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

Clinician Engagement in the Brave New World- Health Service Boards

Clinical Senate Meeting

Final Report

better health • better care • better value

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Introduction

The role of the Clinical Senate of Western Australia (WA) is to provide a forum where collective knowledge is used to debate strategic health issues. Recommendations are made in the best interest of the health of all Western Australians and are subsequently provided to the Director General (DG), the Health Service Boards (HSBs) and through the DG to the Minister for Health.

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 debate was a strategy to facilitate 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 range of experts were invited, including chairs of clinical service associations, medical advisory committees and heads of department for nursing and allied health. Experts included public and private sector clinicians.

Professor Julie Quinlivan, Chair of the Clinical Senate opened the debate by emphasising the importance of the topic given the enactment of the Health Service Act 2016 and appointment of Health Service Provider Boards. She stated the timeliness of this debate was no coincidence as it enabled clinicians the opportunity to provide some strategies for health service boards to consider as they developed clinical engagement strategies.

Professor Quinlivan stressed the importance of a shared understanding of clinician engagement and offered a definition of clinician engagement 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 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 emphasized the need to invest in skills that deliver better engagement directed towards greater organisational good and not individuals. He spoke of the importance of engaging with clinician stakeholders. This required partnerships.

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 both 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.

A panel comprising 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 debate in clinical engagement. The plenary was run under Chatham House rules in order to address the 'elephants in the room' and work collectively to progress change.

1. Process

The Clinical Senate in Western Australia was established in 2003. Debates follow an agreed standard. The process ensures senators have a clear understanding of process and receive sufficient information to discuss the topic and develop recommendations for the Director General of Health (DG) as System Manager and Health Service Boards (HSBs) as Operational managers (Appendix 1).

Prior to the debate, attendees received pre-reading documents containing information in preparation for the debate. Speakers and additional expert witnesses provided additional information on the day (Appendix 2).

The full day Senate debate traditionally commences with a Welcome to Country, which for this debate was offered by Mr Brett Collard, Yelakitj Moort Nyungar Association Inc.

Clinical Senate Chair, Professor Julie Quinlivan then welcomed attendees and provided an update on senate activities. She introduced the topic for debate calling on senators and other experts in the room to “tell us what good engagement might look like. We must also consider what we can learn from the past. What has and has not worked, and how we can ensure our organisations are cohesive and working as teams.” She called on senators to determine how they could collaboratively work in the brave new world of Health Service Boards (HSBs).

Director General, Dr David Russell-Weisz officially opened the debate stating it was the first Clinical Senate since the passage of the Health Service Act 2016. The debate was unique as the Deputy Director General, Board Chairs and Chief Executives were in attendance. He encouraged Senators to engage with them throughout the day as they considered clinician engagement at both a state and health service level.

The Director General also reported on the recommendations from the previous debate on Transforming Teaching, Training and Research (TTR). He stated the TTR recommendations were the first set impacted by the governance changes. He advised senators that in considering his response he determined the need for a new category of response “Referral to Health Service Boards’.

The next stage of the Clinical Senate process was a panel consisting of the Health Service Board Chairs and Chief Executive Officers. The Health Service Board Chairs were asked to respond to these three questions:

1. What is the vision of your health service?
2. How do you plan to engage clinicians at a local level?
3. How do Board Chairs plan to ensure Clinical Senate Recommendations are implemented?

The presenters for this session included Health Service Board Chairs/Members:
Professor Bryant Stokes, AM, Adjunct Associate Professor Kim Gibson, Mrs Suzie May,
Dr Neale Fong and Ms Deborah Karasinski.

The afternoon session consisted of working groups made up of the five health services: North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS); East Metropolitan Health Service (EMHS); Child and Adolescent Health Service (CAHS); and WA Country Health Service (WACHS).

The session was run in two parts with participants focussing on:

1. developing recommendations to assist the system manager to improve clinical engagement at a state-wide level
2. developing suggestions specific to Health Service Boards in order to inform its strategy to improve local engagement

Recommendations from the workshops were presented in the final session of the day and ranked in order of importance by the full Senate. The Clinical Senate Executive issued a request for a response by the Director General of Health to each recommendation at the next debate. Responses could be:

a) endorsed,
b) endorsed in principle,
c) not endorsed, or
d) refer to health service boards.

