up due to the culture that developed throughout the organisation. The management of the organisation had led to an extremely poor culture and a total lack of trust and disconnect between management and clinical staff. The structural changes led to departments and clinical networks not able to work together which in turn led to individual facility breaking down.

Termed the Big Bang of 2011 the presenters shared changes within their organisation over the past five years. Changes occurred at both a macro and micro level.

In describing what they did between 2011- 2015 he spoke of the importance of relationship investment. They introduced a clinician led organisation. Central to this was moving from a command and control regime to one of devolved distribution and accountability. Important to this was the need to support senior clinicians in understanding the business, understanding what driving performance was and supporting them in understanding the contribution they needed to make as leaders within the organisation.

Lessons learned along the way were described as fostering a balanced relationship between the Ministry and the Board (board evolution) via: changes to delegation; significant empowerment of clinicians; changes to the accountability regime; improved business information and metrics; and significant devolution of power. Critical to this was the need for leadership and business design and business relationships. Equally important was the establishment of core values and the use of leadership programs to embed these values into "what we do every day".

Five years on there was still a divergence in the sophistication of the NSW Health boards. The Ministry was now a sophisticated purchaser and macro manager of performance. The Districts were more autonomous in running their businesses and there had been substantial progress in

ABF sophistication. A lot of work had been done to educate staff about ABF. They had also benefited from substantial improvement of their information systems.

Panel and Plenary Debate

A panel made up of the five Health Service Board Chairs (or nominee) and Chief Executive Officers opened the plenary session. The Health Service Board Chairs were asked to speak on their vision for their health service; how they planned to engage clinicians and how they plan to implement recommendations made by the Clinical Senate.

These presentations were followed by free flowing discussion/debate whereby all participants engaged in two-way discussion including questions and answers. The plenary was run under Chatham House Rules in order to address the 'elephants in the room' and work collectively to consider a way forward.

North Metropolitan Health Service (NMHS)

Professor Bryant Stokes, Health Service Board Chair
Mr Wayne Salvage, Chief Executive Officer

Professor Stokes stated that 10% of care was delivered by doctors with the remaining 90% delivered by nursing and allied health professionals. He emphasised that all of this makes up the clinical team. He believed those unwilling to make the necessary changes should leave the team or Board in this instance.

The overall priority for the NMHS Board was safety and quality. This included safety of care for both patients and staff. He offered the example of patients on methyl amphetamine harming staff. Therefore, safety and quality policy should promote safe and quality care for patients/clients and staff.

He reported that in NMHS they were in the process of forming a clinical advisory group.

He stated he would be listening to what participants had to say and considering the priorities required within clinical services. The NMHS Clinical Advisory Committee (CAC) would consider these recommendations.

South Metropolitan Health Service (SMHS)

Adjunct Associate Professor Kim Gibson, Board Member
Dr Robyn Lawrence, Chief Executive Officer

Adjunct Associate Professor Kim Gibson spoke on behalf of the SMHS Board stated the SMHS Board was about providing strong leadership to, and representations for SMHS. The Board would not replace the Executive at SMHS or hospital levels. The Board approach was "noses in, fingers out" and was about ensuring good governance. The Board was going to ask hard questions, make hard decisions and be a part of the SMHS team.

She reported the key objectives of the Board: Ensuring best patient safety, quality and patient experience outcomes; achieving high levels of clinical performance; encouraging high levels of staff engagement and communication throughout SMHS; being a place where our people are proud to say they work here and would have their families treated here; encourage leadership and innovation; becoming financially sustainable through efficient and effective operation.

The SMHS Board views clinicians as shareholders working with the Boards towards a shared vision and excellence. They have established a culture and engagement committee, are open to innovation and recommendations for the future, have agreed to do Board walkaround and will give consideration to implementation of clinical senate recommendations.

Ms Gibson reported they are at the early listening stage; open to ideas around clinical engagement and interested in the outcomes from the day.

WA Country Health Service (WACHS)

Dr Neale Fong, Health Service Board Chair
Mr Jeffrey Moffet, Chief Executive Officer

Dr Neale Fong stated the newly formed WACHS Board were defining clear roles of Board Members and identifying opportunities to work cohesively to make a bigger impact. He stated that the goal of WACHS was to be an exemplar for the best provision of rural and remote healthcare.

He stated that clinical engagement was important to improve population health and patient outcomes and that it is important to take the roles of everyone into consideration, not only the doctors. Finally, he reflected that clinical engagement is not about power, it is about influence. He stated the Health Leadership Framework emphasises the importance of engaging each other. Dr Fong reminded Senators that engagement must also include bedside/grass roots clinicians.

