SUMMARY REPORT	ABM University Health Board
Heath Board	Date of Meeting: 25th May 2017 Agenda item : 2 (vi)

Report Title	**Medical Engagement Scale**
Prepared by	Sharon Vickery, Head of HR Delivery Units & Medical Staffing
Approved and Presented by	Hamish Laing, Executive Medical Director

Purpose

The purpose of the paper is to share the Medical Engagement Scale report for ABMU for information and to set out what actions have been undertaken so far.	**Decision**	
	Approval	
	Information	**x**
	Other	

Promoting and Enabling Healthier Communities	**Delivering Excellent Population Outcomes**	**Demonstrating Value and Sustainability**	**Securing a Fully Engaged and Skilled Workforce**	**Providing Effective Governance and Partnerships**
			x	**x**

Executive Summary

To attach the Medical Engagement Scale report for information and to set out what actions have been undertaken so far. Also, to indicate what opportunities exist to further medical engagement across the Health Board

Key Recommendations

- To review the Medical Engagement Scale report
- To note the comments and views expressed by the Delivery Units together with the actions that have taken place so far.
- To acknowledge the opportunities to develop medical engagement further following bespoke training on the 26th May 2017 and the joint BMA/Employers Confederation National Conference on the 24th May 2017 .

Assurance Framework

Next Steps

To support Delivery Units to continue to utilise the results to improve medical engagement.

MAIN REPORT		ABM University Health Board
Health Board		Date of Meeting: 25th May 2017 Agenda item : 2 (vi)
Subject	**Medical Engagement Scale**	
Prepared by	Sharon Vickery, Head of HR Delivery Units and Medical Staffing	
Approved and Presented by	Hamish Laing, Executive Medical Director	

PURPOSE

To share the Medical Engagement Scale (MES) report with the Board for information and to set out what actions have been undertaken so far. Also, to indicate what opportunities exist further to develop medical engagement across the Health Board.

BACKGROUND

An engaged clinical workforce delivers better outcomes for its patients and more discretionary effort. The Medical Engagement Scale is a validated academic tool which measures several domains for engagement. In England MES scores correlate well with CQC inspection results. Medical Directors supported its application in NHS Wales after an initial pilot in Cardiff and Vale University Health Board in 2014. The survey was undertaken in 2016 and the Health Board and all Wales reports were completed in July 2016. The survey covered Consultants and Specialist Associate Specialist Doctors (SAS), but did not include Junior Doctors in Training. The results were presented initially to the Medical Directors in Wales and Welsh Government, before being disseminated to the respective Health Boards.

The response rate was encouraging with almost 50% of doctors in ABMU completing the survey.

It is important to understand the purpose of the survey was to provide a baseline upon which to build and improve future engagement. The intention is to repeat the survey no sooner than 2 to 3 years after the original survey to monitor the improvements that will have been achieved.

MEDICAL ENGAGEMENT SCALE SURVEY

This survey is attached as Appendix A for information. The survey received 340 responses from the medical workforce in this Health Board. Overall, the results are average to low for the Health Board with the Morriston Delivery Unit scoring lower than the other Delivery Units.

The results have been discussed in several fora including the Medical Workforce and Local Negotiating Committee. There have been specific meetings with the Unit Medical Directors to discuss how the Delivery Units can disseminate the messages from the report. The Executive Medical Director specifically asked that Delivery Units refrain from just circulating the results and encouraged face to face discussion, particularly with the consultant body. All the Unit Medical Directors have confirmed

these discussions have taken place. The feedback from the Unit Medical Directors is that they feel that the survey was undertaken before the medical management model was fully populated and embedded. All the Unit Medical Directors feel that medical engagement has improved as a result of the new structures. They have also argued that there may have been a lack of clarification around what constituted line management. The Unit Medical Directors' preference was not to deal with the medical workforce in isolation, but to integrate their approach with any actions flowing from the National and Values Surveys. They felt it was important that the focus should be to improve engagement for all staff.