2. Presentations

Mr Bevan Bessen, facilitator for the day, opened proceedings by welcoming participants, acknowledging the traditional owners both past and present, and introducing Mr Brett Collard who offered the Welcome to Country.

Mr Brett Collard 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 followed and opened the debate by providing an update on Clinical Senate secretariat activity since the last meeting. This included the appointment of Ms Jenny O’Callaghan, Co-director Women’s Health, State-wide Services and Genetics at Women and Newborn Health Service and Dr Jeanette Ward, Consultant Public Health Medicine for WA Country Health Services in the Kimberley onto the Clinical Senate Executive Committee.

Professor Quinlivan reported on the progress towards implementation of the recommendations from two previous debates: March 2015 – Planning for expected deaths in acute health settings and November 2014 – Drug Misuse- are we up to speed. For the end of life care debate she reported that new funding and contracts had been awarded to the Palliative Care Advisory Committee to undertake two palliative care projects recommended by the Clinical Senate on improving after hour’s palliative care and carer support. These projects are now with the Cancer and Palliative Care Research and Evaluation unit at the University of Western Australia. In reporting on drug misuse, Professor Quinlivan acknowledged the WA Government for funding new clinical liaison roles in several emergency departments as part of a strategy to address drug misuse. This was also a recommendation made by the senate.

Professor Quinlivan reported that the new legislative environment had driven the need for the Clinical Senate to reform its Terms of Reference (TOR). This reform needed to occur without losing the capacity of the Clinical Senate to bring consensus driven policy recommendations from clinicians to the Director General or Minister of Health on the important topics selected for debate. Therefore, the executive committee had worked to refine the TOR to ensure the Clinical Senate was still able to deliver state-wide clinical engagement to senior decision-makers in Health.

Professor Quinlivan outlined changes to the way that recommendations are formed and shared examples of flow charts for both the system manager recommendations and operational manger recommendations. Given the way recommendations would now be considered and implemented in the environment of the HSBs. Professor Quinlivan offered all participants the opportunity to provide feedback before the TOR was finalised with the Director General. She called for feedback on this approach by 9 September 2016.

In turning her attention to the topic for debate Professor Quinlivan called on participants to consider how to improve clinical engagement in the brave new world of health service boards in order to drive improvements in patient safety and quality and improve efficacy of care.

She cited numerous studies which link clinical engagement to health service efficiency and quality and safety outcomes. “Where engagement is poor, disaster follows. Likewise, where clinical engagement is high, hospitals are efficient and quality and safety outcomes improve”. Given this knowledge, she asked Senators to consider how we could ensure clinicians who

worked at the coal face of health services, and who had valuable collective knowledge of how local systems worked, could be engaged in our health services by management. Likewise, we must consider how we enable health service boards and hospital management to bring coalface clinicians on their journey of necessary health service reforms.

Professor Quinlivan stressed the importance of a shared understanding of what clinician engagement is and offered following definition of clinician engagement:

> *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.*

Professor Quinlivan asked Senators to address the "elephants in the room" or current barriers to positive engagement in our health services. Clinical senate meetings operate under Chatham House Rules. This means that Senators can voice concerns about barriers to good clinical engagement without fear of recrimination.

Professor Quinlivan informed there would be a break from tradition outlining the afternoon session as working groups. Instead participants would work in health service groups (jurisdictional) firstly to develop recommendations that would assist the system manager to improve clinical engagement at a state-wide level, and secondly to work on suggestions specific to your HSB that would help inform its strategy to improve local clinician engagement. She advised that the recommendations from the previous debate on clinician engagement were included in the information provided and should be considered when determining their recommendations.

Professor Quinlivan welcomed senators and member representatives and formally reminded participants of how the Clinical Senate of WA operates which is:

- To work collaboratively, setting aside individual and organisational agenda.
- To state your opinions freely, drawing on your clinical experience and expertise.
- To empower you to influence others in all your professional spheres with the new perspectives gained through the debate.
- To play a leadership role in health reform, developing strong, valid, priority recommendations in the best interests of the health of all Western Australians.

