THE FIRST ANNUAL AMA/ASMOF

SENIOR HOSPITAL DOCTOR ENGAGEMENT SURVEY

2016

AMA (NSW) and ASMOF (NSW) wish to acknowledge the invaluable assistance of

Dr Alun Pope
AStat | Director | Statistical Consulting Service, University of Sydney
for statistical analysis of the data and compiling a detailed report of the results

Mr Lachlan Jones
Senior Adviser, Media and Communications Strategy, AMA (NSW)
for designing and running the survey

Mr James Lawler
AMA (NSW)
for researching medical engagement and preparing the first draft of the report

Ms Emily Macdonald
AMA (NSW)
for compiling and producing the final reports

May 2016

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Chapter 1 BACKGROUND, METHODOLOGY AND CONCLUSIONS

1.1 Background

In 2006 – 2007 there were a number of high profile adverse incidents in NSW public hospitals. These ultimately resulted in the establishment of a Special Commission of Inquiry, headed by Mr Peter Garling SC (the "Garling Inquiry"). The Inquiry published its report in November 2008.

As part of an extensive submission to the Garling Inquiry, AMA (NSW) and ASMOF (NSW) (together with the NSWNA) commissioned the Workplace Research Centre of the University of Sydney to survey the views and experiences of doctors and nurses in the public hospital system. Within this survey, a number of issues relating to the level of consultation and trust were able to be tested against a national benchmark survey of over 8000 workers. In a startling illustration of the level of distrust between doctors and management, the survey revealed that almost 70% of NSW public hospital doctors disagreed with the statement that *"Managers at my workplace can be trusted to tell things the way they are"*, compared to a figure of only 20% for the "average" Australian worker.

These findings contributed to what was arguably the most quoted part of the Report of the Garling Inquiry. At paragraph 1.73 of the Report Overview, Mr Garling stated:

"During the course of this inquiry, I have identified one impediment to good, safe care which infects the whole public hospital system. I liken it to the Great Schism of 1054. It is the breakdown of good working relations between clinicians and management which is very detrimental to patients. It is alienating the most skilled in the medical workforce from service in the public system. If it continues, NSW will risk losing one of the crown jewels of its public hospital system: the engagement of the best and brightest from the professions who are able to provide world-class care in public hospitals free of charge to the patient."

In the years since the Garling Inquiry AMA and ASMOF have sought to convince successive Health Ministers and Directors-General of the benefits of persuading health service management to make concrete changes aimed at re-engaging with senior medical practitioners. As it happens, convincing Ministers and Directors-General has not been a difficult task. The findings and recommendations of the Garling Inquiry, combined with a plethora of international research, offer compelling evidence that an engaged senior medical workforce results in both better patient care and more efficient hospitals (see Appendix 1 for a summary of some of the international research).

Our initial strategy focussed on getting agreement to some key structural changes in decision-making at the local level as part of the creation of the Local Health Districts (LHDs) in 2010. This involved extensive negotiations at Ministerial level and resulted in documented agreement on several key clinician engagement factors based on the concept of peer nomination. We based this concept on our understanding that previous attempts at clinician engagement had often failed because they had centred on turning doctors into managers, which simply resulted in the doctors losing the trust of their colleagues. We argued that this needed to be addressed by including doctors in decision-making processes who were nominated by their peers and therefore, by definition, enjoyed the trust and confidence of their colleagues. The agreed changes included:

- Boards of LHDs would include local doctors
- All Boards would include peer-nominated doctors appointed by the Minister from a short-list of nominations provided by the Medical Staff Councils of the LHD
- The Chair of the LHD Medical Staff Executive Council would be invited to attend Board meetings (but not be a member of the Board) to represent the views of the senior medical staff of the LHD
- Clinical councils to be established at both hospital and LHD level
- All hospital clinical councils to include peer-selected senior doctors (the Chair of the Medical Staff Council) and peer-selected junior doctors
- All LHD clinical councils to include peer-selected senior doctors (the Chair of the LHD Medical Staff Executive Council)

Following these structural changes, AMA and ASMOF have sought ways of embedding clinical engagement in the system. Again, we started this process at Ministerial and Director-General level. In February 2015 we signed a "Joint Statement of Cooperation" with the NSW Minister for Health (Appendix 2). The Statement reaffirmed the structural changes noted above but more importantly committed the parties to embedding clinician engagement in the culture of the system.

Under the agreed arrangements set out in the Joint Statement, AMA and ASMOF will conduct an annual survey of senior medical practitioners to gauge their level of engagement in the public health system. Over time, these annual surveys will build up a picture of clinician engagement within the NSW public health system, as perceived by senior medical practitioners working in the system. The data will enable a comparison between LHDs and between hospitals within LHDs, and also map LHD trends over time.

In addition, we have worked with the Ministry to "map" relevant questions from our survey to similar questions in the 2015 "Your Say" survey. The results of this mapping exercise are available in a separate report.

The surveys won't achieve anything in themselves. The most important part of the Joint Statement is the agreement with the Minister that the survey results will be considered as part of understanding and assessing the performance of District/ Network senior executive management teams, other relevant managers and senior medical staff. It is this key component of the Joint Statement that we anticipate will drive cultural change in the system.

1.2 Methodology

An on-line survey was created in-house using Informz software and the link emailed to the target audience of AMA and ASMOF VMO, clinical academic and staff specialist members.

Because of the overlap between AMA and ASMOF membership it has not been possible to determine the number of doctors to whom the survey invitation was sent. Consequently, it is difficult to estimate the response rate with any degree of certainty. On the information available to us, the staff specialist response rate was greater than 40% and the VMO response rate was greater than 20%. Our best guess is that the overall response rate was approximately 33%.

Results have not been reported for Far West LHD, Mid North Coast LHD, Southern NSW LHD and Justice Health & Forensic Mental Health Network because of the low number of respondents. These responses have been included in the "Other" category, along with responses that were not able to be assigned to a particular LHD/Network.

The survey provided a number of opportunities for respondents to comment in free text boxes. A selection of quotes from these responses is attached as Appendix 3.

1.3 Conclusions

Comparison between 2008 and 2015

The comparison between the results of this survey and the AMA/ASMOF survey undertaken in 2008 during the Garling Inquiry is encouraging. While it is not possible to establish a cause and effect relationship, it is tempting to speculate that the Minister's commitment to devolution and local management has resulted in improved levels of trust and higher morale.

The 2008 survey revealed that 69% of doctors disagreed with the statement that *"Managers at my workplace can be trusted to tell things the way they are*". Only 17% agreed and 14% were neutral. This compared at the time to the findings of a large-scale survey of the Australian workforce that 71% trusted their managers and 20% didn't, i.e. almost exactly the opposite situation.

Fortunately, this result has improved significantly. The 2015 engagement survey breaks this question into two questions – distinguishing between LHD senior executives and hospital executives – but the results in both cases are clearly better. LHD executives are distrusted by 51% of respondents; hospital executives are distrusted by 43%. It is worth noting that the proportion of respondents who now hold a neutral view has approximately doubled, i.e. it appears that doctors have shifted from "distrust" to "neutral", rather than there being a significant shift to a positive view.

There has been a similar improvement in morale, as indicated by the responses to the question about leaving the public health system. In 2008 65% - 70% of respondent doctors had seriously considered leaving the public health system in the previous 12 months. This figure has improved dramatically to 39%. The question was asked in a different way so a direct comparison is not possible but it is reasonable to conclude that this represents a significant improvement in morale.

State-wide results

Despite the evidence of improvement since the 2008 survey, it has to be said that the 2015 survey reveals a pessimistic picture of the levels of engagement between senior doctors and senior management in the NSW public hospital system.

On most measures, a majority, or close to a majority, of respondents disagree that senior management is effectively engaging with senior doctors. The number of respondents who disagree is consistently about twice as high as those who agree.

On the other hand, most respondents are very positive about their work. For these questions, the proportions are reversed, i.e. the number of positive responses is roughly twice the number of negative responses. Furthermore, 94% of doctors feel highly valued by their patients and co-workers.

LHD/Network results

We have chosen not to focus on the LHD/Network results in this section of the report. Rather, we hope that the detailed local information contained in Chapter 2 of this report will be used by local doctors, management and Boards to work together to identify where engagement strategies are working and where they need to be improved.

Chapter 2
RESULTS

2.1 Demographics

This section reports the roles and locations of respondents.

Table 2.1: Primary role in the public health system

	Frequency	%
Staff specialist	864	69
VMO	388	31
Total	**1252**	**100**

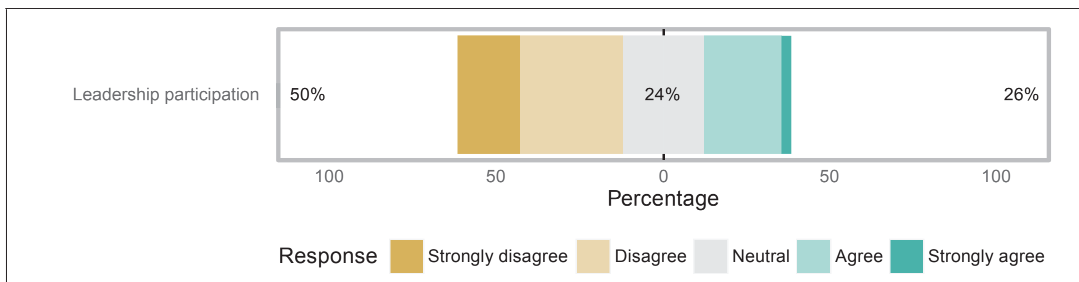
Table 2.2: Primary LHD / Network

	Frequency	%
Central Coast	31	2
Hunter New England	113	9
Illawarra Shoalhaven	42	3
Murrumbidgee	39	3
Nepean Blue Mountains	38	3
Northern NSW	31	2
Northern Sydney	118	9
South Eastern Sydney	172	14
South Western Sydney	111	9
St Vincent's Health Network	79	6
Sydney	113	9
Sydney Children's Hospitals Network	107	9
Western NSW	66	5
Western Sydney	124	10
Other	68	5
Total	**1252**	**100**

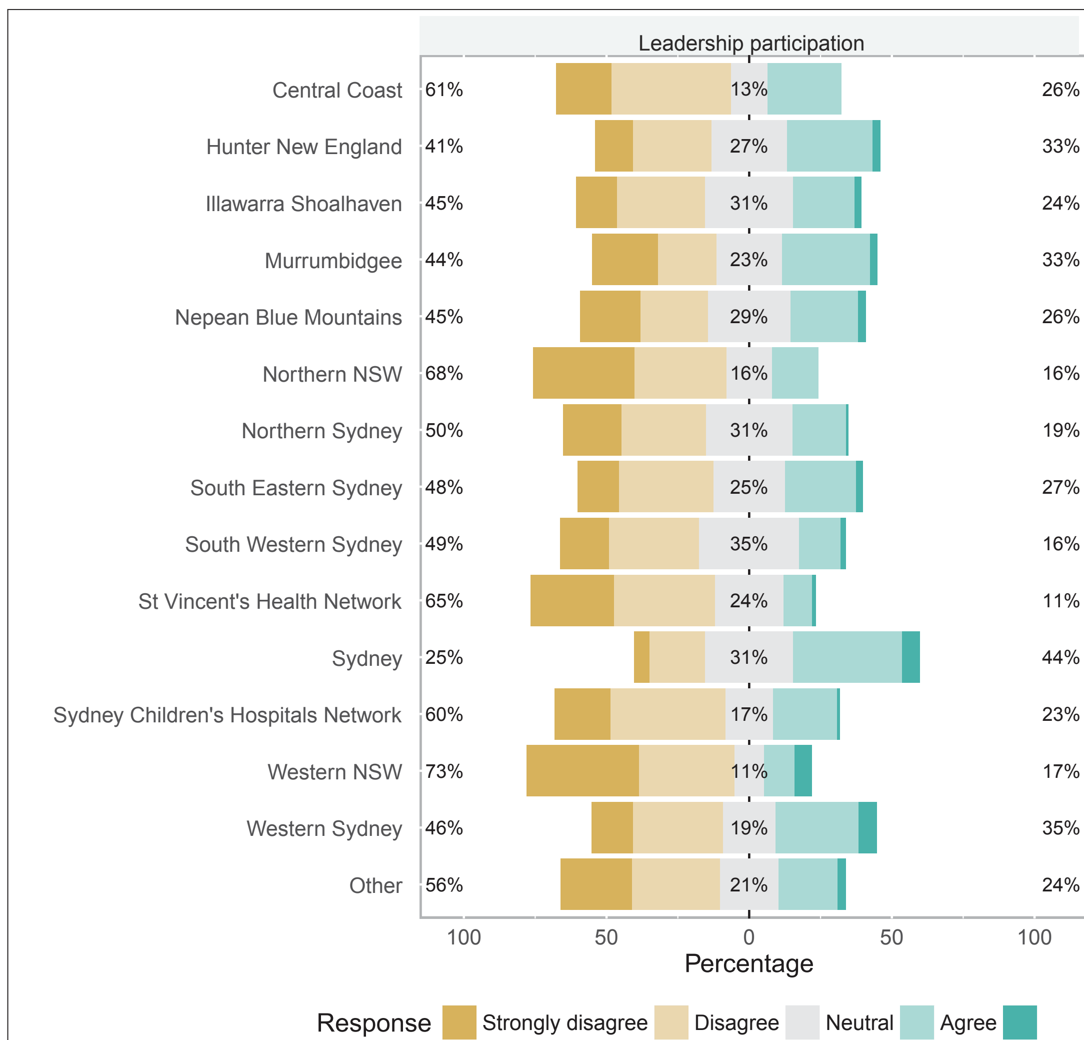
2.2 Leadership and Management

These are the responses to questions about leadership and participation in decision- making.

My LHD/Network has enabled strong medical leadership and participation in decision-making throughout the organization.



Statewide Responses

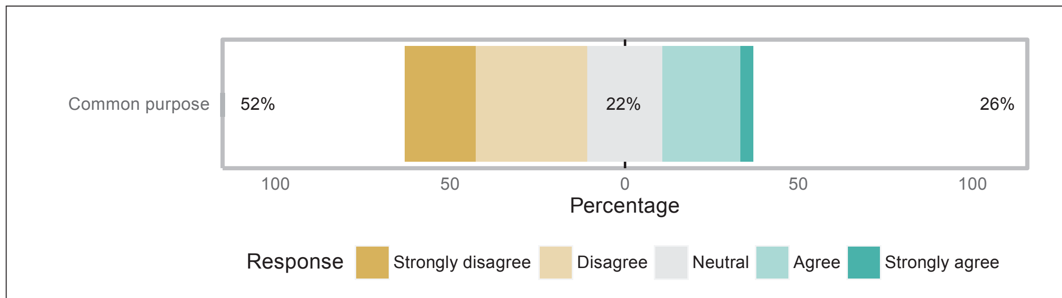


Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Sydney;
- in a *negative* direction: St Vincent's Health Network, Western NSW.

I share a sense of common purpose with management and generally agree on the direction at work, particularly with respect to planning, designing and delivering services.