SPECIFIC EXAMPLES OF GOOD PRACTICE

The Unit Medical Directors have provided some specific examples of improvements in medical engagement:-

- The Neath/Port Talbot Delivery Unit have defined Medical Engagement as "the active and positive contribution of doctors within their normal working roles to maintain and enhance the performance of the organisation which itself recognises this commitment in supporting and encouraging high quality care". This has led to the results being used as part of the quality and safety agenda, and they have quoted inclusive and collaborative schemes to improve patient care through more effective working relationships.

- The Morriston Delivery Unit has established the Clinical Leadership Cabinet which they regard as being the biggest shift in medical leadership in Morriston. This Cabinet has developed and endorsed a behaviour framework for doctors when they are referring patients across specialities to improve doctor's behaviour and improve flow from the Emergency Department. This has greatly reduced the number of complaints previously received by the Unit Medical Director concerned with poor behaviour. This group is at the heart of clinical decision making and is actively planning to improve services for patients whilst engaging with the medical workforce.

NEXT STEPS

On 24th May 2017, there is all Wales Conference hosted by the Employers Confederation and the BMA. Chief Executives, Workforce Directors and Medical Directors will meet to share best practice flowing from this survey across Wales. Hamish Laing has been invited to speak in plenary to the conference. Chief Executives have stated they want to see tangible outcomes from the conference. This will be an opportunity for the Health Board to draw upon other intelligence to help develop better medical engagement.

On 26th May 2017, the Future Work Centre will provide training to develop organisational capacity to action plan following staff experience and engagement surveys. This will be helpful to inform any local planning around the Medical Engagement Scale. The intention is that we will develop some corporate tools to support the delivery units in improving medical engagement. Planning guidance will also provide a key opportunity to place medical engagement at the core of its purpose. A comprehensive training plan is being developed to be rolled out corporately across delivery units and this work will underpin the planning associated with improving medical engagement.

The intention is to repeat the MES in Wales to measure change. The authors advise this should be no more frequently than 3 yearly.

RECOMMENDATIONS

That the Health Board notes:

- The results of the baseline medical engagement scale survey
- The comments and views expressed by the Delivery Units
- The discussions and actions that have taken place so far
- The opportunities that exist to develop medical engagement further following bespoke training on the 26th May 2017 and the joint BMA/Employers Confederation National Conference due to be held on the 24th May 2017.
- The plan to repeat the MES in NHS Wales in 2019

Engage to Perform Ltd

Medical Engagement Scale

'*ABMU UHB*'

www.medicalengagement.co.uk

July 2016

The Medical Engagement Scale (MES) – Engagement of Medical Staff in *'ABMU UHB' (July 2016)*

CONTENTS

PREFACE: MEDICAL ENGAGEMENT IN WALES

This year (2016) is the first year in which linked medical engagement surveys have been systematically undertaken by the following group of eight NHS organisations in Wales which are listed below:

- **ABMU UHB**
- **Aneurin Bevan UHB**
- **Betsi Cadwaladr UHB**
- **Cardiff & Vale UHB**
- **Cwm Taf UHB**
- **Hywel Dda UHB**
- **Velindre Trust**
- **Public Health Wales**

The initial aim of this 'Pan-Wales' medical engagement survey is to provide a reliable and valid baseline of Welsh doctors' perceptions about the opportunities and interests they have in adopting expanded medical roles particularly with respect to the planning, design and delivery of improved patient services.

Each of the participating healthcare organisations in Wales have used a common MES survey structure and this ensures that the results are not only comparable between organisations but also enables the construction of Welsh medical engagement norms which will facilitate reliable benchmarking of progress in future years. Although the advantages of using a common core of engagement items are clear, it is also important that each of the eight survey questionnaires are tailored to incorporate local issues selected as relevant by the participating organisations themselves. By combining common and local items within each of the survey instruments, medical engagement issues may be simultaneously viewed from both a national Welsh and a topical local perspective.