Professor Quinlivan introduced the Director General, Dr David Russell-Weisz to officially open the day, report back on the recommendations from the previous debate and set the scene with regard to the topic of the day.

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

Dr Russell- Weisz reported as customary, he would first spend a few moments to briefly revisit the previous Clinical Senate, and to share the outcomes of the recommendations that were made. He asked participants to refer to the information in their packs on the recommendations from the debate as he provided his comprehensive response.

The Director General reported that in June senators were charged with considering the importance of optimising investment in teaching, training and research. The recommendations from the debate reinforce the need for WA health to have the right strategies in place. He stated the June debate promoted some terrific discussion around how we ensure our clinicians have access to the right learning tools at the right time, regardless of whether they work in a remote hospital in the State's north, or in one of our busy tertiary hospitals in the metro area.

The debate resulted in nine recommendations with five endorsed or endorsed in principle, one not endorsed, and three referred to Health Service Boards. This referral represents the introduction of a new category of recommendation in our Senate debates.

The full list of recommendations is listed here along with the Director General's response of Endorsed, Endorsed in Principle, Not Endorsed and the new category of Referred to Health Service Boards.

Recommendations 1and 8 were Endorsed

Rec 1: Endorsed
Implement a statewide Learning Management System (LMS) that links existing LMS and provides service level reports and individual level data that is transferable between services.

Rec 8: Endorsed
WA Health develops a series of Key Performance Indicators (KPIs) to demonstrate that research is embedded in clinical practice.

This includes conduct of research, publishing with co-branding, and translation of research outcomes into clinical practice.

Response:

The DG stated there was no question that recommendation 1 was a critical initiative, as it would ensure that all of our clinicians have the right training as they move between services. The hurdle we need to overcome is the variable coding methodology of training modules across health services, and to that our System Policy and Planning division has started work to develop a list of mandatory clinical codes across WA Health and to identify a suite of mandatory training modules and minimum competencies required within each training code. Beyond that, further work needs to be done to ensure training data can be transferred from the Human Resource Data Warehouse to all six Learning Management Systems.

I also endorse recommendation 8, and the Office of the Chief Medical Officer, in collaboration with Purchasing and System Performance and health services, is re-establishing the TT & R ABF working group to ensure that appropriate Key Performance Indicators are developed.

Recommendations 2, 4 and 7 were Endorsed in principle

Response: Two recommendations were quite closely related as they concerned budgets, and have been accordingly merged. The Independent Pricing Authority has released the Teaching, Training and Research Costing Study Project Report, and our WA ABF team are looking at that now.

We endorse in principle, recommendation number 7 and we will liaise with the Boards to determine the best way forward with this initiative.

Rec 2: Endorsed in Principle
In order to meet the DOH policy requirement of providing safe, quality evidence based health services; health service accountability will be measured by key performance indicators that should include:

- Quarantined teaching time
- Quality improvement activities
- Leadership Training
- Evaluation surveys/ in relation to the adequacy of teaching and training
- Demonstrate outcomes such as research publications, workshops etc.

WA Health should provide recurrent funding for the Infection Control Automated Surveillance Technology (AST) system, support its implementation, and be responsible for its maintenance.

Rec 4: Endorsed in Principle
That Area Health Service Boards and WA Health quarantine the TTR budget to ensure it is identifiable, visible, flexible in use and rigorously acquitted. The TTR budget can be used to support specific TTR activities such as:

- Research specific information systems and software
- Bio statistics
- Health economics
- Supportive financial structures particularly for multi year research
- Dedicated research support staff
- Ethical and governance processes
- Library services.

Rec 7: Endorsed in Principle
WA Health encourages cross sector research by promoting partnerships across primary to tertiary care focussed on outcomes that decrease demand and increase care closer to home.

This can be achieved by

- Allocating some research funding to cross sector research
- The specific criteria in research grants require cross sector consumer partnerships
- WAHTN include primary care rep on the Board
- WA Health supports effort for WAHTN become a National Centre of Excellence

Recommendation 9: Not endorsed

Rec 9: Not endorsed
WA Health recommends that all health care students that are undergoing hospital based training undergo a quarantined commitment to community based primary health care service.