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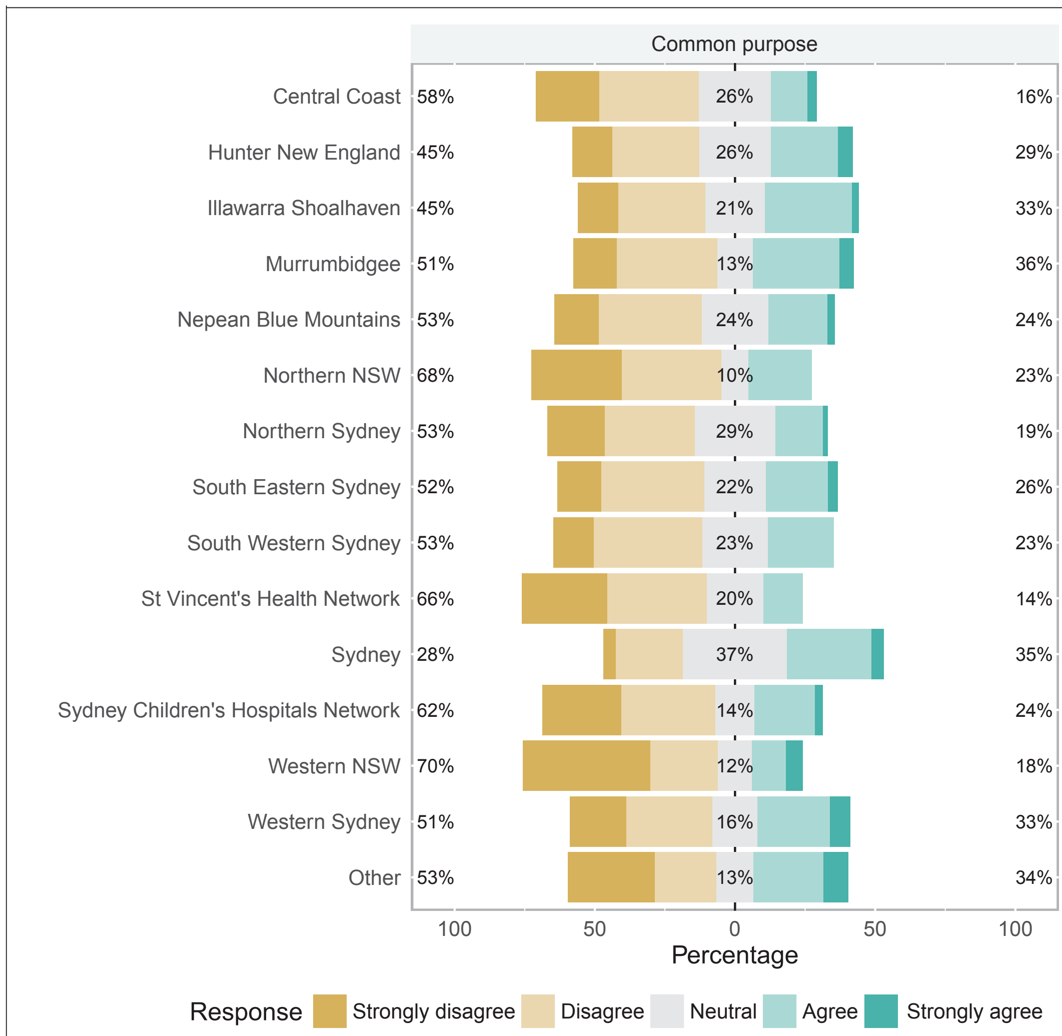


Responses - Local Health Districts

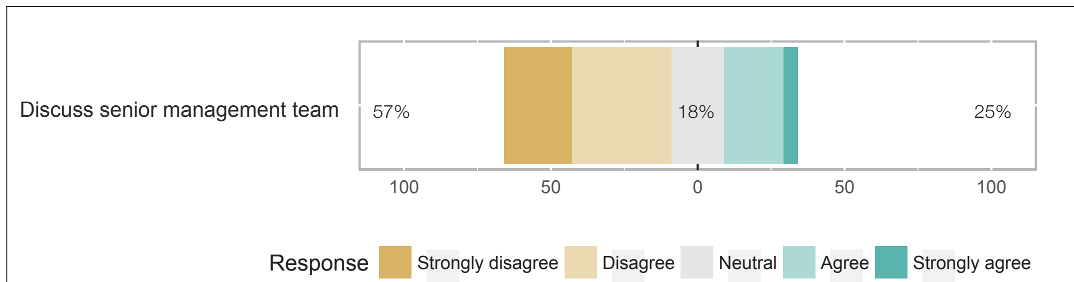
LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Sydney;
- in a *negative* direction: St Vincent's Health Network, Western NSW.

2.3 Communication

These are the responses to questions about communication within facilities.

I have opportunities to authentically discuss issues and problems with the Chief Executive and senior management team of the LHD / network in an open and honest way.



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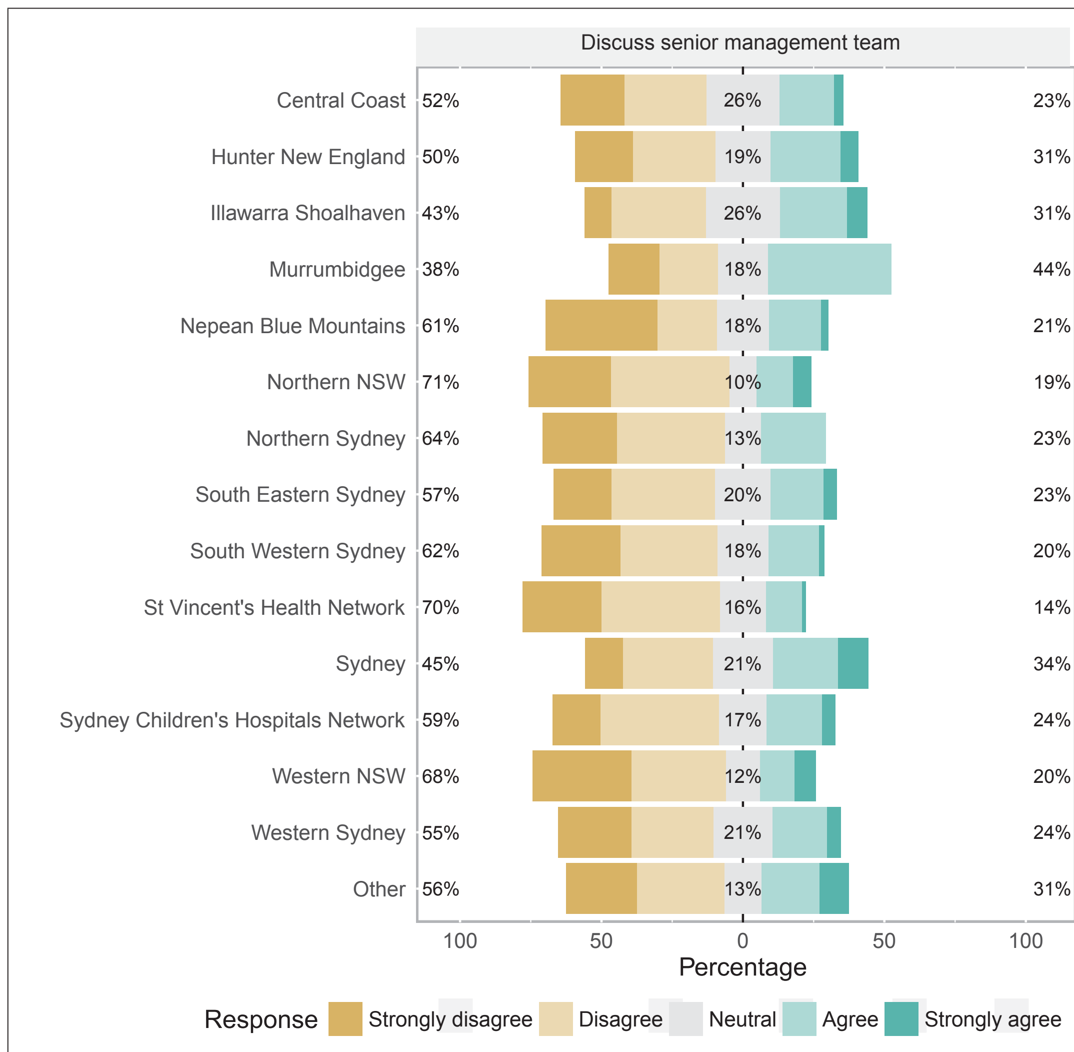
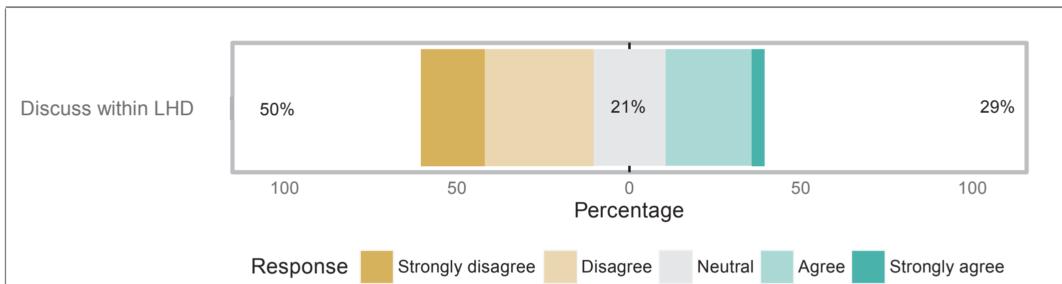


Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Murrumbidgee, Sydney;
- in a *negative* direction: St Vincent's Health Network.

I have opportunities to authentically discuss issues and problems within the LHD / network in an open and honest way.



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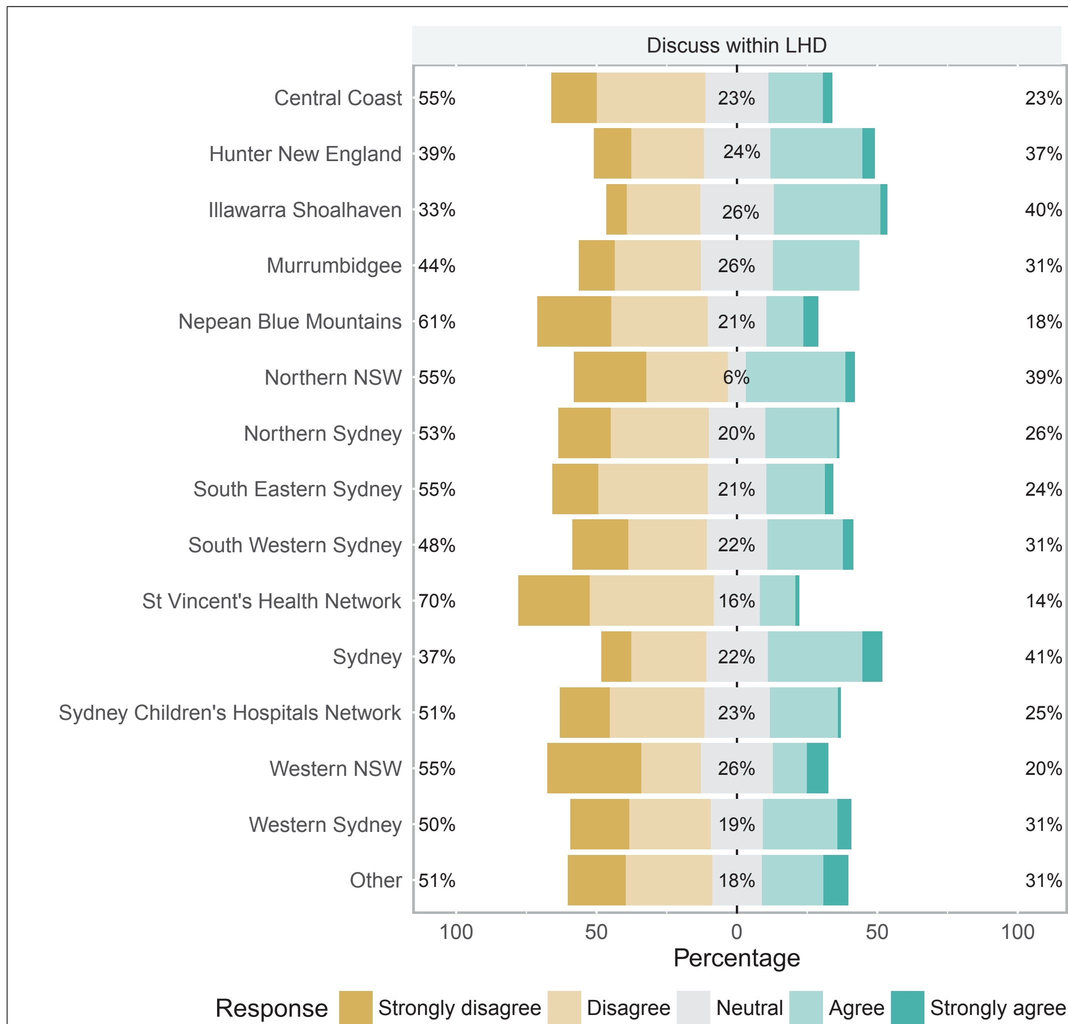
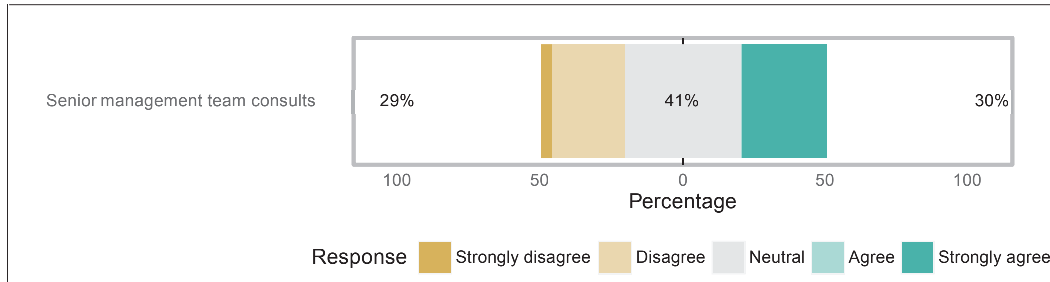


Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Hunter New England, Sydney;
- in a *negative* direction: St Vincent's Health Network.

The Chief Executive and senior management team at my LHD / network consults doctors about issues that affect them.



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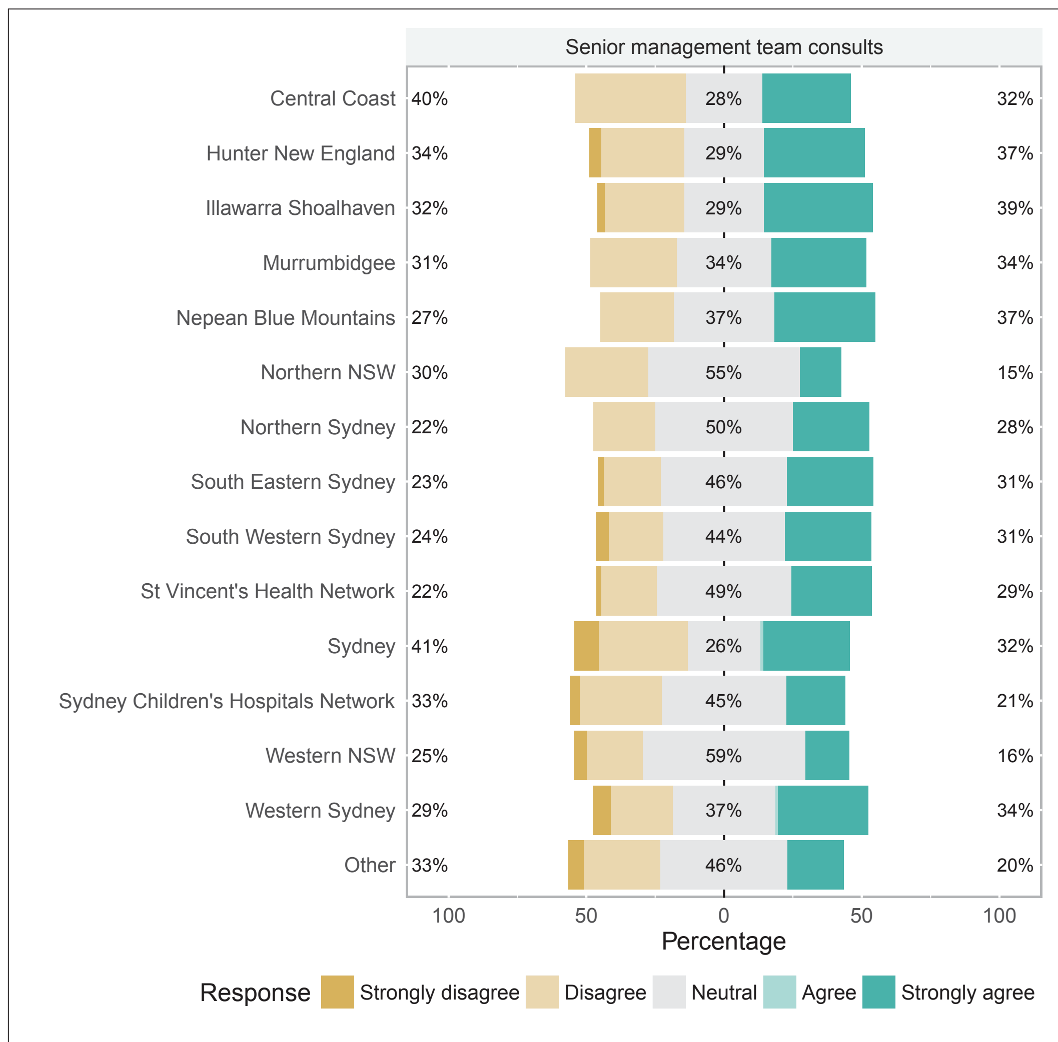
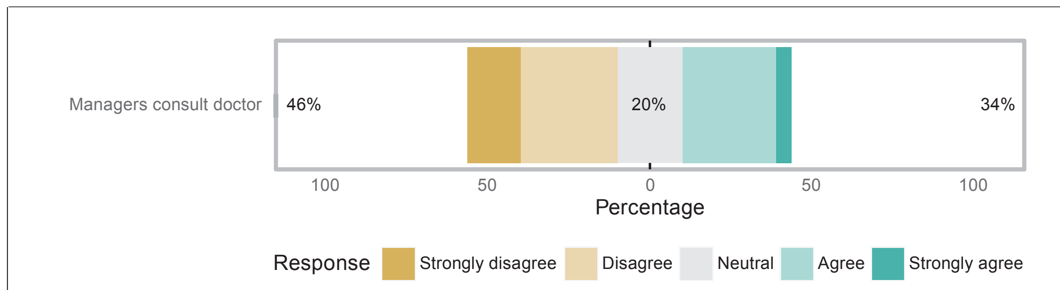


Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring “Neutrals”):

- in a *positive* direction: None.
- in a *negative* direction: None.

Managers at my LHD / network consult doctors about issues that affect them.