Child and Adolescent Health Service (CAHS)

Ms Deborah Karasinski, Health Service Board Chair
Professor Frank Daly, Chief Executive Officer

Ms Deborah Karasinski opened citing one of the functions in the legislation for the Health Service Boards was the engagement of stakeholders. She stated there are many stakeholders in CAHS. She stated the Board was keen to engage all types of stakeholders including clinicians and consumers.

She reflected that she was not convinced clinical engagement was best placed with the Health Service Boards as the Chief Executives had a strong role to play. She was also uncertain on how the Boards might address the Clinical Senate recommendations as she viewed them as more closely aligned with the Chief Executives.

Ms Karasinski conveyed they would focus their engagement around the priorities of the Health Service and they would absolutely engage early.

East Metropolitan Health Service (EMHS)

Mrs Suzie May, Deputy Chair, Health Service Board
Ms Liz MacLeod, Chief Executive Officer

Mrs Suzie May offered the EMHS perspective describing their Board as only eight weeks old with their Executive Team yet to be fully formed. She stated there will be no compromise on patient safety and quality of care. EMHS focus will be to build an integrated health service and foster meaningful relationships and work to improve staff safety.

In order to drive this vision they will form two committees: 1.) Planning and Service Delivery Committee and 2) Engagement and Consultation Performance Committee.

With regard to clinician engagement she reported there is some already occurring as part of an existing engagement and consultation framework. They looked forward to hearing from clinicians in order to improve and build on best practice and what works to inform their strategies.

Plenary

In the plenary session that followed “Rules of Engagement” participants were encouraged to address the “elephants in the room”. It also offered the opportunity for a two way flow of information between clinicians and the Board Chairs and the Chief Executives to collectively consider the key elements required for better clinician engagement.

Specific points raised in the plenary were:

- Responsibility for engagement – Health Service Boards and Chief Executive responsible for engagement
- Clinical engagement encompasses all health professionals and all levels of staff *(Clinical engagement begins at the grass roots level – knowledge and involvement)*
- Communication and collaboration/shared ideas between Boards, respectful, engaging
- Values and behaviours/consider language used, listen trust
- Child/adolescent gap (16-18 years old) * specific issue raised
- Clinical engagement equals safety and quality care for patient and staff
- Clinical engagement measures i.e. metrics
- Investment in training and skilling junior and senior clinicians

Additional points raised for the Boards were:

- Autonomy, empowerment and trust
- Transparency and the need to do away with qualified privilege
- Research as a space for clinician engagement noting that not all clinicians want to do research
- Values and behaviours need to bed from the top and inclusive of cultural respect
- Inequity between clinicians in public health i.e. amount paid

Key Summary points

1. The vision of the organisation was paramount. Unless the vision was practiced throughout the organisation, those who were disengaged would remain disengaged.
2. Clinician engagement must be everybody’s business. Engagement must encompass all health professions and all levels of staff (coalface and managers).
3. Clinician engagement must take advantage of grassroots knowledge. Conversely, clinicians must be taught how to think and be part of the system. There must be investment in training.
4. It is important for the Boards, executives and senior clinicians to take the lead and set the example in order to influence junior clinicians. They are our future leaders.
5. There was strong emphasis on values and behaviours. Communication is crucial and we must all consider the language we use, including tone and talk.
6. Cross board communication is vital especially for state wide clinical pathways and referrals.
7. Clinician engagement must be held responsible for organisational culture.

The afternoon session consisted of several working groups made up of the five health services. Senators made recommendations for the System Manager on state wide clinician engagement and developed suggestions for each of the Health Service Boards to consider as they develop clinical engagement strategies.

In conclusion, the Clinical Senate debate signalled the start of an important conversation between the newly established Health Service Boards, the System Manager, current health service executives and clinicians. The debate allowed for a robust exchange of information and ideas at a critical juncture of reform in WA Health.

The Clinical Senate recommendations and suggestions aim to assist the System Manager and Health Service Boards to create alignment across WA Health by providing a foundation that ensures a vision inclusive of clinician engagement for their health services and a culture for all of WA Health.

A response from the Director General to each of the system recommendations of endorsed, endorsed in principle, or not endorsed is requested**.**

Sincerely,

Professor Julie Quinlivan
Chair
Clinical Senate of Western Australia

Dr D J Russell-Weisz
Executive Sponsor
Director General
Department of Health Western Australia

Clinician Engagement in the Brave New World – Health Service Boards

Recommendations for the Director General

1. Clinical Senate recommends that the System Manager develops (within 12 months) a policy framework on clinician engagement that incorporates:

    - Key Performance Indicators (KPIs) (as part of Health Service Performance Reporting)
    - An expectation that Health Service Boards (HSB) will have a clinical engagement strategy

    Elements of a clinical engagement strategy should include:

    - Measuring clinical engagement (using the KPI tool in recommendation 2)
    - Shared values across the system
    - Common principles
    - Transparency
    - Investment in leadership e.g. Institute for Health Leadership programs

2. Adopt a 'measurable KPI' (using an identical tool across all HSBs) for clinical engagement and include it in safety and quality outputs within HSB agreements; linking the score to a performance bonus/penalty. Results (after an introduction phase of 1-2 years) must be transparent and published so all internal and external stakeholders can see and compare outcomes across WA Health.