Response:

The DG reported that this recommendation is not viable at this time due to the breadth of its scope. The accreditation bodies for university courses require that students' complete hospital based placements. This will need to change, if we are going to be able to encourage students to undertake their placements in primary care, rural and remote settings. WA Health is involved in discussions with the Council of Australian Governments (COAG) and the accreditation bodies to influence this change; however we are not there yet.

Recommendations 3, 5 and 6 will be referred to Health Service Boards

Rec 3: Referred to Health Service

The Health Service Boards should establish multi-disciplinary joint academic /clinical appointments that report through to the Chief Executives who are responsible for:

- Development of relevant, multidisciplinary research portfolios
- Increase the awareness of a workplace culture towards improving patient outcomes through education, training and introduction of new processes that translate research findings.
- Increase collaboration and partnerships with patient and other stakeholders.
- Developing reporting research relevant KPIs.
- Streamline approval and governance processes.
- Involve junior clinicians.

Rec 5: Referred to Health Service Boards
Department of Health partner with all relevant stakeholders to increase capacity of rural and regional settings in the provision of valid training opportunities for all professionals.

> E.g. Rural Clinical School, Western Australian General Practice Education and Training (WAGPET), WA Primary Health Alliance (WAPHA), Students and Practitioners Interested in Rural Practice Health Education (SPINRPHEX), the Aboriginal Health Council of WA (AHCWA), Aboriginal Community Controlled Health Organisation (ACCHO) and Rural Health West.

Rec 6: Referred to Health Service Boards
Department of Health to require in the Health Service Agreements (HSAs) that metropolitan (NMHS, SMHS & EMHS) and children's health services (CAHS) contribute to Teaching and Training for WACHS to ensure specialist knowledge is shared statewide.

Response to recommendations 3, 6 and 5:

The DG reported these recommendations were purposely left until last as they provide a neat segue into the topic for today.

He reported that recommendations 3 and 6 require a joint discussion between the System Manager and the Health Service, with very clear and defined tasks for each.

As the System Manager, we support a measure that sees a culture of continuous excellence in learning and research, and are happy to set those benchmarks across WA Health, however the practicalities around how we integrate joint academic and clinical appointments is a discussion that needs to occur at Board level.

In addition, we also need to find an equitable solution to the costs of the training, being mindful that the burden is overwhelmingly borne by WACHS. The existing outreach services and rotations had left tertiary hospitals left with the 'salary' cost of staff members while WACHS received the 'activity' income, which needs to change. That part of the discussion will be led by the System Manager to the Boards, to find an agreement that is workable for all of WA Health.

Dr Russell-Weisz stated that with respect to the suggestion that hospitals employ senior academics in hospitals to lead teaching, training and research, the feedback he had received from Senators would strongly suggest that this is an idea with a great deal of merit. From the patient's perspective, this proposal sends a clear signal that our hospitals provide the very latest in treatment and in care, which in itself, is a very powerful message to convey on multiple levels.

As we progress, we will also need to engage with the universities and seek their input as to how this initiative should work from their perspective, and I look forward to hearing how the Boards progress this issue.

Dr Russell-Weisz next set the scene for debate. In doing so he spoke of a culture of clinical engagement reminding that engagement is not an event; it is a journey and needed to be embedded within an organisation and sustained. He reported that evidence supports high performing hospitals have Boards who encourage clinician engagement.

He spoke of the importance of genuine engagement with all clinician stakeholders. This required partnerships at all levels.Dr Russell-Weisz emphasized the need to invest in skills that deliver better engagement directed towards greater organisational good and not individuals.

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, clinical and financial performance and conceded we can do better with clinician engagement.

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. Also, to consider how the Boards should communicate and collaborate with each other and, equally important, how the areas should share their resources and expertise.

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. He called for the outcomes from the day to be a series of clear strategies from senators that identify how to improve clinical engagement at a state and health service level. He stated this is only the start of the conversation; we should reconvene in 18 months' time with the Health Service Boards to see what progress has been made.

Mr Bessen thanked the Director General for his comprehensive response to the recommendations from the previous debate and for setting the scene for the current debate. He then introduced 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 the following experiential insights to facilitate discussion for the debate.