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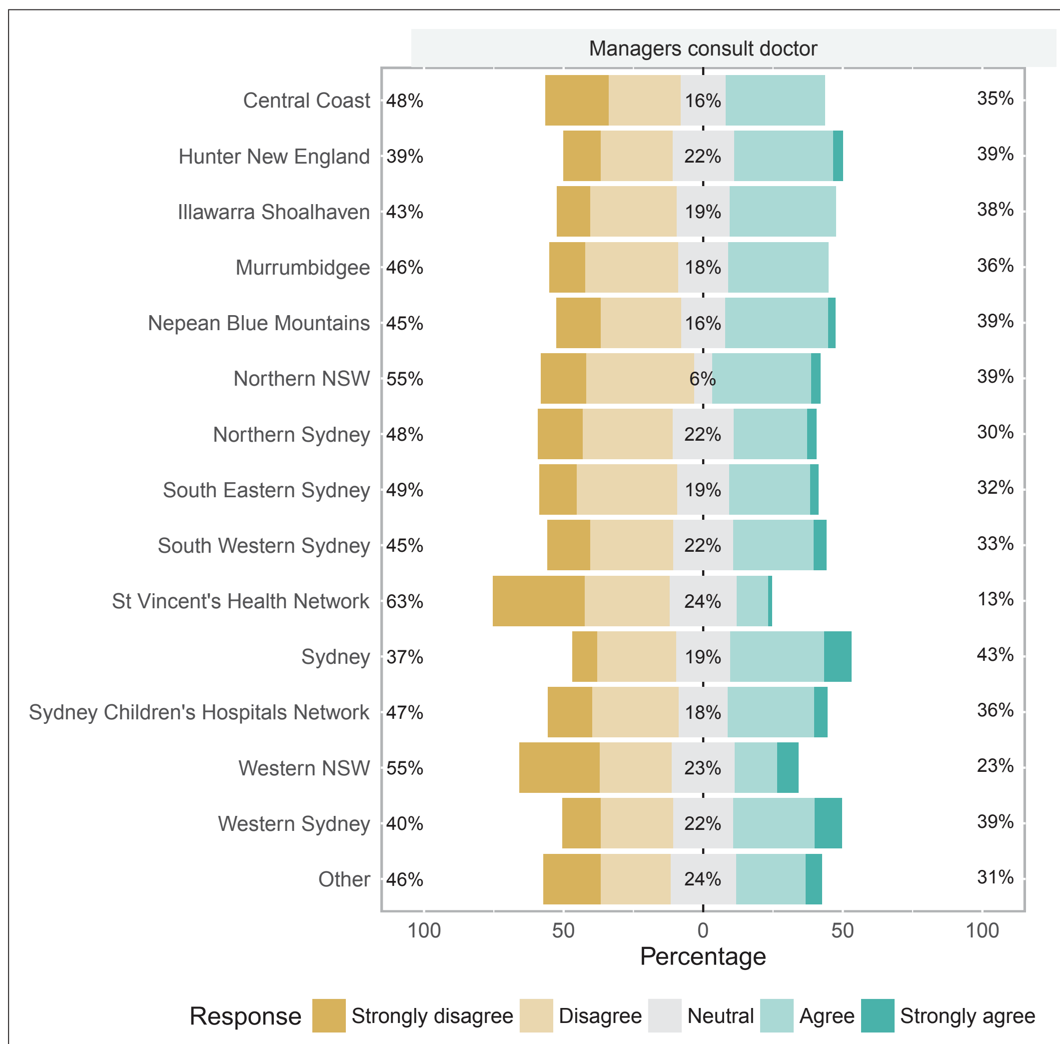
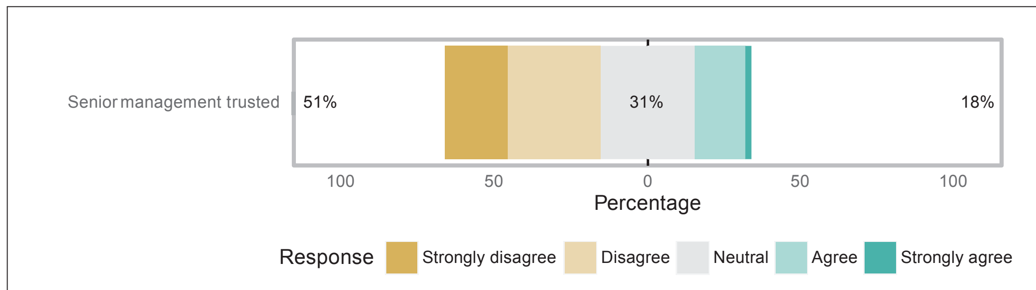


Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: None
- in a *negative* direction: St Vincent's Health Network.

The Chief Executive and Senior Management team at my LHD/Network can be trusted to tell things the way they are.



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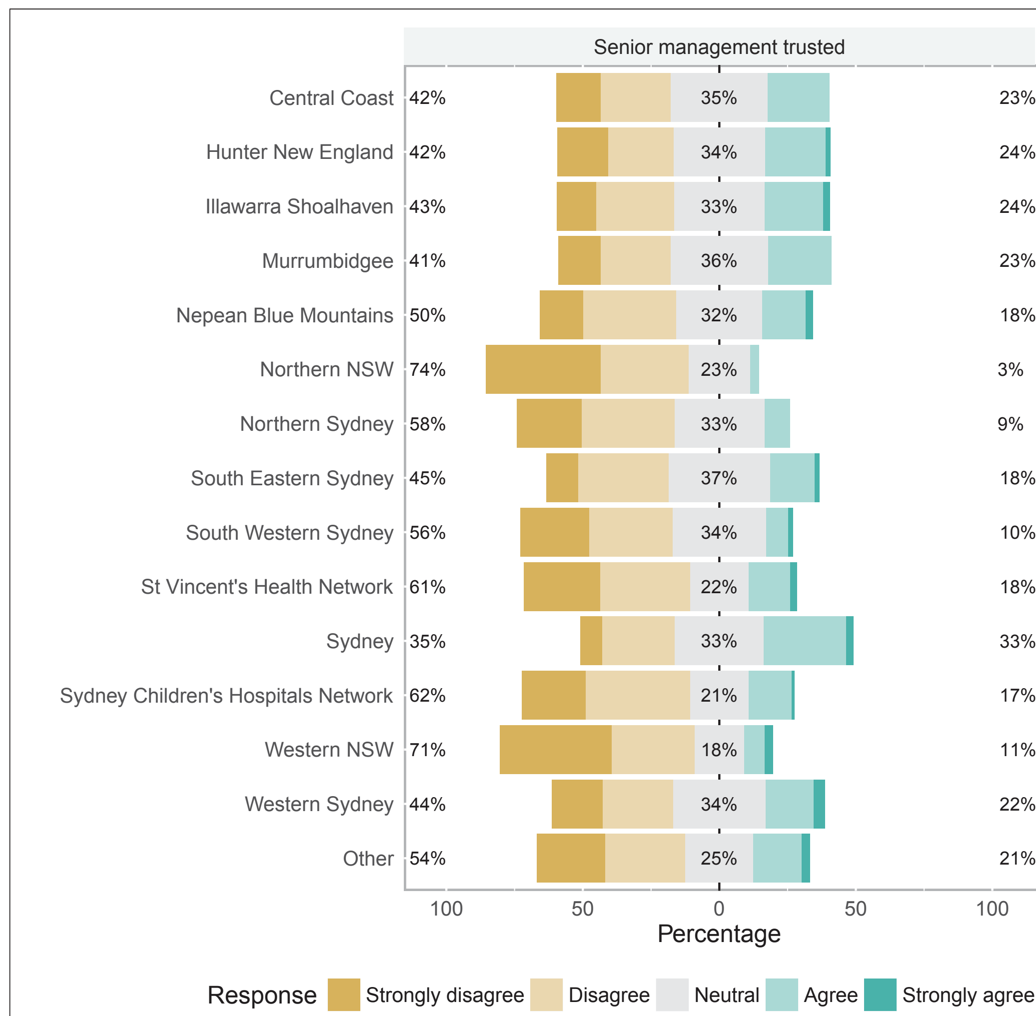
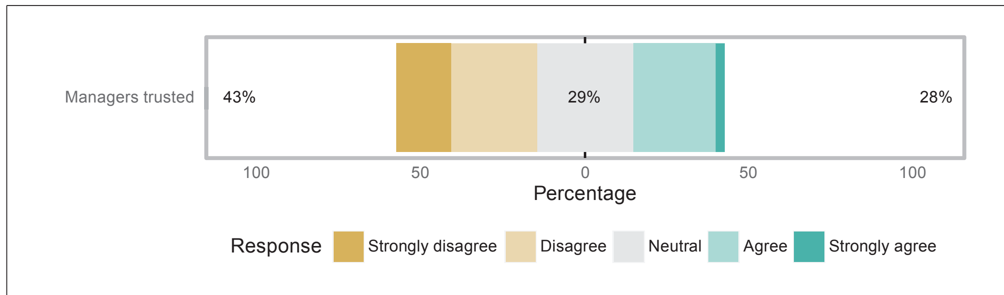


Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Sydney;
- in a *negative* direction: Northern NSW, Northern Sydney.

Managers at my LHD / network can be trusted to tell things the way they are.



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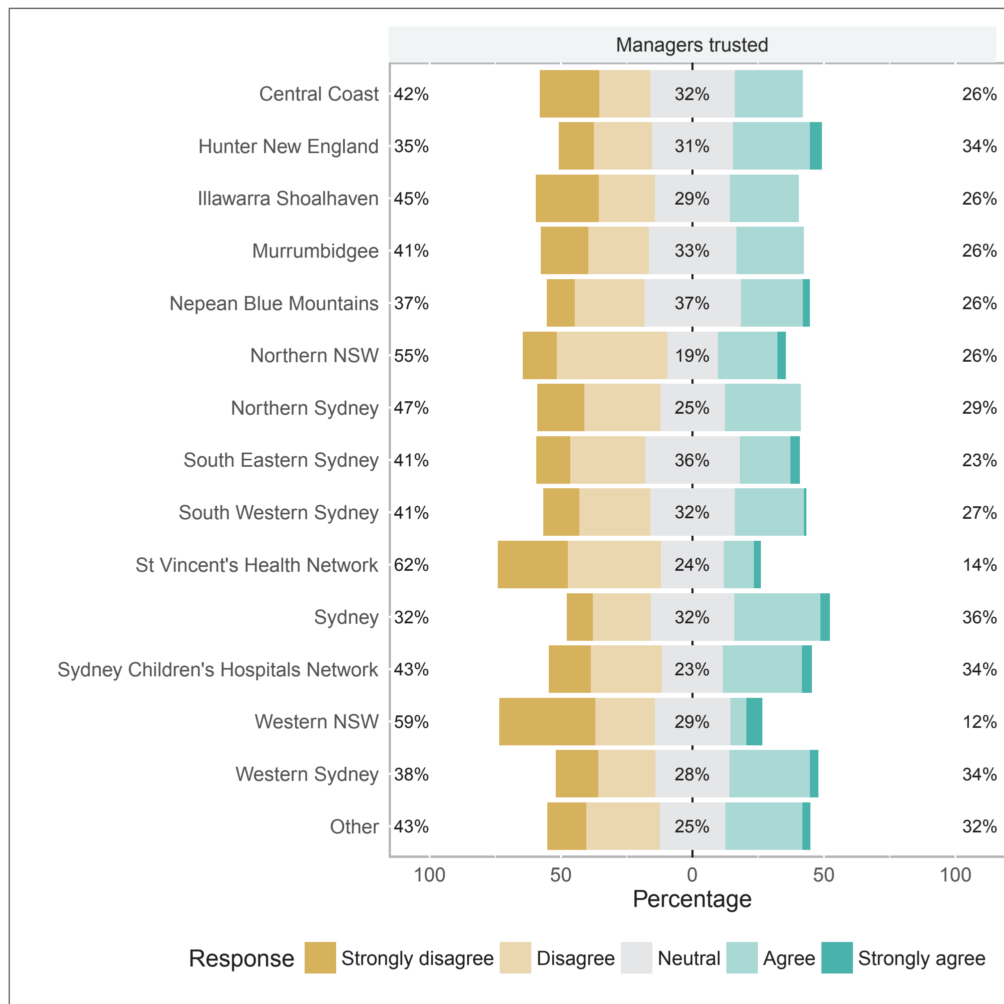


Responses - Local Health Districts

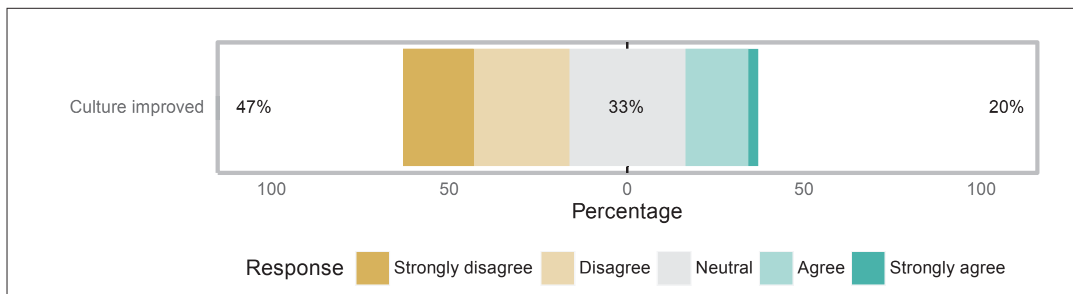
LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Sydney;
- in a *negative* direction: St Vincent's Health Network, Western NSW.

2.4 Culture and Engagement

These are the responses about workplace culture and sense of engagement.

The culture at my workplace has improved over the last 12 months.



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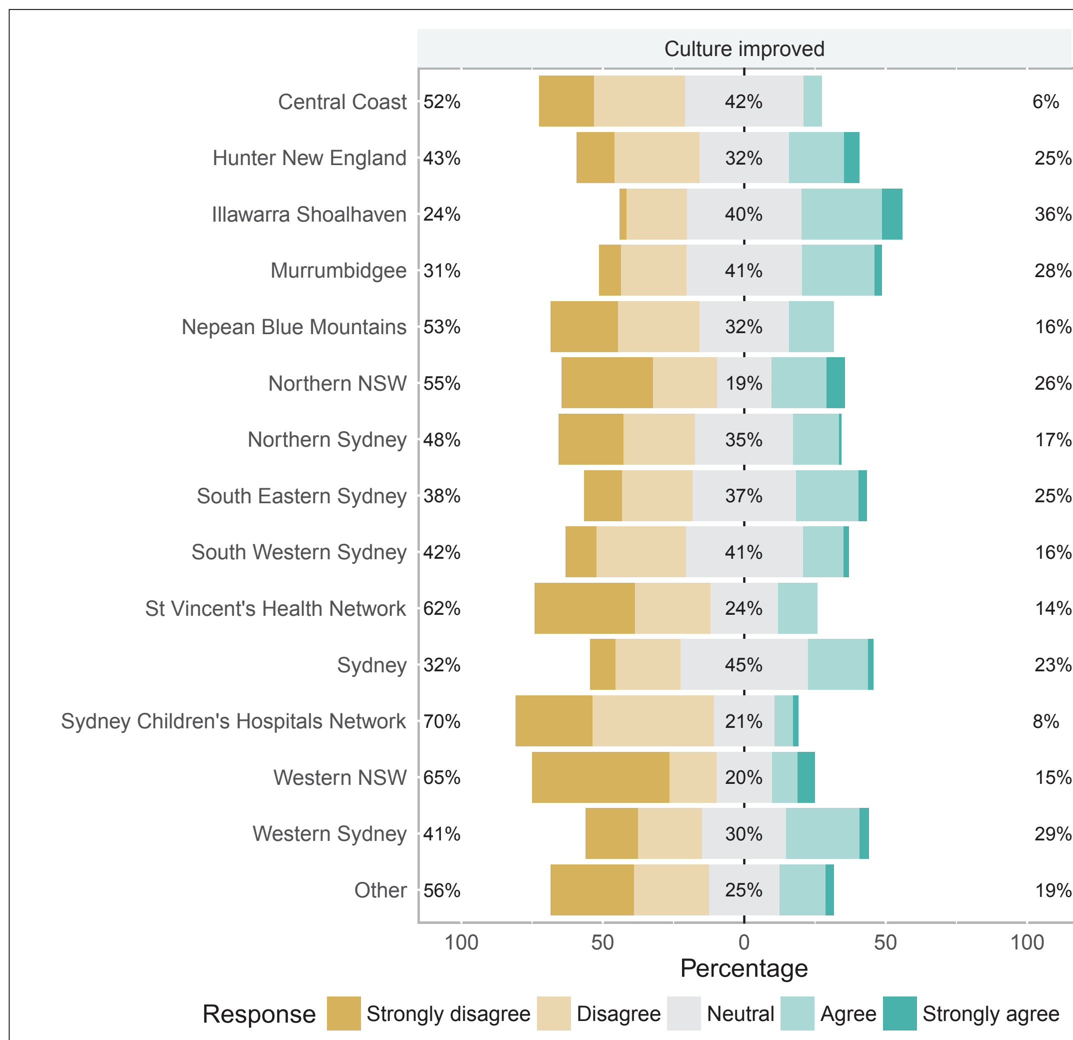
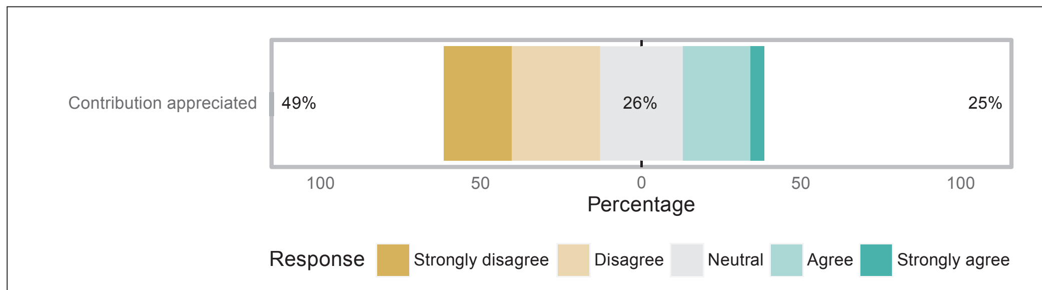


Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Illawarra Shoalhaven;
- in a *negative* direction: Sydney Children's Hospital Network.