3. That the System Manager, when considering or developing a direction or policy that has operational impacts, ensure a broad range of clinicians from all Health Service Providers are consulted, engaged and recorded.

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Suggestions for each of the Health Service Boards on Clinician Engagement

North Metropolitan Health Service (NMHS)
• Develop mechanisms/strategies for grass roots "floor upwards" and 2-way communication - Communication for input/change/innovation - Avoiding filtering of information by middle level managers
• Investment in skill development for clinical engagement (e.g. backfill staff) e.g. IHL also at a local level.
• Use common terminology for engagement.
• Re-engage the disengaged and develop strategies to do so.
• Repository of researchers /tools to share.
• Visibility /transparency of leadership.
• Walk around by leadership and HSB Members to meet staff on the floor and exchange ideas.
• Feedback to clinicians after their input.
• There is the need for decentralisation of power.
• Set culture and values for health service and engagement.
• Invest in clinical engagement activities.
• Good metrics are required to benchmark and assess progression –'what you can't measure, you can't manage'. - This requires good quality information and data systems
• Consideration of different methodologies for different craft groups
• Employee- organisational (through performance management; recruitment) and behavioural based retention.
• Culture for NMHS as an organisation.
• Improved communication; empathy.
• Favouritism – 'who yells loudest' - There is a lack of trust and transparency.
• Channels of communication (two way) through the full management chain (floor – Health Service Board) – support safe and legal environment for reporting of risk beyond standard reporting structures.
• Clinician engagement framework: holistic and that you have to report against.
• Over 'x' period, develop robust ICT that has been developed through clinician input and that is able to be practically used.
• Introduce a 'Junior' inter-professional clinician senate in the Health Services.
• Provide additional resources for leadership development and maintain the healthy leadership programme.
• NMHS interdisciplinary senate with regular meetings to promote collaboration.
• CAC- engagement tree; transparent reporting – there are concerns that information will not be disseminated through adequately.
• Concerns about the makeup of the Board- 5 are doctors, none from NMHS and there is no nurse representative. How will the Board and clinicians communicate?
• We want the Health Service Board to come visit Divisions and Departments to understand the environment and challenges we work in.

South Metropolitan Health Service (SMHS)
• Audit current processes in place for clinician engagement in SMHS (environmental scan).
• Analyse current governance structures to determine if appropriate delegation of responsibility and accountability is in place. “Flatten the hierarchy”.
• “Incentivise innovation” e.g. to create private income that can be used to improve patient experience. - E.g. capture ideas from junior staff and offer an award for the best ideas. - E.g. staff suggestion boxes with best weekly suggestion being noted.
• Ensure values and behaviours are consistent.
• Adopt a framework for clinician engagement and let individual the health service operationalise it.
• Implement voice of staff (survey) with results shared across SMHS.
• Be transparent with the voice of staff survey results.
• Values need to be more than motherhood statements; they need to actually be a part of how we work.
• Need to see the values in action.
• Recognise that staff are time poor, need to make information more easily available and accessible.
• Supervisors and middle managers need the skills/training to engage with their staff.
• Increase/improvement of engagement with general practitioners (GPs).
• Re-build SMHS culture.
• People are trying to get their own area working- maybe they don’t have time for the ‘bigger picture’.
• Need to communicate real-time information.
• Look at what other areas/services are doing well.
• Communication screen, ward screen: ask people/staff what information they need/want to know.
• Integrated mental health meetings/leadership groups.
• Tell people what systems/structures are in place.
• Integrate leadership programs (mentoring/training) at the beginning of the clinician’s career. Doesn’t necessarily need to be specialist/clinical area.
• Recommend “Cup of tea with the Board” sessions.
Note: refer to recommendation 8 from last Clinical Senate debate “Patient Opinion” to be implemented.

East Metropolitan Health Service (EMHS)
• That the Health Service Board will ensure the Clinician Engagement Framework is implemented (and adequately resourced) in partnership with clinicians, (internal and external) and consumers.
• Must establish short and long term goals.
• Show incremental achievements.
• Include a rotating representative from clinical and consumer groups to attend Board meetings.
• Identify centres of excellence globally for clinician engagement and model EMHS Clinician Engagement.