Mr O'Connor stated that he and Dr Datyner would jointly address participants providing both a chief executive and clinician's perspective. Together, they shared their organisations 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 breakdown of departments and clinical networks not working together which in turn led to individual facilities breaking down.

Termed the Big Bang of 2011 the presenters shared changes within their organisation over the past five years. The core thing that happened - similar to what is happening here in WA is that Boards and their committees were introduced. Changes occurred at both a macro and micro level.

Macro level changes in relation to governance included: Boards and Committees; the introduction of CORE values (collaboration, openness, respect, and empowerment); Annual service agreements; a performance framework; and introduction of Activity Based Funding (ABF). There was a real drive towards community engagement and the voice of the consumer and we worked to develop both private and public and private sector partnerships.

Changes at the State level included establishment of four pillars: Agency of Clinical Innovation (ACI), Clinical Excellence Commission (CEC), Health Education and Training Institute (HETI) and the Bureau of Health Information (BHI). They reported that these pillars provided an ideological shift in the sector.

At the District level they introduced a Clinical Counsel and establishment of the Executive Clinical Director across Districts. They became the mouthpiece for doctors and other clinicians and allowed for direct consultation with the Chief Executive regarding all clinical matters

In terms of the Hospital / Facility Level they devolved responsibilities to local mangers, including program, stream and unit leaders. Lastly, at the clinical unit level they engaged clinicians to be involved in clinical care redesign with monitoring of safety and quality care data at the unit level.

He also reported on changes at the micro level for the WSHLD some of which included changes in governance and a series of health reforms. These included establishing Boards and Committees (8 committees of the Board); charged with responsibility for setting strategic direction, governance, financial and service delivery performance; stakeholder engagement; and disaster preparedness. Clinical councils were established to devolve power and accountability. There was also development of a community engagement framework and work to create and grow partnerships across for example primary health, universities, and private and business sectors.

Mr O'Connor shared that the goal within the first two years (2011-2012) was to be a trusted organisation by anyone dealing with them and, within the first five years (2011-2015) they set out to be a reliable, safe place for patients and staff alike by creating a genuine environment of cooperation, openness, with utmost respect and empowerment.

Mr O'Connor stated his vision as Chief Executive was for the health service to be a clinician led organisation, and to serve those who serve. The focus was to bring power to relationships in order to drive design and delivery of the business. Their vision included the need to create a stable and well performing business with cooperative partnerships. In order to do so they needed to understand what drives the business. Also important was the need to gain the confidence of the Minister, her office and government in their ability to succeed. We needed strengthened engagement between administration and senior clinicians and to be valued partners to others in matters of mutual interest and importance. In this regard historically, the business acumen and clinical balance acumen of the organisation was woefully inadequate and they had to repair hostile relationships with the minister and government. Today, there is 2 billion dollars in capital works for the district earned through working to recreate and reposition the business to one that is solid and putting clinicians at the centre of leadership.

In describing what they did between 2011- 2015 he spoke of the importance of relationship investment. They launched and grew their new governance structure within the organisation and introduced additional machinery that not only spoke of the need of a clinician led organisation but enabled mechanisms to make sure it occurred. 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 were 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 a divergence in the sophistication of the NSW boards, with a view to look forward. The Ministry is now a sophisticated purchaser and macro manager of performance. The Districts were more autonomous in running their business and there has been substantial progress in ABF sophistication. A lot of work had been done to educate staff around ABF and there is now a tremendous understanding. They have also benefited from substantial improvement of their information systems.

The organisation has built a strong foundation through the Centre, The Boards and the Districts and going forward will continue to focus on paying for outcomes, the consumer experience, social benefits and partnerships for a healthy society. Clinicians have a clear role to play similarly; consumers must also be involved with a concept of ownership. As an organisation we have grown from one of 'we can't do that' to 'that's a good idea how do we make it happen'. Going forward we will foster relationships both inside and outside of health and we recognised that the new Boards will require a different composition of members as we move forward.

Both Mr O'Connor and Dr Datyner then took questions from participants. Questions related to successful models for integrated care, metrics on clinician engagement; consumer involvement; managing contractors; clinical councils and dealing with cultural issues and blame.