- ***A Note about the MES Reports***

The current 2016 assessment of medical staff engagement within the eight Welsh health organisations listed above is being undertaken concurrently, although there will inevitably be variations between organisations with respect to the time spent in the local organisation and administration of each of their MES surveys and, more importantly, securing sufficient medical returns in the data collection phase. Consequently, as survey data becomes available for each organisation it will be analysed in turn and an engagement report for each organisation will be produced. This report (for the ***'ABMU UHB'***) is intended to be a focused feedback document that has been designed to give an overview of the levels and types of medical engagement which have been identified within the organisation together with some brief recommendations of potential methods for enhancing medical engagement if and where the results have identified scope for improvement.

In addition to producing the eight separate medical engagement reports for each participating organisation, the final report will present a more integrated and focussed assessment of medical engagement in Wales, based on constructing a database of Welsh medical norms from the MES survey results and using this to statistically benchmark levels of engagement against the new Pan-Wales normative database.

The Medical Engagement Scale (MES) – Overview Summary for *'ABMU UHB'*

Overview Summary

In all, 340 members of medical staff completed the MES survey at ***'ABMU UHB'***. A comparison of the current survey results with the other Trusts in the normative database (comprising over 100 Trusts and more than 12,500 medical staff - i.e. Consultant, Associate Specialist/Staff Grade and trainees) indicated the following: -

- For the average of all responding medical staff, nine of the ten MES scales were rated within the ***low*** relative engagement band compared to the external norms and the remaining one MES scale (i.e. **Sub-Scale 1: Climate for Positive Learning**) was rated a little more positively within the ***medium*** relative engagement band.

- ***'Consultants' rated*** nine of the ten MES scales within the ***low*** relative engagement although the other two staff groups both had a more 'mixed' engagement profile. However, **Meta-Scale 3: Being Valued and Empowered** and its two constituent subscales (i.e. **Sub-Scale 5: Development Orientation** and **Sub-Scale 6: Work Satisfaction**) were all rated in line with the ***lowest*** relative engagement band by non-consultant medical staff.

- Although ***'Associate Specialists'*** (n = 16) rated **Sub-Scale 2: Good Interpersonal Relationships** in line with the ***lowest*** relative engagement band compared to the norms, they rated both **Meta-Scale 2: Having Purpose and Direction** and **Sub-Scale 4: Participation in Decision-Making and Change** within the ***high*** relative engagement band.

- Medical staff affiliated to **Glanrhyd Hospital** (n = 7) and to **Neath Port Talbot Hospital** (n = 14) were, on average, predominantly ***highly engaged*** across most of the MES scales whereas, in contrast, medical staff affiliated to **Morriston Hospital** (n = 152) were, on average, ***disengaged*** across all of the ten MES scales.

- When the aggregated medical engagement results were broken down to the finer-grain ***Specialty*** level, the engagement profiles of medical staff affiliated to the various specialties varied a great deal. These are detailed in the main body of the report.

- Medical staff ***with*** a position of managerial responsibility were more engaged with respect to all ten MES scales compared to their colleagues ***without*** a position of managerial responsibility and the biggest differences occurred for the **Meta-Scale 3: Having Purpose & Direction**, **Sub-Scale 4: Participation in Decision-Making & Change** and **Sub-Scale 6: Work Satisfaction**.

- There was a consistent tendency for managers to ***overestimate*** levels of medical engagement possible reflecting an over-optimistic managerial belief that some members of medical staff are more positively engaged than they actually consider themselves to be. These perceptions might support low levels of management motivation to provide more facilitative opportunities for encouraging the development of medical staff engagement at ***'ABMU UHB'***.