I feel that my contribution is properly appreciated and valued by my LHD / network and not taken for granted.



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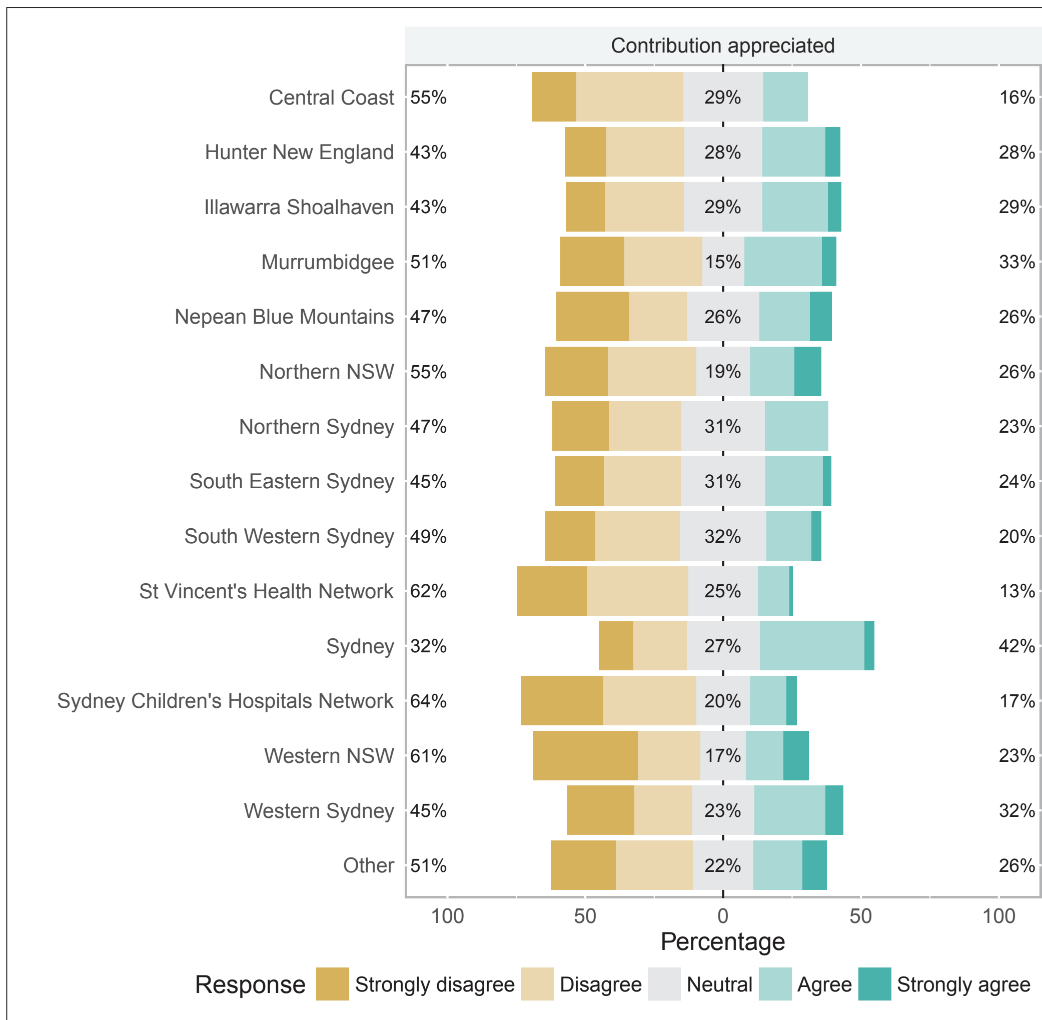
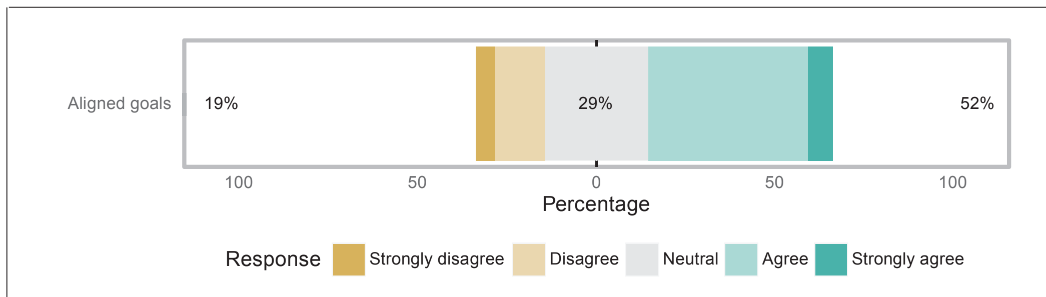


Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Sydney;
- in a *negative* direction: St Vincent's Health Network, Sydney Children's Hospitals Network.

I consider that my work is aligned to the wider organisational goals and mission of my LHD / network.



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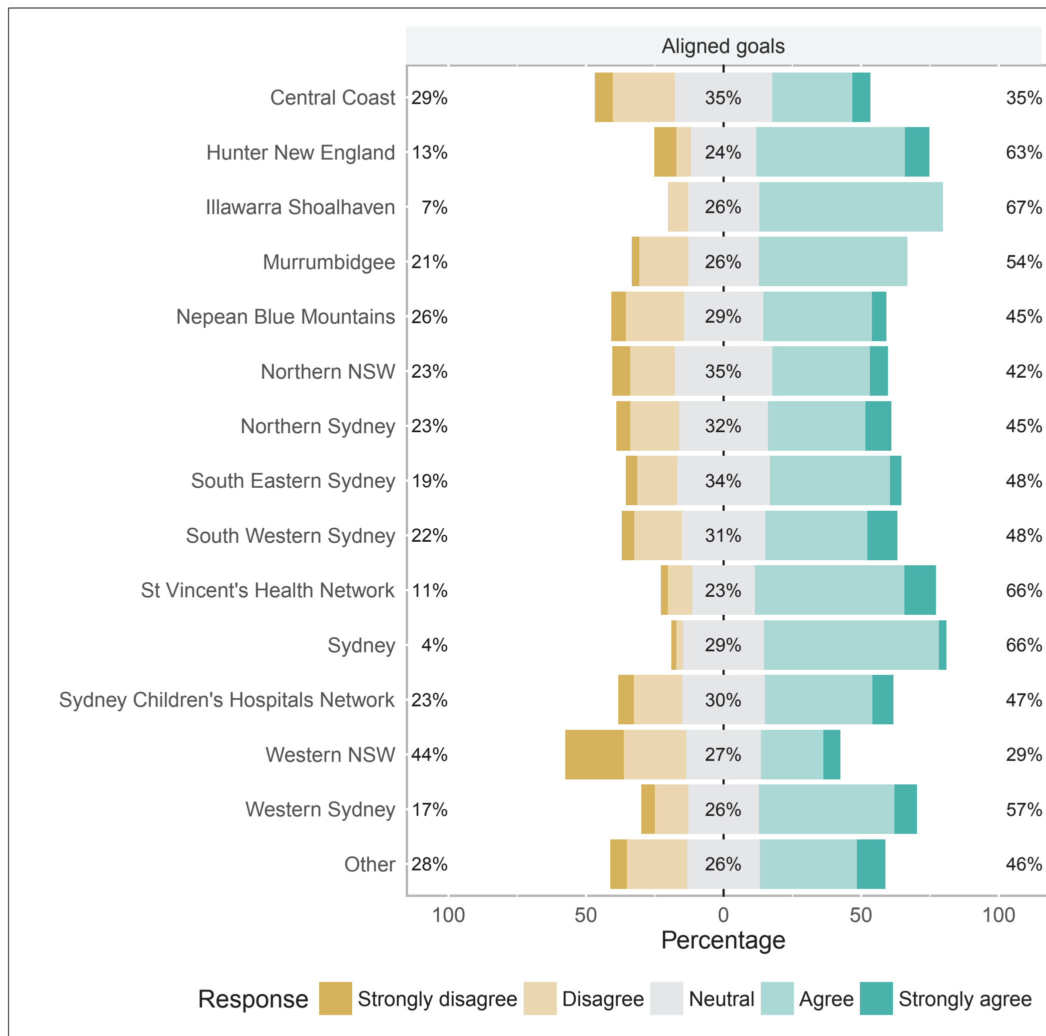
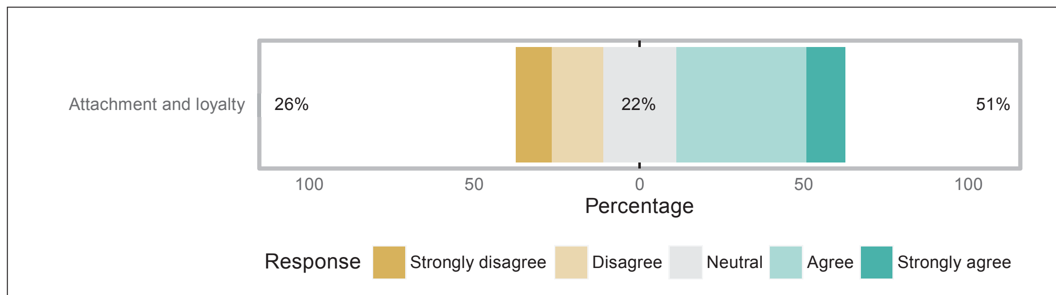


Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Sydney;
- in a *negative* direction: Western NSW.

I feel a real sense of attachment and loyalty to my LHD / network.



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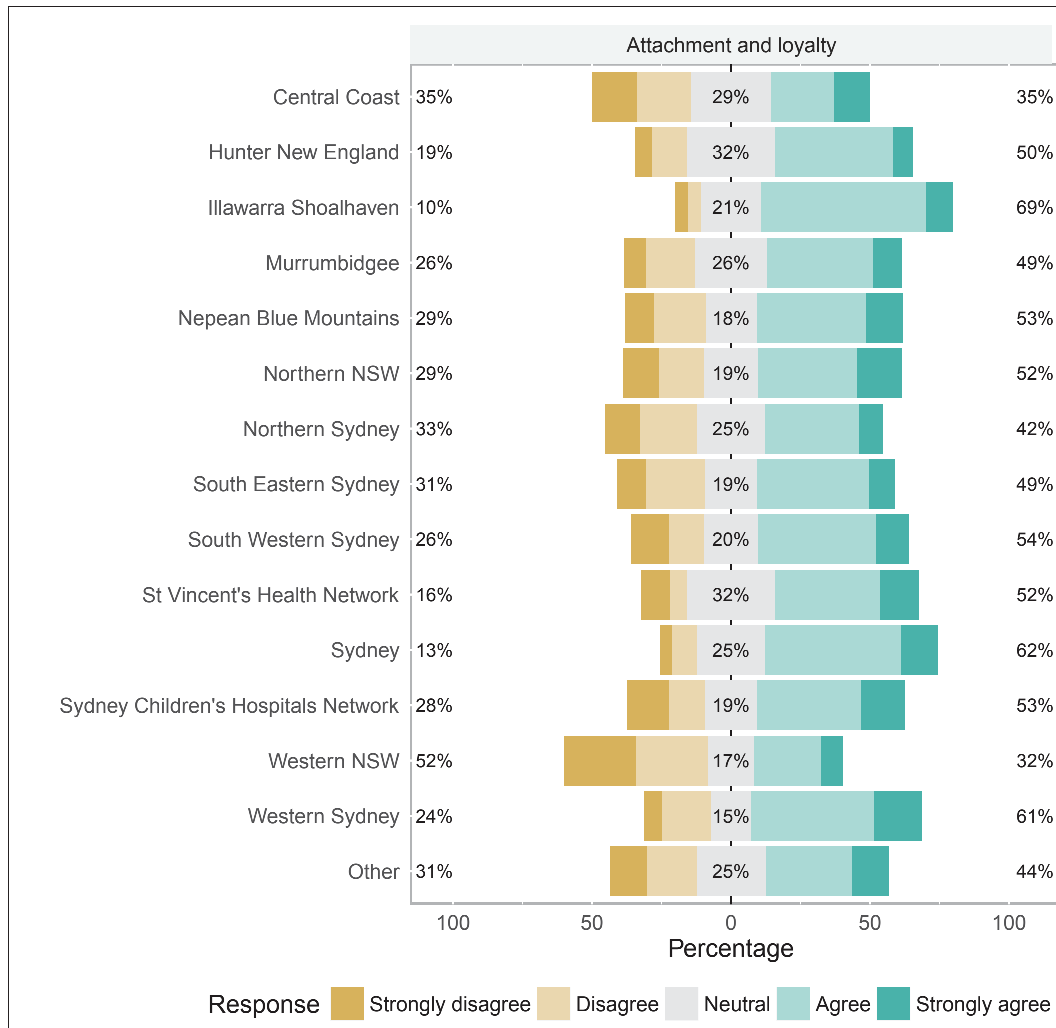
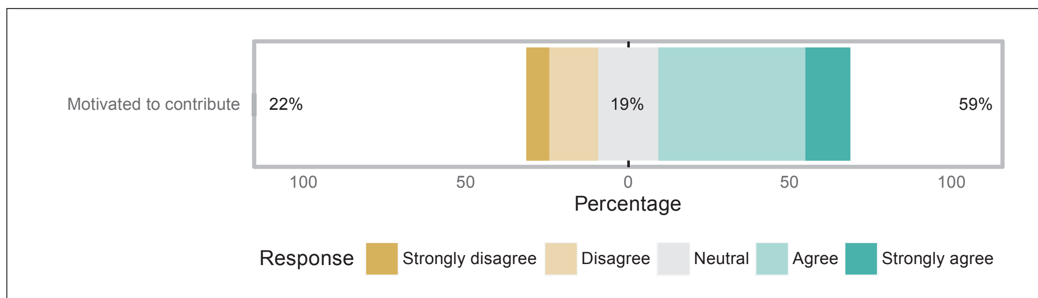


Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Illawarra Shoalhaven, Sydney;
- in a *negative* direction: Western NSW.

I feel motivated to contribute above and beyond what is normally required at work.