With regard to excessive management and bullying behaviour Mr O'Connor stated he believed a flat management structure with devolved accountability is key (need the metrics and management structures to drive performance). Furthermore, Dr Datyner reported their clinicians have been strong in calling our and initiating formal actions with regard to behaviour. There has been a significant empowerment of clinicians in decision making on the delivery side of health services and a change to accountability regime.

Presentations from the day can be found on the Clinical Senate website:

http://ww2.health.wa.gov.au/Improving-WA-Health/Clinical-Senate-of-Western-Australia/Clinical-Senate-debates-and-publications

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Following the morning break, Senators heard from the Health Service Board Chairs and engaged in a free flowing plenary debate.

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3. Panel session and plenary debate

3.1 Rules of engagement

Facilitator — ➢ Mr Bevan Bessen

Board Chairs/panel members

- Professor Bryant Stokes AM
- Mr Wayne Salvage
- Adjunct Associate Professor Kim Gibson
- Dr Robyn Lawrence
- Dr Neale Fong
- Mr Jeffrey Moffet
- Ms Deborah Karasinski
- Professor Frank Daly
- Mrs Suzie May
- Ms Liz MacLeod

Expert witnesses

- Ms Rebecca Brown
- Dr Christopher Griffin
- Dr Paul Hill
- Dr Mark Monaghan
- Dr John Anderson
- Dr Simon Wood
- Dr Catherine Cole
- Dr David Mountain
- Ms Kellie Blyth
- Ms Bronwyn Fitzgerald
- Ms Dianne Bianchini
- Adjunct Associate Professor Tony Dolan
- Ms Sue Peter
- Dr Peter Reid
- Ms Marie Baxter
- Ms Maha Rajagopal
- Ms Taylor Carter
- Ms Suzanne Spitz
- Associate Professor John Buchanan.
- Ms Ann Whitfield

Mr Bessen outlined the process for the session as one that would consist of short panel presentations followed by free flowing discussion/debate.

The plenary session “Rules of Engagement” opened with a presentation from the five Health Service Board Chairs/proxies.

This was followed by a plenary session. The Board Chairs, Chief Executives, the Director General and Deputy Director General joined senators and experts in sharing shared their honest views and outlined the critical issues in relation to clinician engagement in the new world of devolved governance. Collectively they engaged in robust discussion and active listening around what is required for good clinician engagement at both at a statewide and health service level. They also considered what currently exists and other strategies to improve clinician engagement.

Health Service Board Chairs/Designee were asked to provide a response to the following questions:

1. What is the vision of your health service?
2. How do you plan to engage clinicians at a local level?
3. How do Board Chairs plan to ensure Clinical Senate Recommendations are implemented?

A short summary of the key points from each Board Chair was as follows:

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 walkarounds and will give consideration to implementation of clinical senate recommendations.

Ms Gibson closed stating 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.

Dr Neale Fong stated the newly formed WACHS Health Service 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 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.

Following on from the presentations the facilitator introduced the additional experts that included chairs of the clinical staff associations as well as leaders in nursing and allied health. He advised the focus of the session as to consider clinician engagement in the brave new world of devolved governance first by looking at the issues and challenges of clinician engagement and then to focus on opportunities. All participants were encouraged to engage in the conversation.

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) * <u>specific issue raised</u>
- 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.

Closing comments

Before closing the session the Board Chairs and Chief Executives were asked to offer a final comment. Comments included:

- The timing of discussion is absolutely right in terms of stepping into new governance arrangements.
- Opinions around clinical engagement are important. I expect the various health service groups to come together to develop practical solutions.
- Practical solutions are really useful at the time.
- I am not interested in structural solution, very interested in how to engage people at the grass roots level.
- Really interested in what is said, terminology is important. This is quite different to last year and a much more important discussion.
- Very interested in the outcomes from today.

At the conclusion of the plenary session Mr Bessen confirmed that the key themes emerging from the full morning session had been captured using mind map software and would inform senators in the afternoon workshops.

All participants then broke for lunch.