Child and Adolescent Health Service (CAHS)
• Assign executive responsibility.
• Provision of evidence of clinical engagement with front line staff – regular meetings and/or staff forums.
• Needs to be a mechanism for front line staff to offer suggestions for service improvement in a safe/+1- confidential way.
• Involve grassroots staff in strategic planning at health service level regarding content of the plan/design/execution/enablers of the plan.
• Board and Executive need to acknowledge that effective clinician engagement can lead to improved patient safety and clinical outcomes.
• Have a mechanism to close the feedback loop following clinician consultation and engagement i.e. communication both ways regarding implementation, outcomes, evaluations etc.
• We want the Board to understand the business of front line staff at CAHS.
• The Board should sit down with front line staff and discuss the issues regularly.
• The Board needs to be approachable, accessible, affable and available.
• Board to ensure transparency in communication of information (dashboard – budget, activity, FTE etc…) down to department level.
• Board to have open staff forums of open meetings periodically.
• The Board should do ‘walkarounds’.
• Establish sessions “cup of tea with the Board”.
• Improve visibility of executive with front line staff e.g. shadowing or working with clinical areas.

WA Country Health Service (WACHS)
• Clinician’s involvement in budget setting and management.
• Restructure Safety and Quality Department to include clinicians from the coal face.
• Resource and invest in clinicians to undertake/participate in clinical engagement (time, admin, support. Locum cover backfill) GST vs engagement.
• WACHS Board in resident/trainee clinician engagement.
• Staff feedback to the Board (mechanism) RAPID increase.
• Investment in leadership development for clinicians.
• Elevate the voice of the clinician through innovative means (portal).
• Walk the facilities to find information from staff and consumers.
• Ask clinicians to identify things to stop doing that don’t add value.
• Health Service Boards work with Area Health Services on Clinical Senate Recommendations with clinical experts from the floor and local consumer representatives.
• Consider the development of a ‘clinician voice’ forum that provides opportunity for clinician representation in service planning and delivery.
• Develop an internet based “engagement portal” that provides for sharing of successful engagement strategies from frontline clinical teams.
• Consider re-branding the C4 Framework to “Person Centred Engagement Framework” - Clinicians - Consumers - Carers - Communities

Presenters & Expert Witnesses

- Mr Brett Collard, Yelakitj Moort Nyungar Association Inc.
- Professor Julie Quinlivan, Chair, Clinical Senate of Western Australia
- Dr David Russell-Weisz, Director General, Department of Health Western Australia
- Mr Danny O'Connor, Chief Executive, Western Sydney Local Health District, NSW
- Dr Michael Datyner, VMO, Geriatric Medicine and Medical Director, Acute Medicine Division, Blacktown and Mt Druitt Hospitals, Western Sydney Local Health District NSW
- Professor Bryant Stokes AM, Chair, North Metropolitan Health Service Board
- Dr Neale Fong, Chair, WA Country Health Service Board
- Ms Deborah Karasinski, Chair, Child and Adolescent Health Service Board
- Adjunct Associate Professor Kim Gibson, Board Member, South Metropolitan Health Service Board
- Mrs Suzie May, Deputy Chair, East Metropolitan Health Service Board
- Mr Wayne Salvage, Chief Executive, North Metropolitan Health Service
- Dr Robyn Lawrence, Chief Executive, South Metropolitan Health Service
- Ms Liz MacLeod, Chief Executive, East Metropolitan Health Service
- Professor Frank Daly, Chief Executive, Child and Adolescent Health Service and Perth Children's Hospital (PCH) Commissioning
- Mr Jeffrey Moffet, Chief Executive Officer, WA Country Health Service
- Ms Rebecca Brown, Deputy Director General, Department of Health Western Australia
- Dr Paul Hill, Director, Emergency Medicine, Armadale Health Service and Chair of the Medical Advisory Committee
- Dr Christopher Griffin, Consultant Obstetrician, Head of Department, Midland Hospital and member of the Clinical Staff Association
- Dr Peter Reid, Specialist Obstetrician and Gynaecologist and Chair of the Medical Advisory Committee at Ramsay Healthcare, Peel Health Campus
- Dr John Anderson, Acting Director, Clinical Services, Fiona Stanley Fremantle Hospitals Group and Chair, Clinical Staff Association
- Dr Catherine Cole, Head of Department, Haematology at Princess Margaret Hospital for Children
- Ms Dianne Bianchini, Chief Health Professions Officer, Department of Health Western Australia and Chair, WA Clinical Training Network
- Dr Simon Wood, Director of Medical Services, Joondalup Health Campus (JHC), Ramsay Health Care
- Dr Mark Monaghan, ED physician and current Head of Service, Fiona Stanley Emergency Department
- Associate Professor David Mountain, ED specialist, Sir Charles Gairdner Hospital

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