- The 'local' questions provided a 'mixed' picture of working in ***'ABMU UHB'***. Whereas 49% endorsed that they have regular contact with the leadership team within their speciality only 33% endorsed the statement that ***'I feel able to provide the best care to patients within the resources available'***. Similarly, 53% endorsed (i.e. either ***'agreed'*** or ***'strongly agreed'***) that the working arrangements in the organisation helps them engage in personal training and professional development programs, whereas only 24% endorsed the statement that ***'Working arrangements in this organisation facilitate my opportunities to discuss quality, safety and performance with Senior Managers including the Chief Executive (formally or informally).'***

1) INTRODUCTION

a) What is Medical Engagement

It is increasingly recognised that improvement in healthcare needs the positive involvement and engagement of doctors who are willing and able to adopt roles that make them highly influential in planning and delivering service change. Although competence may be thought of as what doctors "can do", medical engagement requires a "will do" attitude. The reliable and valid measurement and monitoring of medical engagement is critical since this will inform and shape effective improvement initiatives. Although, many definitions of engagement focus solely on individual and personal aspects the current approach also incorporates organisational conditions and culture. Our definition of Medical Engagement is: -

'The active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation which itself recognises this commitment in supporting and encouraging high quality care.'

b) Hierarchical Structure of the MES Instrument

The Medical Engagement Scale (MES) is a simple and short 30-item survey instrument consisting of ten reliable and valid scales. The instrument has a hierarchical structure and provides an overall index of medical engagement together with an engagement score on three reliable meta-scales with each of these three meta-scales itself comprising two reliable sub-scales:

Meta-Scale 1: Working in a collaborative culture

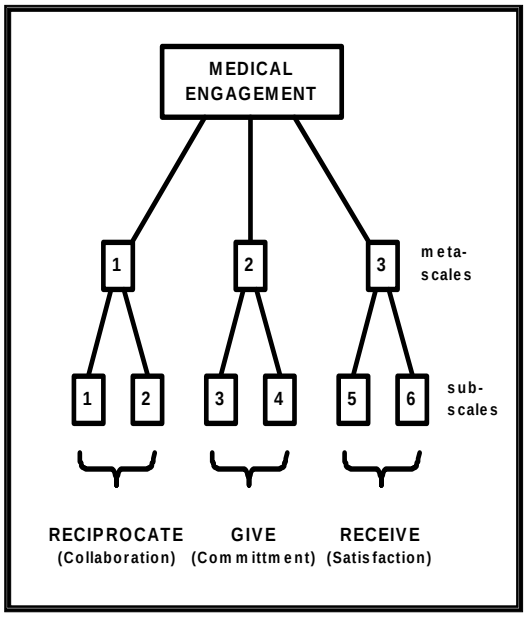
- Sub-Scale 1: Climate for positive learning
- Sub-Scale 2: Good interpersonal relationships

Meta-Scale 2: Having purpose and direction

- Sub-Scale 3: Appraisal and rewards effectively aligned
- Sub-Scale 4: Participation in decision-making and change

Meta-Scale 3: Feeling valued and empowered

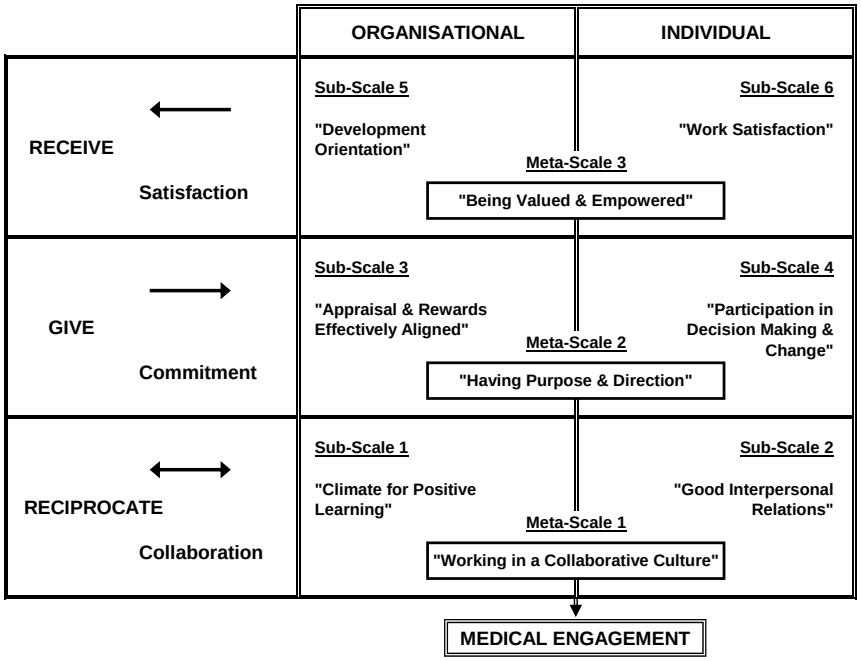
- Sub-Scale 5: Development orientation
- Sub-Scale 6: Work satisfaction