Following the lunch break Senators participated in small health service working groups to consider firstly, recommendations for the system manager and secondly, suggestions for the health service boards on how they wish to be engaged as clinicians in the WA health system.

What follows are the working group notes and final senate recommendations.

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4. Afternoon Working Groups

4.1 Working Groups

Facilitators	Mr Bevan Bessen Mr Will Bessen
Executive Committee Member(s)	Professor Julie Quinlivan Ms Tanya Basile Dr Sharon Nowrojee Ms Marani Hutton Ms Mary Miller Dr Jeanette Ward Ms Pip Brennan
Expert Witnesses	Dr Chris Griffin Dr Mark Monaghan Dr Michael Datyner Mr Danny O'Connor Mr Peter Reid
Support	Ms Kimberly Olson Ms Barbara O'Neill Ms Paula Camer-Pesci

Mr Bevan Bessen opened the workshop stating the working groups would be made up of the five health services and would work to determine clinician engagement at both a system manager and health service level.

In the first part of the workshop groups worked to develop one recommendation for the System Manager in regards to clinician engagement. In the second half of the workshop they proposed suggestions for their Health Service Board on how they would like to be engaged at their health service level.

Participants self-selected to one of the following five health service groups:

1. WA Country Health Service (WACHS) x 2 tables
2. North Metropolitan Health Service (NMHS) x 2 tables
3. South Metropolitan Health Service (SMHS) x 2 tables
4. East Metropolitan Health Service (EMHS)
5. Child and Adolescent Health Service (CAHS)

A summary of the recommendations proposed from each group is provided below.

Group 1 & 2 WA Country Health Service

There were two tables for WACHS. The two recommendations put forward were:

1. The System Manager when considering or developing a direction or policy that has operational impacts that a broad range of clinicians from all area health services are consulted engaged and recorded.
2. Develop a clinician engagement framework with agreed outcomes for implementation by the Boards.

Group 3 & 4 – North Metropolitan Health Service

There were two tables for NMHS. The two recommendations put forward were:

1. Clinical senate recommends that the System Manager develops (within 12 months health service) a policy framework on clinician engagement that incorporates
   - KPIs (as part of health service performance reporting)
   - Expectation that each health service will have clinical engagement strategy (report on that)

   Elements of policy framework:
   - Measuring clinical engagement
   - Share values across system
   - Common principals
   - Transparency
   - Investment in IHL programs (statewide approach)
2. Through clinician engagement and input the system manager develop and implement a clinician engagement framework that measures safety and quality KPIs, clinician engagement and consumer experience across all levels of service provision

Groups 5 & 6 – South Metropolitan Health Service

There were two tables for SMHS. The two recommendations put forward were:

1. Adopt a 'measurable KPI' (using an identical tool across all Health Service Boards) for clinical engagement and put into safety and quality outputs within HSB agreements and link 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.
2. Within the new health environment, adopt a consistent tool to measure engagement (e.g. voice of staff survey).

Group 7 – East Metropolitan Health Service

There was one table for EMHS. The recommendation put forward was:

1. Develop a framework for clinical engagement that includes:
   - A definition of clinician engagement
   - To define the roles and responsibilities of the system manager and boards in achieving clinical engagement, including across jurisdictions and sectors
   - The relationship between clinician and consumer engagement

- Determine the deliverables and performance measures that relate to clinical engagement and the links to health outcomes.

Group 8 – Child and Adolescent Health Service

There was one table for CAHS. The recommendation put forward was:

1. The System manager to direct the boards to develop a framework for clinician engagement with common principles of the framework to be negotiated across Boards.

   The details of the framework and the implementation of the framework to be determined at Area Health Service level and tailored to that service. Both stages to involve staff at grass roots level as well as senior management across all disciplines and specialities.

In the second part of the workshop participants remained in their groups and workshopped suggestions for the Health Service Boards with regard to clinician engagement. (Refer Section 7).

All suggestions put forward have been sent to the Health Board Chairs and Chief Executive Officers of the Health Services for consideration.

A total of eight recommendations were developed by participants in the seven working groups. Participants agreed that the executive committee would merge similar recommendations with the top three put forward to the Director General.