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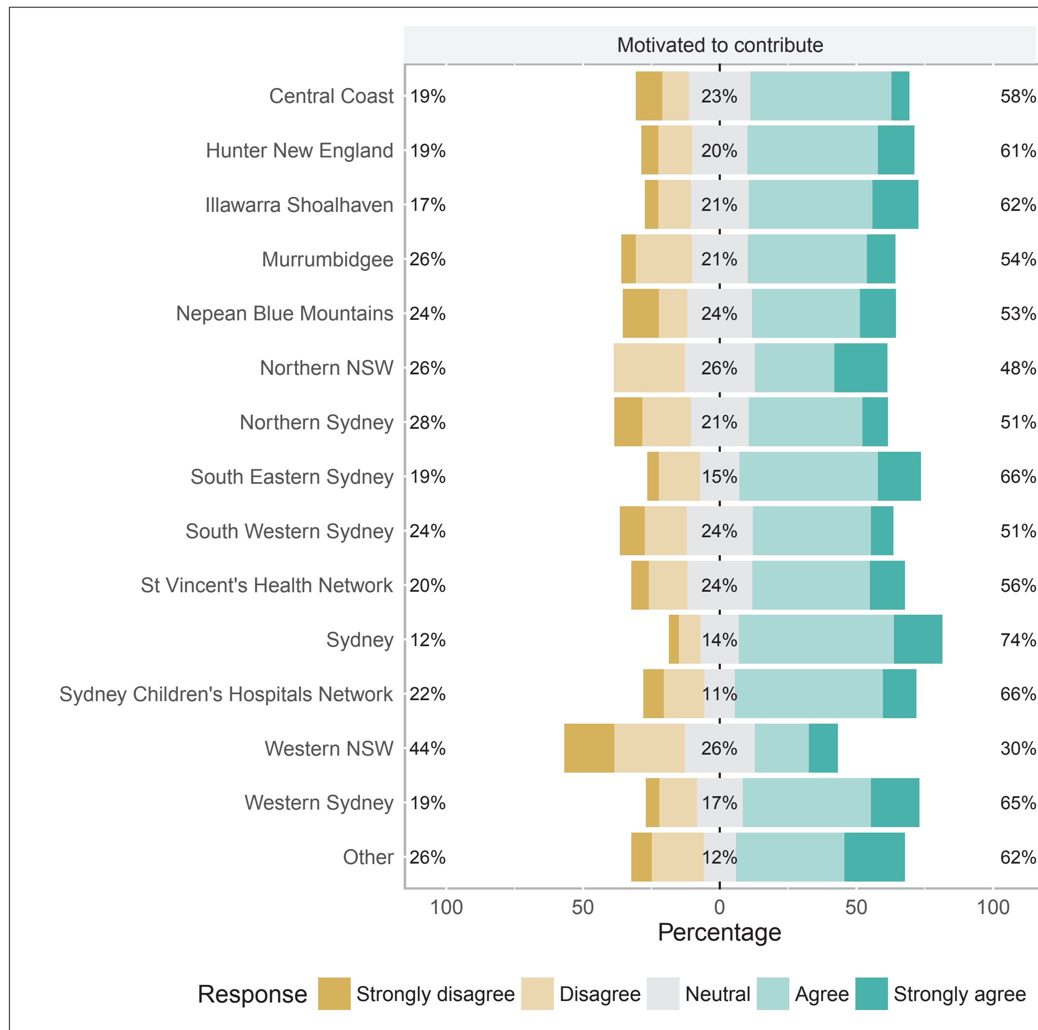
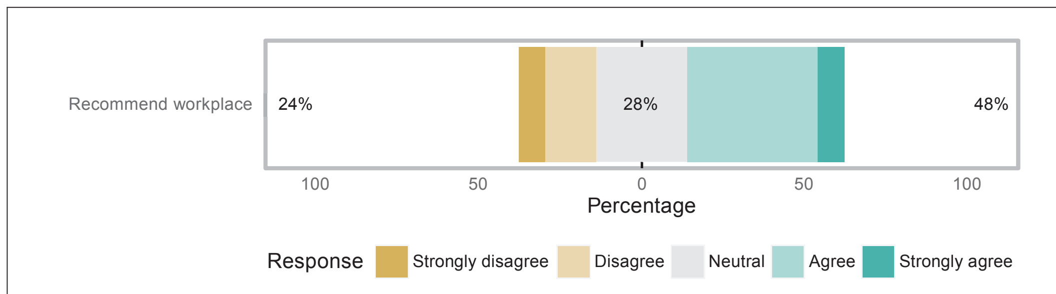


Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Sydney;
- in a *negative* direction: Western NSW.

I would recommend my workplace as a good place to work.



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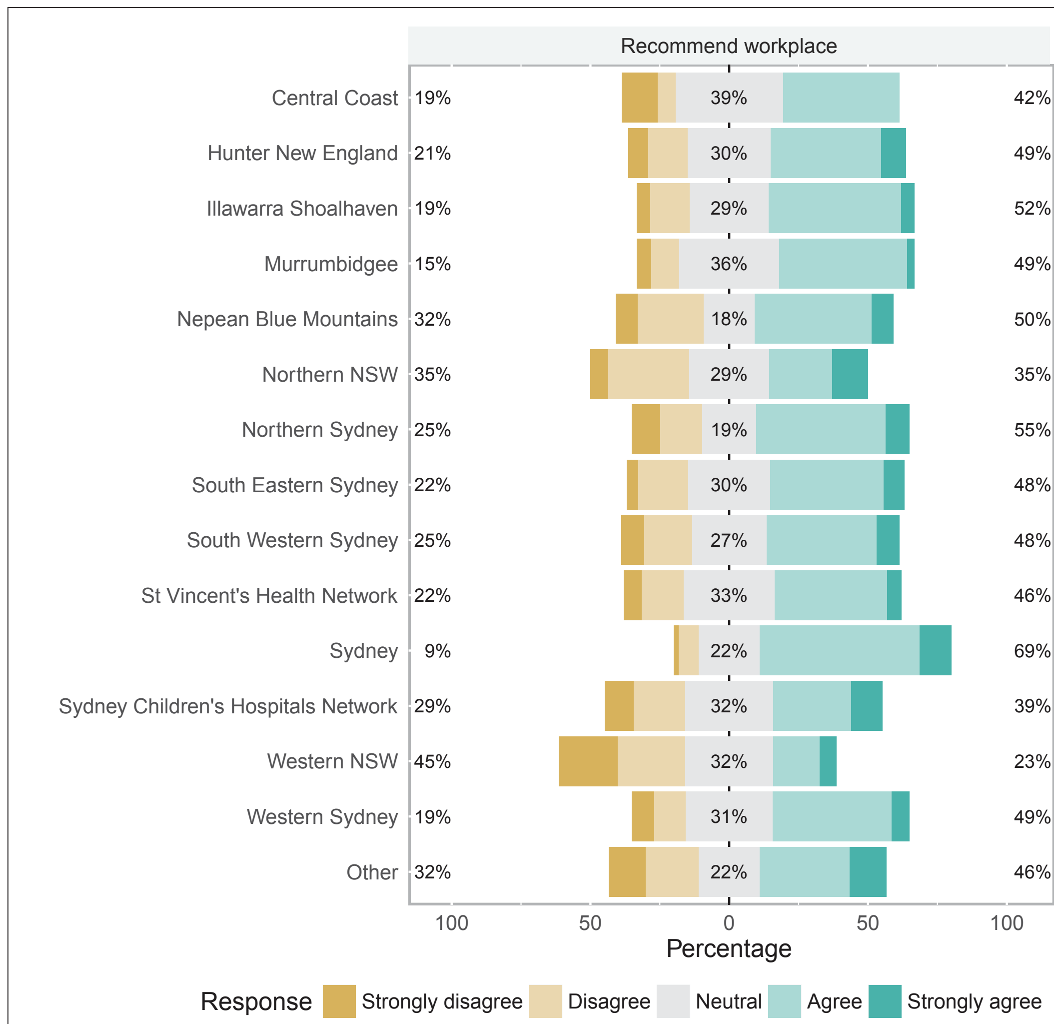
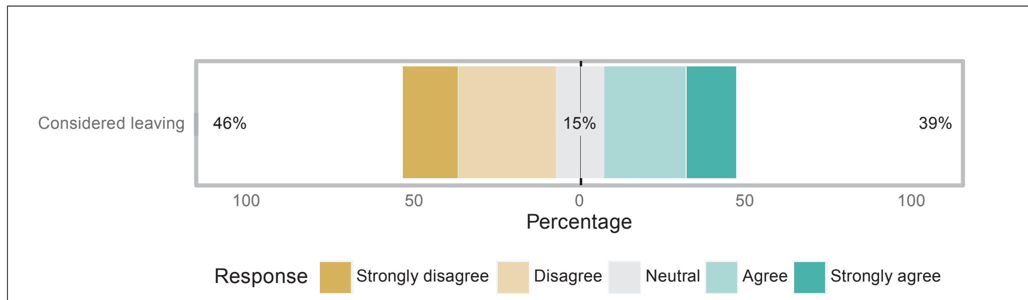


Responses - Local Health Districts

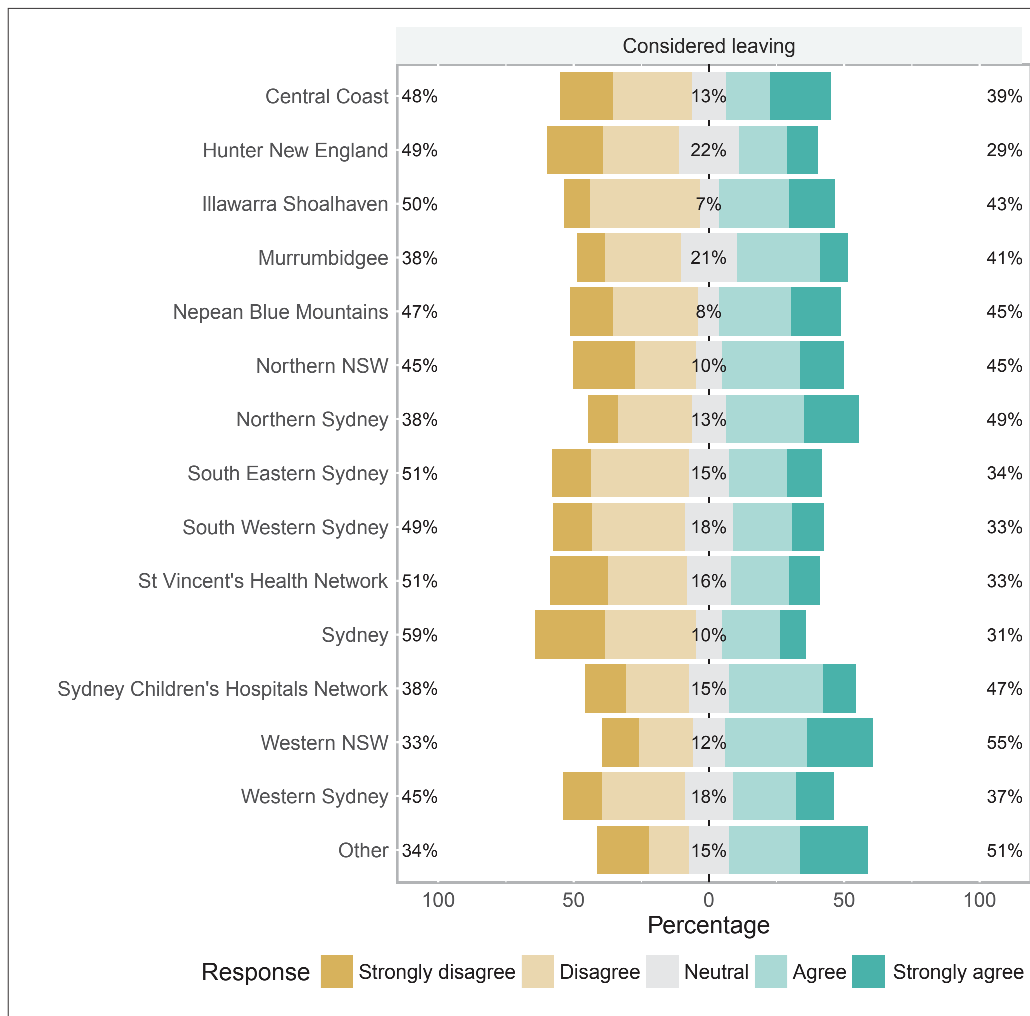
LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Sydney;
- in a *negative* direction: Western NSW.

I have seriously considered leaving the NSW Public Health system in the last 12 months.



Statewide Responses



Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring “Neutrals”):

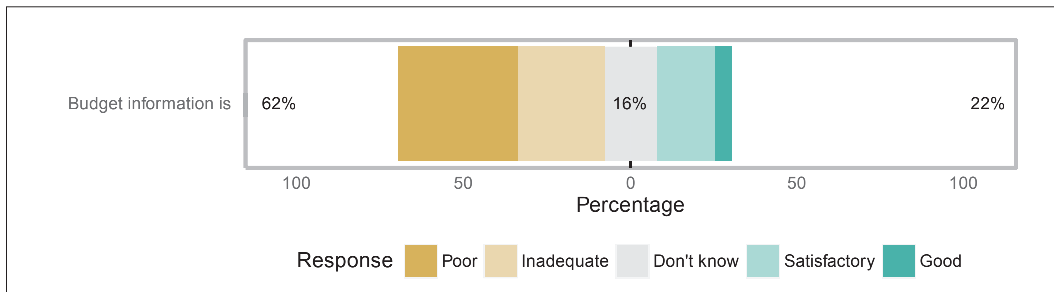
- in a *positive* direction: None;
- in a *negative* direction: Sydney.

Note that the way the question was asked indicates that any positive response is really a negative comment about the LHD /Network and vice versa.

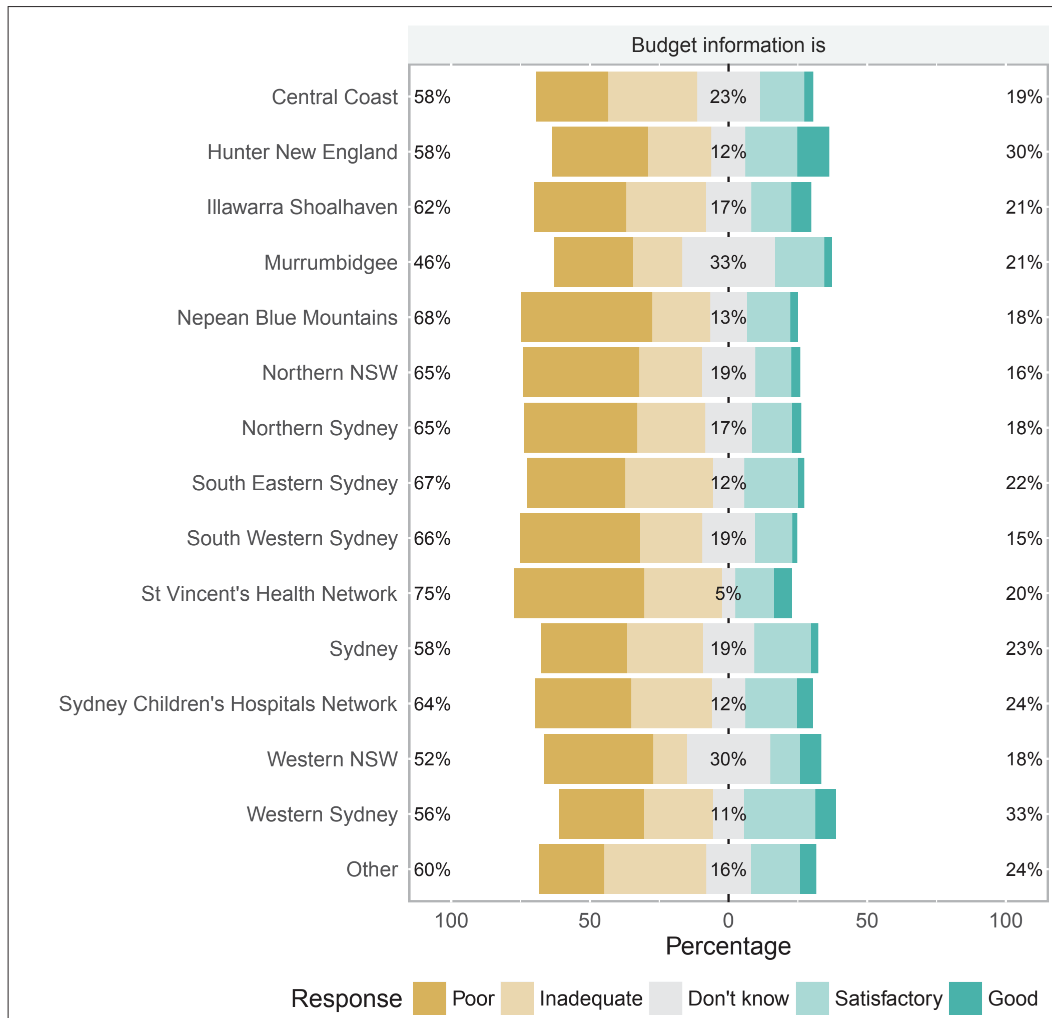
2.5 Budget

These responses relate to communication around budget issues.

The information provided to me about the budget in my department/unit.