Furthermore, the structure of the MES comprises two ***types*** of engagement sub- scale: -

- **Three ORGANISATIONAL Sub-Scales (1, 3 and 5)** which reflect the cultural conditions which facilitate or inhibit medical staff to be more actively involved in leadership and management

- **Three INDIVIDUAL Sub-Scales (2, 4 and 6)** which reflect medical empowerment and confidence to tackle new management and leadership challenges



Brief definitions of each of the MES scales are shown in the table below.

MES Scale		Scale Definition *[The scale is concerned with the extent to which…..]*
Index:	**Medical Engagement**	**...doctors adopt a broad organisational perspective with respect to their clinical responsibilities and accountability**
Meta Scale 1:	**Working in a Collaborative Culture**	**...doctors have opportunities to authentically discuss issues and problems at work with all staff groups in an open and honest way**
Meta Scale 2:	**Having Purpose and Direction**	**…medical staff share a sense of common purpose and agreed direction with others at work particularly with respect to planning, designing and delivering services**
Meta Scale 3:	**Feeling Valued and Empowered**	**...doctors feel that their contribution is properly appreciated and valued by the organisation and not taken for granted**
Sub Scale 1: [O]	**Climate for Positive Learning**	**...the working climate for doctors is supportive and in which problems are solved by sharing ideas and joint learning**
Sub Scale 2: [I]	**Good Interpersonal Relationships**	**...all staff are friendly towards doctors and are sympathetic to their workload and work priorities.**
Sub Scale 3: [O]	**Appraisal and Rewards Effectively Aligned**	**...doctors consider that their work is aligned to the wider organisational goals and mission**
Sub Scale 4: [I]	**Participation in Decision-Making and Change**	**...doctors consider that they are able to make a positive impact through decision-making about future developments**
Sub Scale 5: [O]	**Development Orientation**	**...doctors feel that they are encouraged to develop their skills and progress their career**
Sub Scale 6: [I]	**Work Satisfaction**	**...doctors feel satisfied with their working conditions and feel a real sense of attachment and commitment to the organisation**

Complementary Approaches to Interpreting MES NORMS

To date, MES surveys have been undertaken in over 100 participating hospital Trusts and these have been used to establish a large, valid normative database consisting of the collated engagement ratings from over 12,500 members of medical staff. This main normative database provides a growing set of valid reference scale scores against which to benchmark the medical engagement profiles of all grades of doctor who work in healthcare organisations. The purpose of this report is to provide feedback about the relative levels of medical staff engagement at ***'ABMU UHB'*** based on statistical comparisons with the norms and to discuss the implications of these results with respect to helping identify the priority for potential managerial interventions.

There are two broad ways in which to consider the meaning of MES scale scores. For any particular staff sample or sub-sample in question, the first approach is based on calculating the mean (i.e. the average) scores for each of the ten MES scales and to compare the level of these averages scores with the external normative database. The second approach is based on comparing the frequency distribution of scores rather than comparing averages.

This second approach involves comparing the expected number of doctors who fell into different levels of engagement bands with the number of doctors actually observed within those bands at a particular site. In other words, this second method compares ***expected frequencies*** (i.e. derived from the norms) with ***observed frequencies*** (i.e. derived from the survey scores). Both methods are helpful in understanding the MES scale scores and their interpretation.