The working groups also considered suggestions for the Health Service Board Chairs. All suggestions from the working groups have been sent to the Health Board Chairs and Chief Executive Officers of the Health Services for consideration.

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5. Final Session

In the final session senators reviewed each of the recommendations presented from all working groups. A total of eight recommendations were put forward for final voting.

Three recommendations were voted to go forward to the Director General. The Clinical Senate will seek a response from the Director General to the three recommendations of endorsed, endorsed in principle, or not endorsed. These recommendations will also be shared with the Chief Executives and Health Service Board. The suggestions for the health service boards will also be shared.

In conclusion, the Clinical Senate debate signalled the start of an important conversation between the newly established Health Service Boards, System Manager, current health service executives and clinicians. The forum 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.

6. Clinical Senate Recommendations

Clinician Engagement in the Brave New World – Health Service Boards

1. Clinical senate recommends that the system manager develops (within 12months) a policy framework on clinician engagement that incorporates
   - KPI (as part of Health Service Performance Reporting)
   - Expectation that Area Health Boards will have a clinical engagement strategy (and report on that)

   Elements of policy/framework:
   - Measuring clinical engagement
   - Share values across system
   - Common principles
   - Transparency
   - Investment e.g. IHL programs (state-wide approach)

2. Adopt a 'measurable KPI' (using an identical tool across all HSBs) for clinical engagement and put it into safety and quality outputs within HSB agreements and link 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, a broad range of clinicians from all Area Health Services are consulted, engaged and recorded.

   Develop a clinician engagement framework with agreed outcomes for implementation by the Boards.

7. Suggestions for 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

Appendix 1: Program

Clinician Engagement in the Brave New World – Health Service Boards

Friday 2 September 2016
The University Club of Western Australia
Crawley, Western Australia

7.45am	Registration	Tea & coffee

Executive sponsor: **Dr David Russell-Weisz, Director General, Department of Health**

Facilitator: **Mr Bevan Bessen**

8.30am	Welcome to Country	Mr Brett Collard
8.40am	Welcome and senate update	Professor Julie Quinlivan
8:55am	Director General – setting the scene for debate	Dr David Russell-Weisz
9.10am	NSW experience – interactive session with presentation and questions	Mr Danny O'Connor Dr Michael Datyner

10.10am	Morning tea	Banquet Hall Foyer

10.30am Panel Presenters – Chairs of the Health Service Boards

Professor Bryant Stokes AM
North Metropolitan Health Service

Adjunct Associate Professor Kim Gibson
South Metropolitan Health Service

Dr Neale Fong
WA Country Health Service

Ms Deborah Karasinski
Child and Adolescent Health Service

Mrs Suzie May
East Metropolitan Health Service

Chief Executive Officers:
Mr Wayne Salvage NMHS - Dr Robyn Lawrence SMHS - Mr Jeffrey Moffet WACHS
Professor Frank Daly CAHS - Ms Liz MacLeod EMHS

11.00am Plenary- Rules of Engagement

Additional Expert Witnesses: Ms Rebecca Brown, Dr Christopher Griffin, Dr Paul Hill, Dr Mark Monaghan, Dr John Anderson, Dr Simon Wood, Dr Catherine Cole, Dr David Mountain, Ms Kellie Blyth Ms Bronwyn Fitzgerald Ms Dianne Bianchini, Adj Assoc Prof Tony Dolan, Ms Sue Peter, Dr Peter Reid, Ms Marie Baxter, Ms Maha Rajagopal, Ms Taylor Carter, Ms Suzanne Spitz and Assoc Prof John Buchanan.

12.00pm	Lunch	Banquet Hall Foyer

12.50pm Working Groups - State Wide and Local Area Clinical Engagement

North Metropolitan Health Service	South Metropolitan Health Service	East Metropolitan Health Service	Child and Adolescent Health Service	WA Country Health Service

2.15pm	Afternoon tea	Banquet Hall Foyer

2.35pm Final session

2.35pm	Presentation of 'suggestions' for Health Service Boards	Mr Bessen
3.00pm	Presentation and prioritisation of recommendations for System Manager	Mr Bessen
3.25pm	Closing remarks	Ms Tanya Basile
3.30pm	Close	

Appendix 2: 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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