Statewide Responses

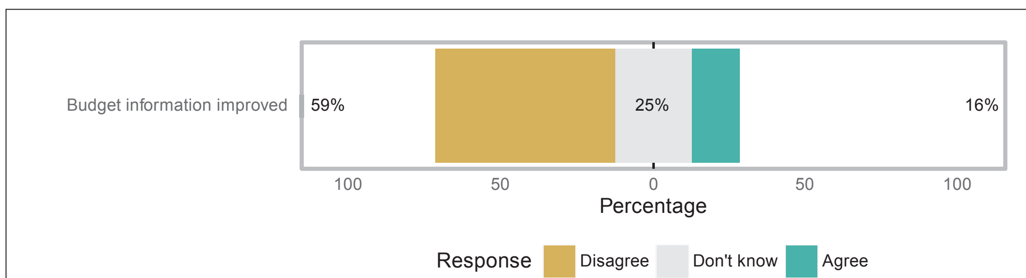


Responses - Local Health Districts

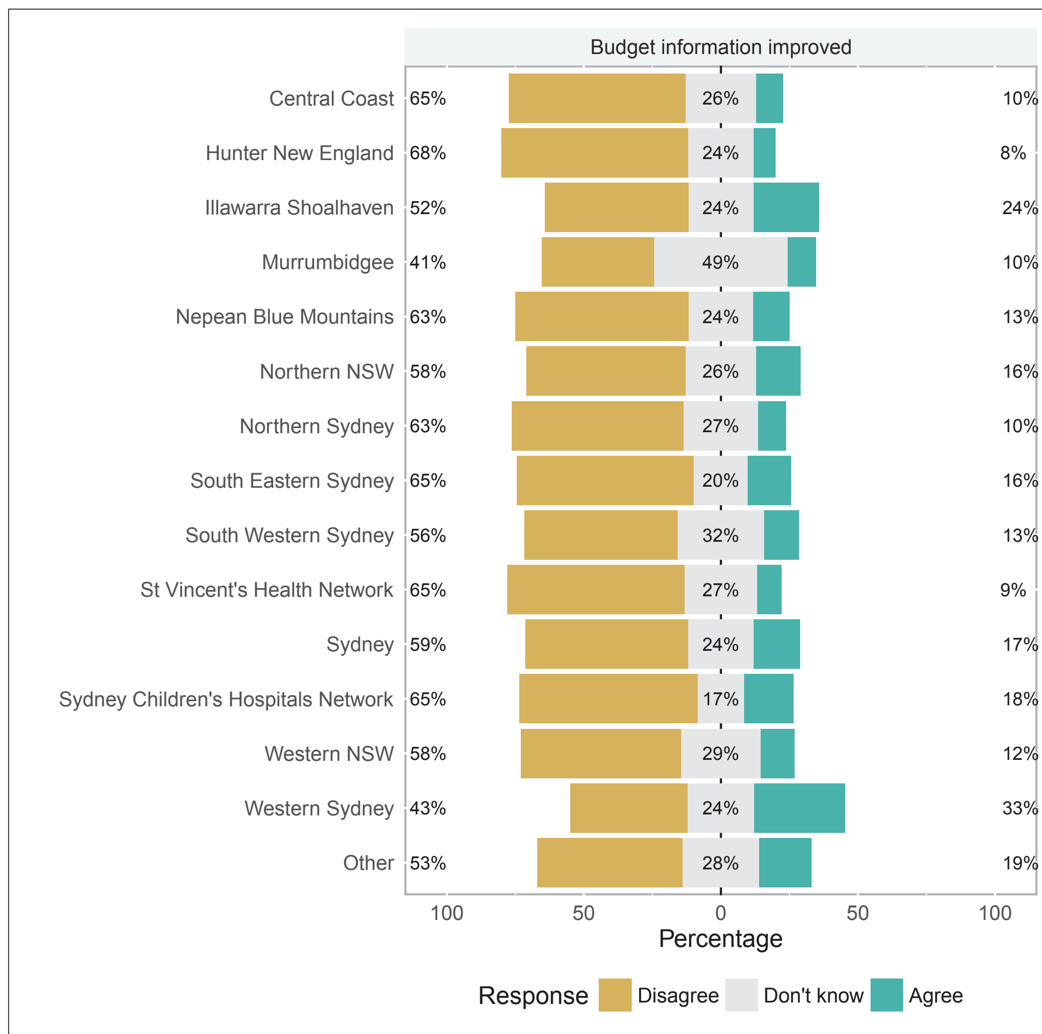
LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Western Sydney;
- in a *negative* direction: None.

The information provided to me about the budget in my department / unit has improved over the last two years.



Statewide Responses



Responses - Local Health Districts

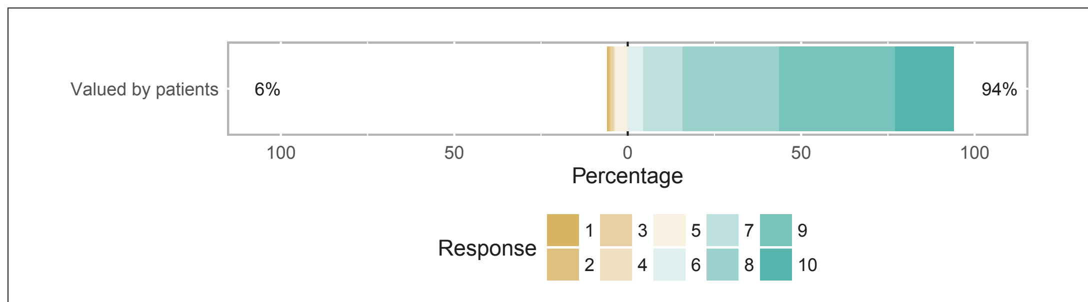
LHD/Networks with significantly above average response (ignoring “Neutrals”):

- in a *positive* direction: Western Sydney;
- in a *negative* direction: Hunter New England.

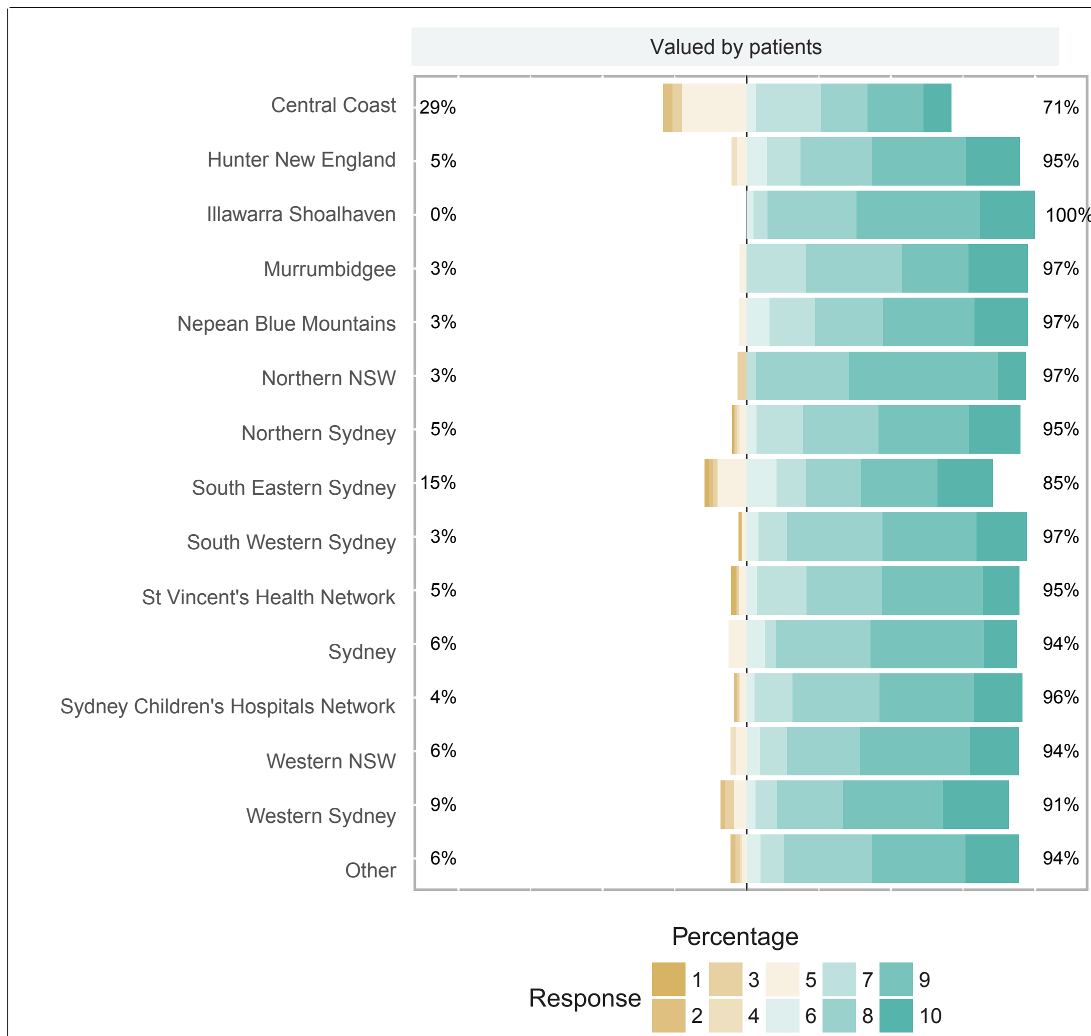
2.6 Perceptions of work value

These are questions about how various groups value the work done by respondents. These responses are on a scale of 1 to 10, with 1 indicating a low level of agreement with the statement given and 10 a high level.

Patients value my skills and effort at work.



Statewide Responses

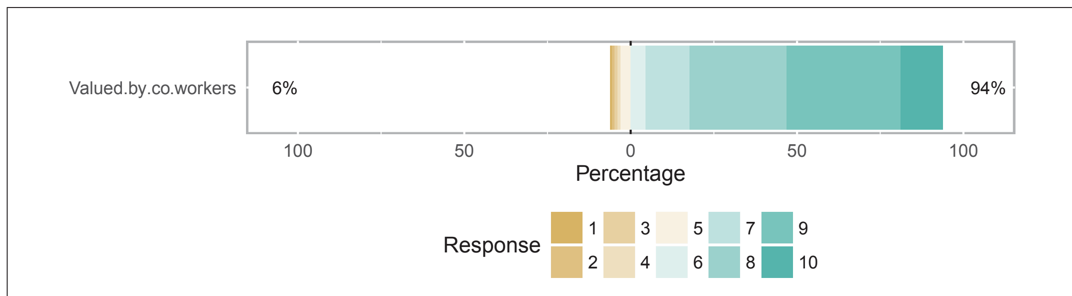


Responses - Local Health Districts

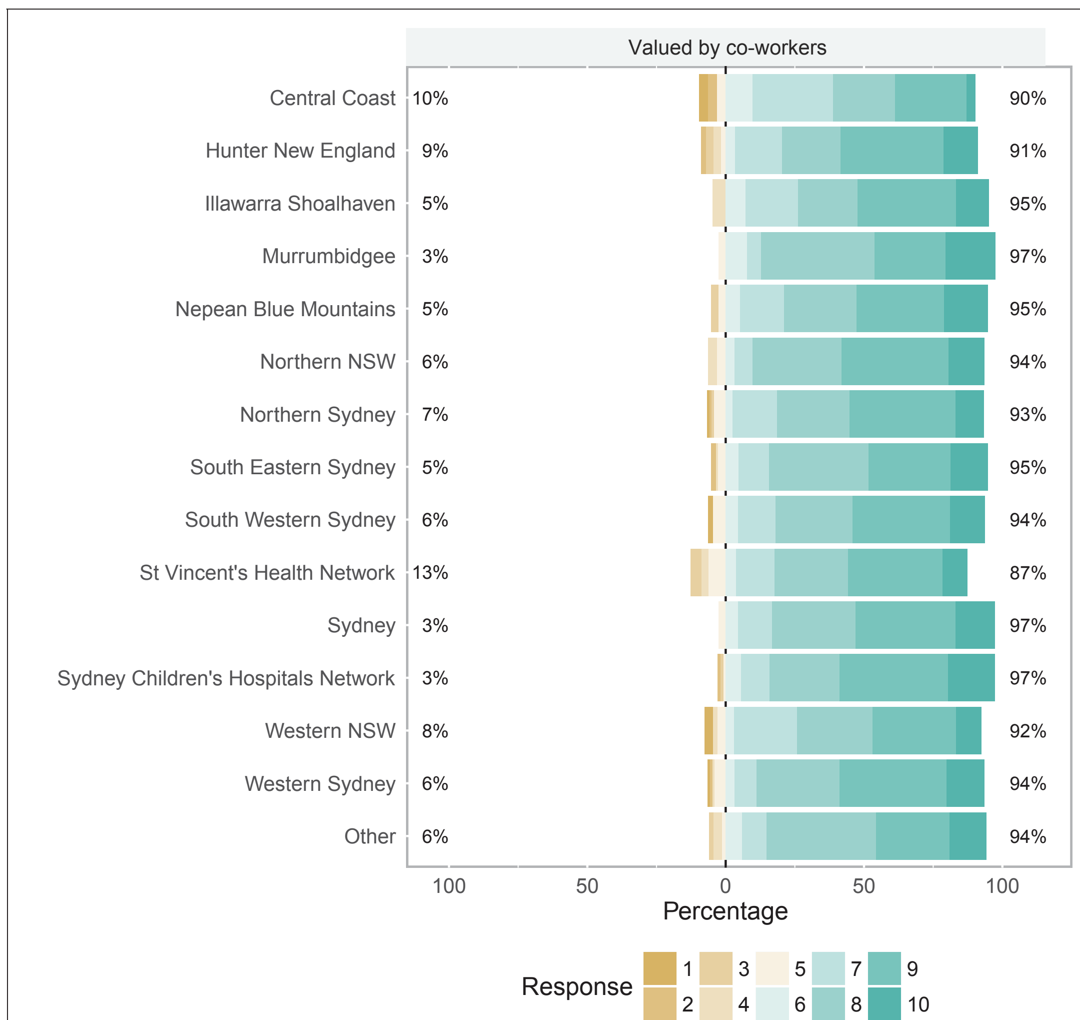
LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: None;
- in a *negative* direction: Central Coast; Other.

Co-workers in my department/unit value my skills and effort at work.



Statewide Responses

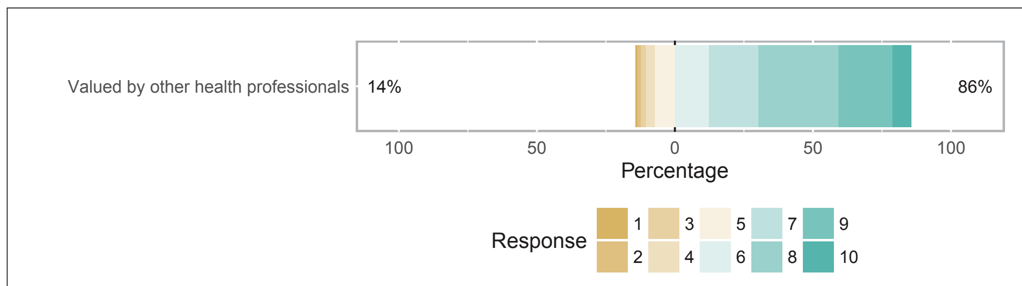


Responses - Local Health Districts

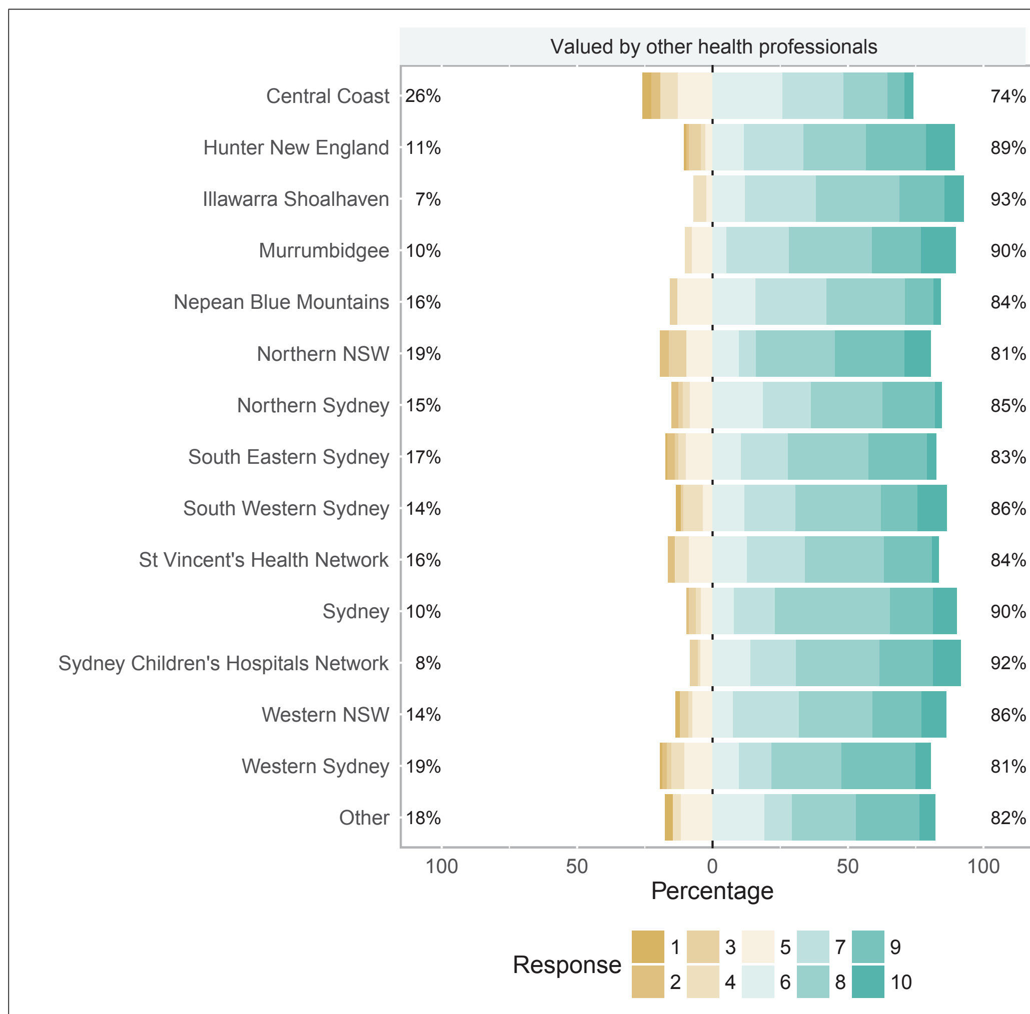
LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: None.
- in a *negative* direction: None.

Other health professionals in the hospital/service value my skills and effort at work.