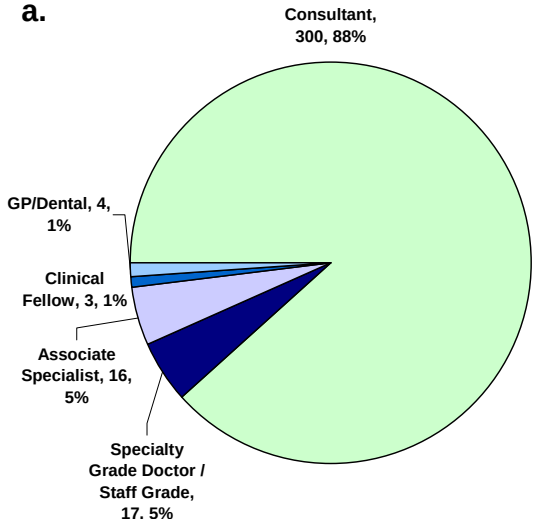
2) SURVEY RESULTS

a) Composition of the *'ABMU UHB'* Medical Sample

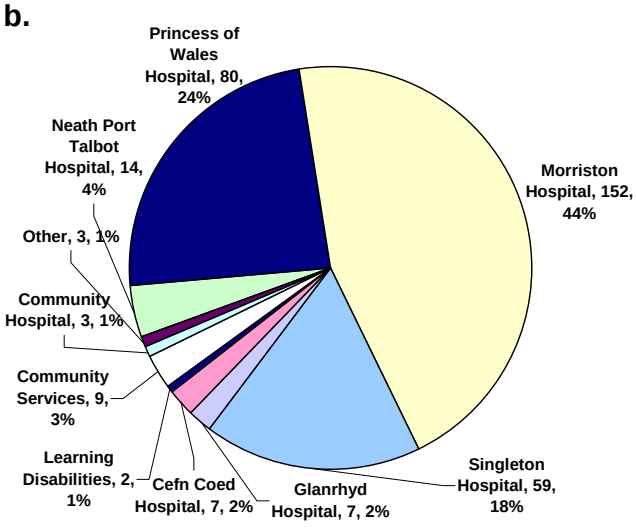
In all 340 members of medical staff participated in the current MES and the two pie charts and table shown below detail the percentage breakdown of MES survey respondents by:

a) **Staff Group**
b) **Main Base**
c) **Specialty**

a.



b.



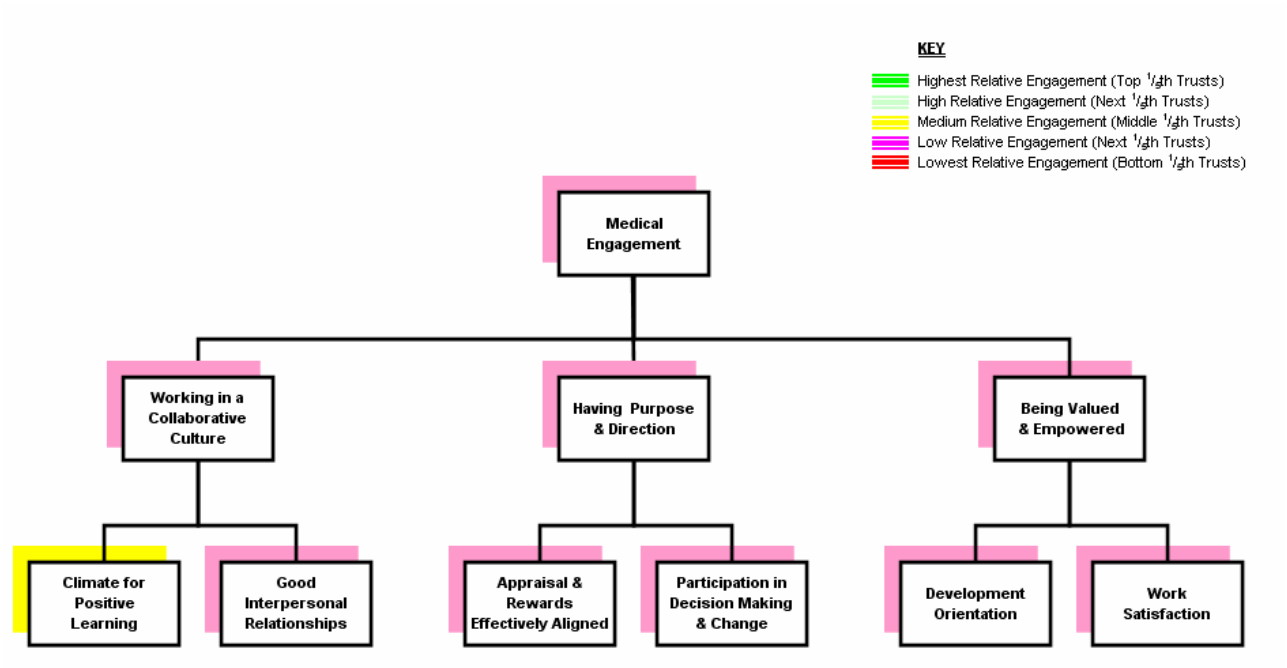
The low numbers of respondents in some specialties meant that further analysis for these was not pursued since this might prove statistically unreliable or could compromise the anonymity of medical staff respondents. For this reason, specialties with less than 5 respondents have been aggregated into 3 larger categories as detailed in the table overleaf.