Statewide Responses

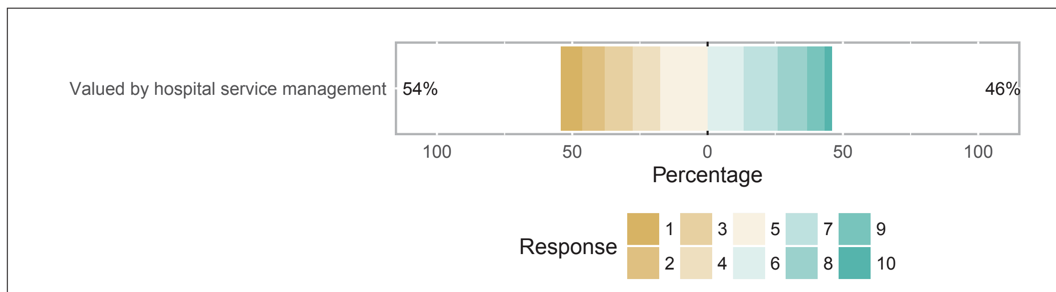


Responses - Local Health Districts

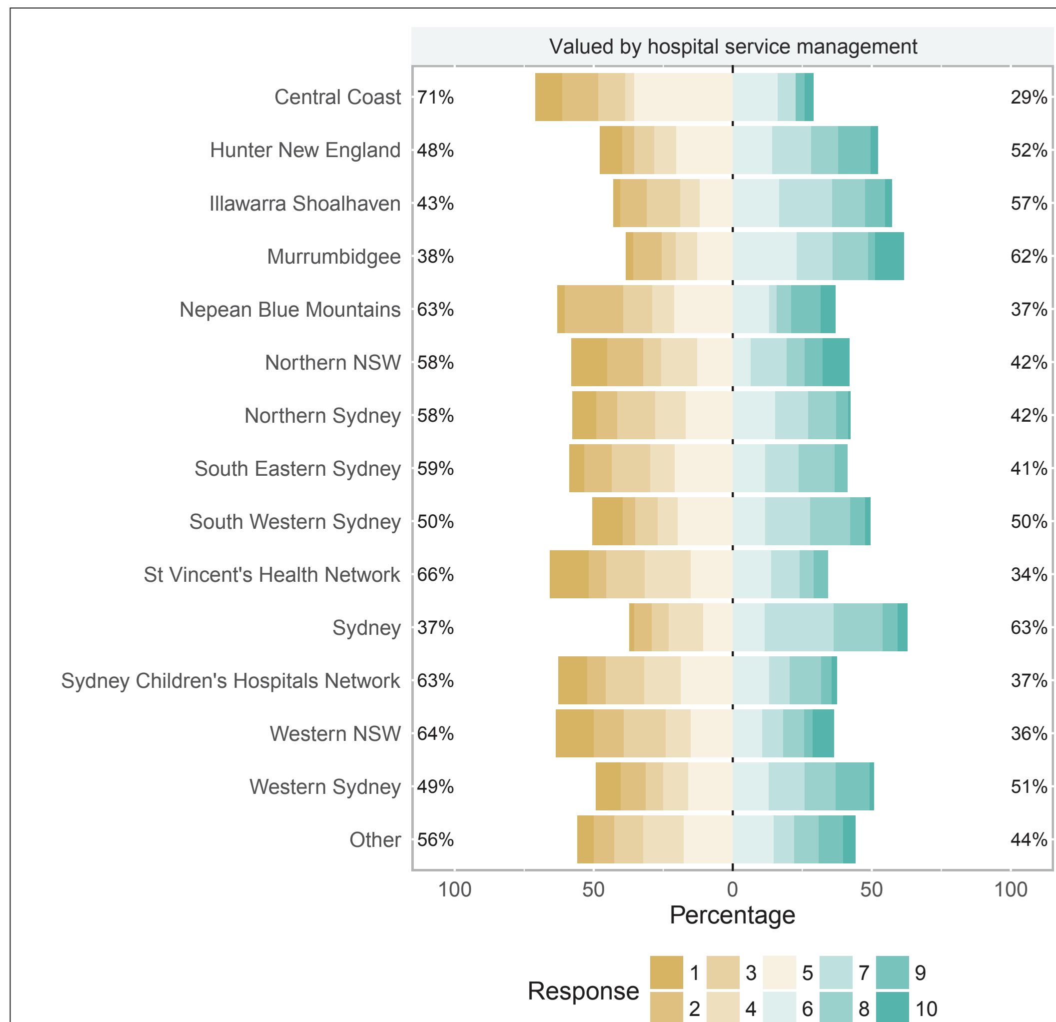
LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: None.
- in a *negative* direction: None.

Hospital / service management value my skills and effort at work.



Statewide Responses

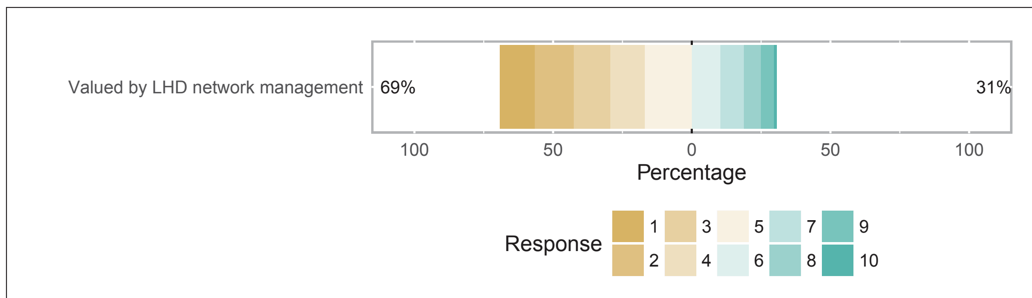


Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Sydney;
- in a *negative* direction: None.

LHD / network management value my skills and effort at work.



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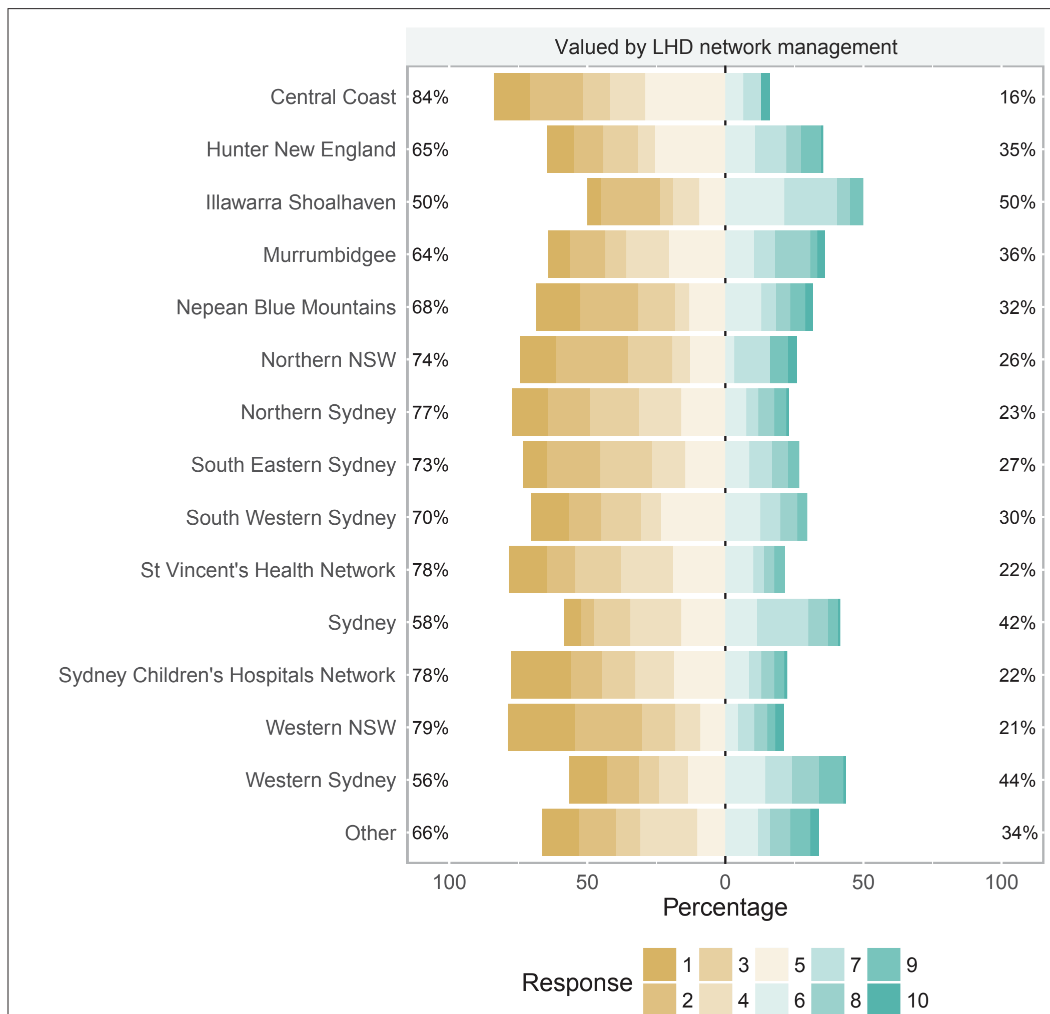
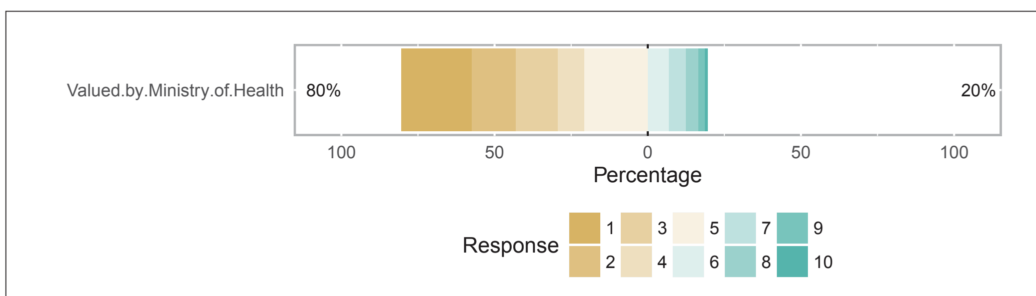


Responses - Local Health Districts

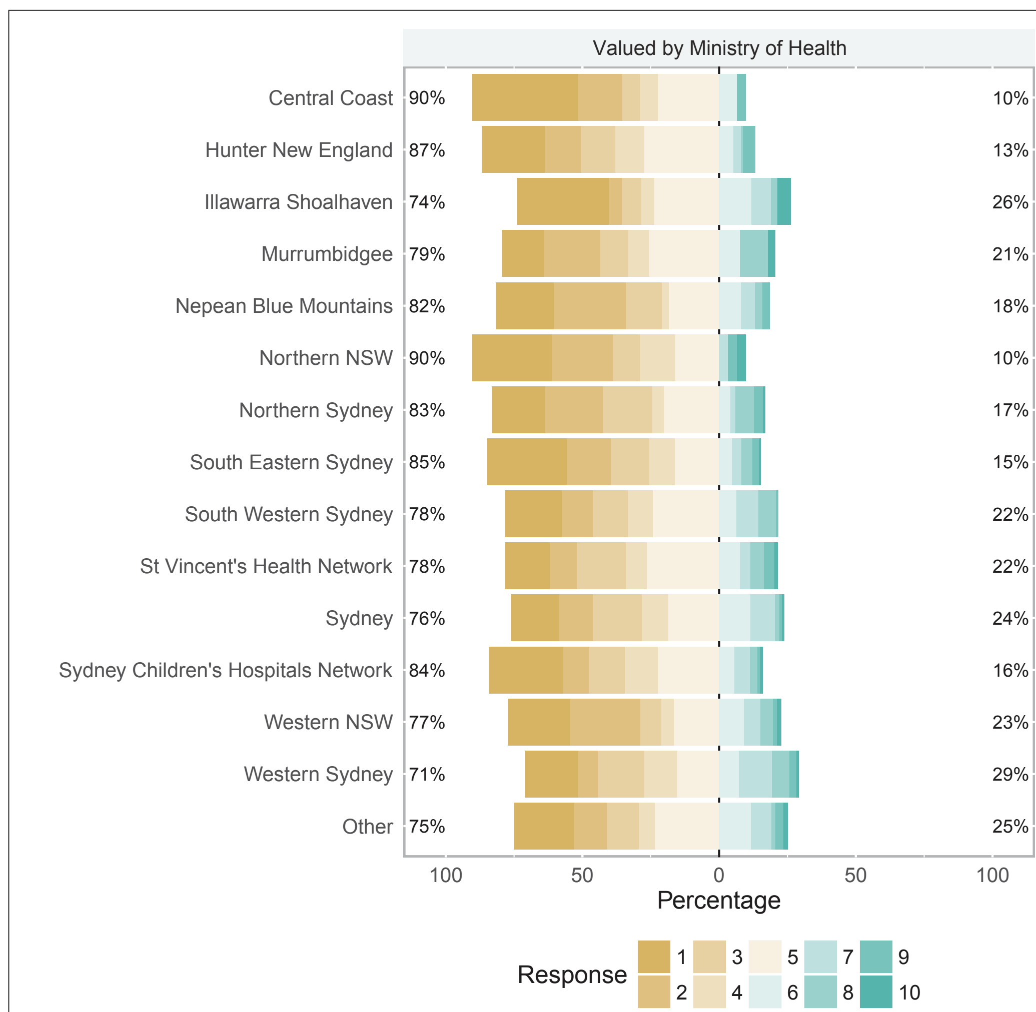
LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Illawarra Shoalhaven, Sydney, Western Sydney;
- in a *negative* direction: None.

Ministry of Health value my skills and effort at work.



Statewide Responses



Responses - Local Health Districts

LHD/Networks with significantly above average response (ignoring "Neutrals"):

- in a *positive* direction: Western Sydney;
- in a *negative* direction: None.

Appendices

Appendix 1: Medical Engagement - A Literature Review

Appendix 2: Joint Statement of Cooperation

Appendix 3: Selected Quotes

Appendix 1
MEDICAL ENGAGEMENT - A LITERATURE REVIEW

What is 'engagement'?

There is a range of literature discussing the term 'engagement', inside and outside of the medical field. Broadly, 'engagement' is one measurable aspect of a relationship between an employee and their organisation: organisations with high levels of employee engagement are those in which 'the business [values] the employee and the employee [values] the business'.[1]

Engagement is a two way process, where 'an organisation must work to engage the employee, who in turn has a choice about the level of engagement to offer the employer'.[2] In assessing employee engagement, organisations consider how well they work to develop and nurture their staff, and whether staff hold 'a positive attitude…towards the organisation and its values, [being] aware of the business context, and working with colleagues to improve…for the benefit of the organisation'.[3]

There is a growing body of evidence to suggest that organisations with engaged employees will perform well overall. MacLeod and Clarke demonstrate a correlation between engagement and performance in companies and organisations in the UK: when employee engagement improves, overall company performance improves.[4]

Engagement Theory in Hospitals

In the medical field, discussions about 'engagement' consider how medical practitioners operate in the context of hospital organisational structures, and how their interactions within those structures impact hospital performance and, ultimately, health outcomes for patients.

The work of hospitals is complex. It relies heavily on the skills and knowledge of medical professionals, who often have greater say over day-to-day management of affairs than managers in formal positions of authority. However, effective patient care also depends upon competent administration of standardised and perfected procedures that are not managed by medical professionals. Hospitals are one example of a 'professional bureaucracy'[5] in which most necessary co-ordination between staff is automatic and procedural, with professionals working independently of many of their colleagues, but closely with the clients they serve.[6]

In a hospital setting, control is managed through horizontal relationships rather than hierarchies. Where in more traditional organisations it is the role of line managers to develop standards and procedures that manage employee performance, medical professionals often draw upon best practice protocols that originate from outside of the hospital structure (such as those set by independently governed professional associations). Power within the hospital is shared as managers and administrators spend time with, and gain the trust of, the professionals in their organisation, handling disturbances in the structure by sitting down and working closely with them. Medical practitioners contribute to efficient cost management and effective delivery of patient care through being involved in decisions regarding resources, procedures, and priorities. Thus, a key element of a successful hospital is the effective collaboration of its administrators and professionals, and high level of clinician investment in the hospitals operations. Collective leadership is essential.[7]

[1] Macleod, D., & Clarke, N. (2009). *Engaging for Success: Enhancing performance through employee engagement.* United Kingdom: Department for Innovation, Business and Skills.
[2] Robinson, D., Perryman, S., & Hayday, S. (2004). *The Drivers of Employee Engagement.* Brighton, United Kingdom: Institute of Employment Studies.
[3] Robinson, et al. (2004)
[4] Macleod, D., & Clarke, N. (2009).
[5] Mintzberg, H. (1989). *Mintzberg on Management: Inside our strange world of Organizations.* New York, USA: The Free Press.
[6] Mintzberg,H. (1989)
[7] Ham, C., & Dickinson, H. (2008). *Engaging Doctors in Leadership: What can we learn from international experience and research evidence?* Coventry, United Kingdom: NHS Institute for Innovation and Improvement.

Prior Research: Clinician Engagement

Much of the available research on clinical engagement comes from studies of the NHS. British health policy charity The Kings Fund commissioned the Institute of Employment Studies to carry out a number of studies on the importance of leadership, management and medical engagement. These were designed to inform changes to the NHS that would 'recognise the value of leadership that is shared, distributed and adaptive. In the new model, leaders must focus on systems of care and not just institutions, and on engaging staff and followers in delivering results'.[8] According to the Institute, levels of employee engagement are impacted by many factors, some of which are:

- *Appraisal and support from management:* Employees who had received a well-structured appraisal in the 12 months prior were more engaged than those who had not; however those who had received a poorly structured appraisal reported being even less engaged than those who had no appraisal at all.[9] On the whole, employees with clear performance expectations[10] and perceived support from the organisation and their supervisors[11] reported being the most engaged.
- *Team work:* Employees in well-structured teams were more engaged than those who worked in no teams; however those who worked in poorly structured teams were less engaged than those who did not work in teams at all.[12]
- *Pressure:* Employees who felt low levels of work pressure and high levels of interest in their task reported high levels of engagement.
- *Responsibility:* Managers and professionals reported higher levels of engagement than their colleagues. However, health care assistants had higher levels of engagement than doctors and nurses;
- *Autonomy:* Employee engagement was impacted by the level of autonomy in roles, and the extent to which the task could be performed from beginning to end, with a visible outcome.[13]
- *Age:* Engagement levels decline with an employee's age.[14] Employees in their 40's and 50's had the highest level of workplace stress, which correlated with lower workplace engagement. Those with caring responsibilities had significantly lower levels of engagement than those without.

Whilst all of these factors contribute, perhaps the strongest driver of engagement is an employee's sense of their own value and importance.[15] Engagement was low for employees who had experienced accidents, injury, or bullying in the workplace.

The benefits of engaged employees to the workplace were clear: staff with high levels of engagement were less likely to report work-related stress, were less likely to feel pressure to come to work when they were not fit to do so, and reported higher levels of general health and wellbeing. High staff engagement levels were also linked to high staff retention rates and low levels of staff absenteeism.

Evidence also exists for the correlation between high clinician engagement and patient satisfaction. Patient satisfaction is higher in UK NHS trusts with high levels of clinician engagement, and a link has been suggested between patient mortality and clinician engagement at health trusts dealing with acute cases. West and Dawson suggest that increasing the rates of clinician engagement by one standard deviation could reduce mortality rates by 2.4%.[16]

[8] The King's Fund. (2012). *Leadership and Engagement for Improvement in the NHS: Together we can.* London: The King's Fund.
[9] West, M., & Dawson, J. (2012). *Employee Engagement and NHS Performance.* The King's Fund.
[10] The Kings Fund, (2012)
[11] West and Dawson. (2012)
[12] Ibid.
[13] Ibid.
[14] The exception is employees above 60, who were the most engaged respondents.
[15] Robinson et al (2004)
[16] West and Dawson (2012)

Clinician Engagement in NSW Hospitals

Following a number of public and fatal incidents in NSW hospitals, a rift emerged between medical professionals and hospital management, with each blaming each other for failures in clinical care. The Garling Review (2008) described this rift as 'the great schism of 1054' and attributed the breakdown of working relationships between clinicians and management as both 'very detrimental to patients' and a disincentive for medical professionals to remain in the public hospital system.[17] These tensions reflect a similar pattern in the UK, where a shift in the way doctors were managed (due to financial pressures) led decreased autonomy of clinicians and a breakdown of clinician-management relationships.

- The Agency for Clinical Innovation was established
- Executive Clinical Directors were appointed at the LHD level, to be consulted by the CEO on clinical procedures
- In each hospital, clinicians and managers were to be reconnected through delegating more power to local managers
- Clinicians were to be involved at a clinical level in safety and quality assurance.

Jillian Skinner, the NSW Minister for Health, has expressed the NSW Government's commitment to improved engagement with clinicians to deliver better patient outcomes.

Poor engagement with doctors

"I have a classic example of management devaluing the senior medical staff. A meeting was to be arranged between human resources, IT, senior management and the senior doctors in the anaesthetic departments at two hospitals. I received a phone call about 10 days prior notifying me that the date had been set for the meeting, accompanied by the statement 'sorry it's taken a while to organise, the people who needed to attend were unavailable until now'. What was most belittling was that my head of department and I were not asked if this date was suitable which would be the case if they valued our input."

– Staff Specialist, Canterbury Hospital

Moving forward

Engaging doctors

"To engage doctors, a clear value proposition of "what's in it for me" needs to be developed. There is no overriding need for doctors to get engaged as they can still look after patients completely without engagement…getting involved means taking time that they could otherwise spend on direct patient care…"

– Dr Lee Gruner, President: Royal Australasian College of Medical Administrators

The AMA's Position Statement *Doctors' Engagement in the Management of Hospitals* highlights the importance of engaging with medical staff, nursing and allied health staff, and patients themselves.[18] Providing employees opportunities with to be involved in decision making, to voice their ideas, develop their jobs, and feel well cared for in their organisation are critical in increasing staff engagement.[19] Many of these opportunities can be created by individual line managers.

[17] Garling, P. (2008). *Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals.* Sydney, Australia: NSW Government.
[18] Australian Medical Association. (2010). *Doctors' engagement in the management of hospitals.* Canberra: AMA.
[19] Robinson et al. (2004)

Some evidence suggests that doctors must be the focus of attempts to improve hospital reform,[20] as almost all health care actions in a hospital setting are derivative of their decisions and recommendations.[21] Doctor engagement may be improved through providing doctors with:

- Opportunities to participate in decision making and job development
- Access to mentoring and ongoing education
- Support from leaders who can help them deliver their attention to patients
- A sense of the organisation's values, to guide their decisions
- Up-to-date process, outcome and patient experience data

In real terms, this may include management staff arranging informal opportunities for face-to-face meetings with medical staff, having fixed formal meetings with clinicians outside of medical staff committee structures, and meeting newly appointed consultants/principals as part of their induction program. Doctors themselves have suggested some measures that senior leaders could take to improve the working relationships in the hospital setting.[22] These include empowering junior doctors, ensuring the system does not suppress doctors' interests, removing barriers to dual clinician and managerial roles, ensuring flexibility in job descriptions, and ensuring that doctors are involved in decisions about the services provided.

Effective engagement with doctors

On the first day of joining the healthcare organisation, Foundation Year (FY) 1 doctors met, as a group, with the trust medical director. At that meeting, the medical director asked the FY1 doctors to record every time they saw a service issue that resulted in patients receiving sub-optimal care. A few weeks later, when the FY1 doctors met again with the medical director, they were asked what issues they had recorded and what they had done to correct or improve the service issue for patients. This simple action by the medical director emphasised that it was the responsibility of all doctors to improve services for patients and empowered junior doctors to be involved.

– Source: Hamilton, P., Spurgeon, P., Clark, J., Dent, J., & Armit, K. (2008)

The Medical Engagement Scale, developed in the UK, objectively assesses how doctors engage with the organisation in which they work. The scale assess three aspects of engagement: whether employees are working in an open culture, have purpose and direction, and feel valued and empowered. Data from use of this scale suggests that NHS trusts with higher levels of engagement provided a range of opportunities for doctors to discuss quality, safety and performance with management, and had CEO's and other executive members at doctor induction days. A tool such as the MES may be useful for hospitals and LHD's in auditing their own medical engagement.[23]

Doctors in Training and General Practitioners

Whilst doctors in training are often transient, busy and inexperienced, the longevity of their clinical careers means that efforts to engage them will produce a large return on investment. Establishing effective collaboration in medical leadership will require input from doctors in training, who spend most time on the wards with patients, are the back bone of hospital out-of-hours services, and sit at the interface of co-ordination with other medical teams, allied health and administrative services.

General practitioners must also be considered. GPs in rural areas may play direct roles in hospitals as Visiting Medical Officers; they also escalate urgent cases to hospital emergency departments, follow up with patients in community after discharge, and deal with preventative care and chronic disease management that reduce hospitalisation rates. Thus working collaboratively with GPs is important when aspiring to high quality and integrated hospital health care. The Australian Medical Association's Position Statement on Medical Engagement calls for structures which include GPs in hospital medical committees.[24]

[20] Hamilton, P., Spurgeon, P., Clark, J., Dent, J., & Armit, K. (2008). *Engaging Doctors: Can Doctors influence organisational performance?* Coventry: NHS Institute for Innovation and Improvement
[21] Reinertsen, J., Gosfield, A., Rupp, W., & Whittington, J. (2007). *Engaging Psyicians in a Quality Agenda.* Cambridge, USA: Institute for Healthcare Improvement.
[22] Hamilton, P., Spurgeon, P., Clark, J., Dent, J., & Armit, K. (2008). *Engaging Doctors: Can Doctors influence organisational performance?* Coventry: NHS Institute for Innovation and Improvement.
[23] Engage to Perform Ltd. (2012). Retrieved November 10, 2015, from Medical Engagement Scale: www.medicalengagement.co.uk; Spurgeon, P., Barwell, F., & Mazelan, P. (2008). *Developing a Medical Engagement Scale.* International Journal of Clincal Leadership, 213-23.
[24] Australian Medical Association. (2010).

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Appendix 2:

JOINT STATEMENT OF COOPERATION

BY

The Hon. Jillian Skinner MP, New South Wales Minister for Health and Minister for Medical Research

Australian Salaried Medical Officers' Federation (NSW)

Australian Medical Association (NSW)

Purpose

Effectively and meaningfully engaging clinicians in the decision-making processes of health organisations significantly contributes to positive patient outcomes. To that end, we are committed to ways of working in which the effective and meaningful engagement of medical practitioners is a cornerstone of decision-making to deliver patient centred care within the NSW public health system.

Continuing Commitment

The Minister is committed to continuing devolution, localism, transparency and accountability as the basis for an effective, patient-centred public health care system. In particular the Minister has a commitment to continuing the following initiatives:

- Embedding of the CORE values of collaboration, openness, respect and empowerment across NSW Health.
- One or more executive clinical directors being appointed in each Local Health District and Specialty Network to advise on medical matters and improve links between management and medical clinicians.
- Local doctors as members of District and Network boards.
- a co-ordinated process through Medical Staff Councils for providing nominations for District board membership to the Minister of Health.
- Opportunities for Medical Staff Council representatives to attend District Board meetings as observers.
- The strengthening of clinical councils and the inclusion of the Medical Staff Council Chair on LHD and facility clinical councils.
- Supporting participation of doctors-in-training on facility clinical councils.

Further work

Surveying senior medical staff

- The ASMOF (NSW) and AMA (NSW) intend to conduct regular surveys of their senior medical members to gauge their level of engagement in the public health system.

- The Ministry has worked with these organisations to map relevant questions from their survey to its own staff "Your Say" survey in 2015 to provide greater granularity around senior medical staff engagement as indicated by the engagement index developed for the Your Say survey.
- AMA (NSW) and ASMOF are committed to encouraging participation of their senior doctor members in the next Your Say survey with the aim of maximising senior doctor participation rates in that survey.
- The Minister supports results from the Your Say survey (or any future staff survey for or on behalf of NSW Health), and results from AMA/ASMOF surveys relating to questions about the engagement of senior medical clinicians, which have been agreed with the Ministry of Health:

  (i) being considered as part of understanding and assessing performance under the annual District/Network service agreements;

  (ii) being considered as part of understanding and assessing the performance of District/Network senior executive management teams, other relevant managers and senior medical staff,

  in establishing meaningful clinician participation and involvement in local decision-making to deliver patient-centred care.

  (Note: there needs to be sufficient response rates from senior doctors to make reasonable analysis possible at a District/Network level).

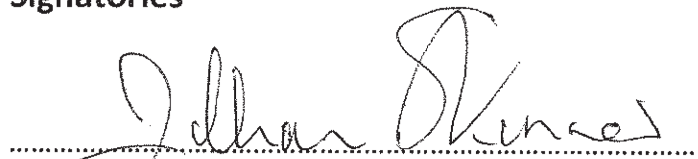
Model By-laws

- The Minister is committed to continuing the engagement initiatives outlined under "Continuing Commitments". It is recognised that some of these initiatives are currently set out in the Model By-Laws, and agreed that these are important determinants as to the level of engagement with medical practitioners at the District and Network level.
- The current Review of the Model By-Laws retains a commitment to supporting effective clinician engagement at the local level, and to this end:

  (i) the Ministry of Health will consult closely with the AMA and ASMOF in the Review, to ensure revisions being considered are consistent with the principles of maximising local, frontline engagement;

  (ii) The AMA and ASMOF will provide constructive input into the process of revision of the Model By-Laws.

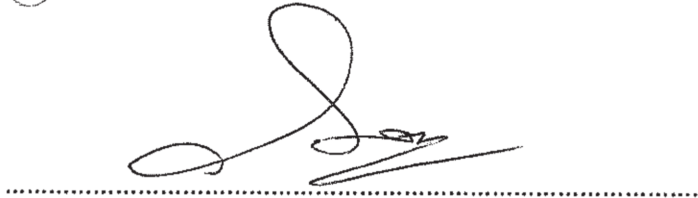
Signatories



Date: 12.2.15

The Hon. Jillian Skinner MP

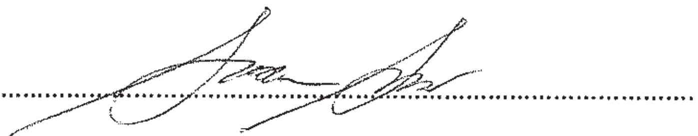
Minister for Health and Minister for Medical Research



Date: 17/2/15

Dr Tony Sara

President, Australian Salaried Medical Officers' Federation (NSW)



Date: 17/2/2015

Dr Saxon Smith

President, Australian Medical Association (NSW)

Appendix 3
SELECTED QUOTES

I think my colleagues work extremely hard and are dedicated way above the norm, but there are virtually no messages from admin or management to thank, reward or congratulate people. In corporate life these things are embedded in quality HR processes. The public hospital system runs on the goodwill and morale of its employees, but management seems to disregard their needs and fails to show concern about inept decision making and lack of acknowledgement.

One cardiologist retired after >30y on the procedural on call roster and didn't even get a word of thanks let alone any official recognition…

I feel engaged in the life of my hospital but not at all valued or engaged at LHD level.

This service is surviving on the good will of the people who work within it - and that good will is slowly being worn down and is fast evaporating.

I am motivated to work above and beyond but that is not as a result of senior management engagement in fact my senior manager totally negates and ignores any extra work I do - I am self-motivated to do what I believe is the right thing - if I waited for senior management recognition then I wouldn't be doing anything.

Unfortunately there is a culture of bullying from the very top. Bullying and harassment is entrenched and accepted behaviour for many senior managers, both medical and nonmedical.

We have a relatively new CEO who seems to be trying to improve things, but we still have all the previous bullying middle and upper layers of managers who do not know what doctors do and don't care.

New CEO in the last 12 months and lots of changes (for the better) in leadership and governance across the organisation. Things still undergoing change, so a bit 'messy' at the moment, but can see her vision and think that new structures will function better than previously.

The leadership on open engagement should come from the Ministry. They do not generally demonstrate a patient-centred focus in their dealings with Local Health Districts, nor do they and the senior management group really understand the literature or the research that has been conducted over the past 20 years into patient safety. Senior executive managers are seen as hypocritical when they talk the talk, as their actions on financial control and micromanagement of LHDs speak much louder to CEOs and middle managers. This makes it very difficult for managers to take risks with anything that might involve initial expenditure (e.g. better staffing), but lead to better patient outcomes and better staff satisfaction. Even when we repeatedly advise that we are below minimum staffing for provision of safe services on 24/7 basis, we find it next to impossible to have open discussions and planning for future increases. Instead we are forced to employ locum and agency staff every week, and the actual amount spent on this is impossible for clinicians to access. Partnership with clinicians and consumers is a myth in which no one believes, as MOH has lost all credibility on these pronouncements and will need to change some basic attitudes and work hard for a long time to regain it.

Our services executive listens to us & supports us. The organisation's executive less so. The Ministry for Health is probably not even sure what we do.

The hospital's current Acting General Manager is superb… she has organised lots of department reviews to get objective feedback, talked one-on-one to many doctors and others and has revived a more positive attitude to the future working of our hospital… Individuals can make a difference to our workplace.

General Manager at the hospital has changed the landscape and has engendered far greater engagement and collaboration locally in the last 12 months than in previous years. This means relationships locally are far better…

My LHD is a grossly under-resourced service that consists of a large geographical and population catchment area. The number of patients that present and are admitted to our hospital is high and the degree of acuity of these presentations is also high. We are almost always busy and almost always have demand on beds. There are often shortages in the rostered medical and nursing staff which puts additional pressure on the remaining staff especially in regards to on call and overtime requirements. Management at all levels have neglected to address these issues repeatedly and as a solution place undue thankless pressure on the staff that remain to make up for the staffing shortfalls. This has occurred to unsafe levels at times. Management also repeatedly fail to address any of these issues with the clinical staff who it impacts most. There is however, ongoing reminders and communication with staff about meeting target key performance indicators for budgetary requirements and where we fail to reach expected targets. This disparity between the communication on budget/funding issues and that same communication, or lack thereof on issues of understaffing, under-resourcing and consequent unsafe clinical practice is alarming.

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