Specialty	***Frequency***	***Percentage***
Accident & Emergency/Acute Medicine	17	5.0
Anaesthetics (including ITU & Critical Care)	59	17.4
Burns and Plastic Surgery	9	2.6
Cardiology	14	4.1
General Medicine (including Endocrinology, Gastroenterology, Respiratory, Stroke)	25	7.4
General Surgery (including Breast Surgery, Spinal Surgery)	23	6.8
Medicine for the Elderly	12	3.5
Mental Health (incl Adult, Old Age, Psychiatry)	28	8.2
Neurosciences	6	1.8
Obstetrics and Gynaecology	12	3.5
Oncology	11	3.2
Ophthalmology	6	1.8
Paediatrics	17	5.0
Pathology	10	2.9
Radiology	9	2.6
Renal Medicine	6	1.8
Trauma and Orthopaedics	14	4.1
* Combined Category 1 (Lower scoring pattern) *[Cardiothoracic Surgery, Oral and Maxillofacial Surgery, Thoracic Medicine, Vascular Surgery]*	*18*	5.3
* Combined Category 2 (Mid range scoring pattern) *[Community (incl. Frailty, Salaried GP's, GP Out of hours), ENT, Haemotology, Rehabilitation]*	*13*	3.8
* Combined Category 3 (Higher scoring pattern) *[Dermatology, Integrated Sexual Health Medicine, Learning Disabilities, Palliative Medicine, Rheumatology, Urology]*	*20*	5.9
No response	*11*	*3.2*

* Specialties with 5 or fewer responses

b) Average Levels of Medical Engagement

The average medical engagement scores for all Trusts in the external normative database (currently over 100 and growing) were ranked and split into five main engagement bands for each of the ten MES scales. These bands are defined in the table below and can range from high relative engagement (coloured *green*) to low relative engagement (coloured *red*). Based on all members of medical staff who completed the current MES survey (n = 340), the coloured hierarchical figure and the table below shows where this particular Trust fell with respect to the normative database.



The hierarchical MES figure shows that for the average of all responding medical staff, nine of the ten MES scales were rated within the ***low*** relative engagement band compared to the external norms (coloured *pink* in the hierarchy). The remaining MES scale (i.e. **Sub-Scale 1: Climate for Positive Learning)** was rated within the ***medium*** relative engagement band compared to the external norms (coloured *yellow* in the hierarchy).

These results indicate a fairly consistent low engagement response across the scales but it must be remembered that these are averages based on data aggregated across a number of organisational categories and consequently the 'peaks' and 'troughs' would inevitably tend to 'flatten out'. In order to examine the levels and pattern of medical engagement in greater detail, these overall results were disaggregated in several ways as shown below.

- **By Staff Group**
- **By Main Base**
- **By Specialty**
- **By Managerial Responsibility**

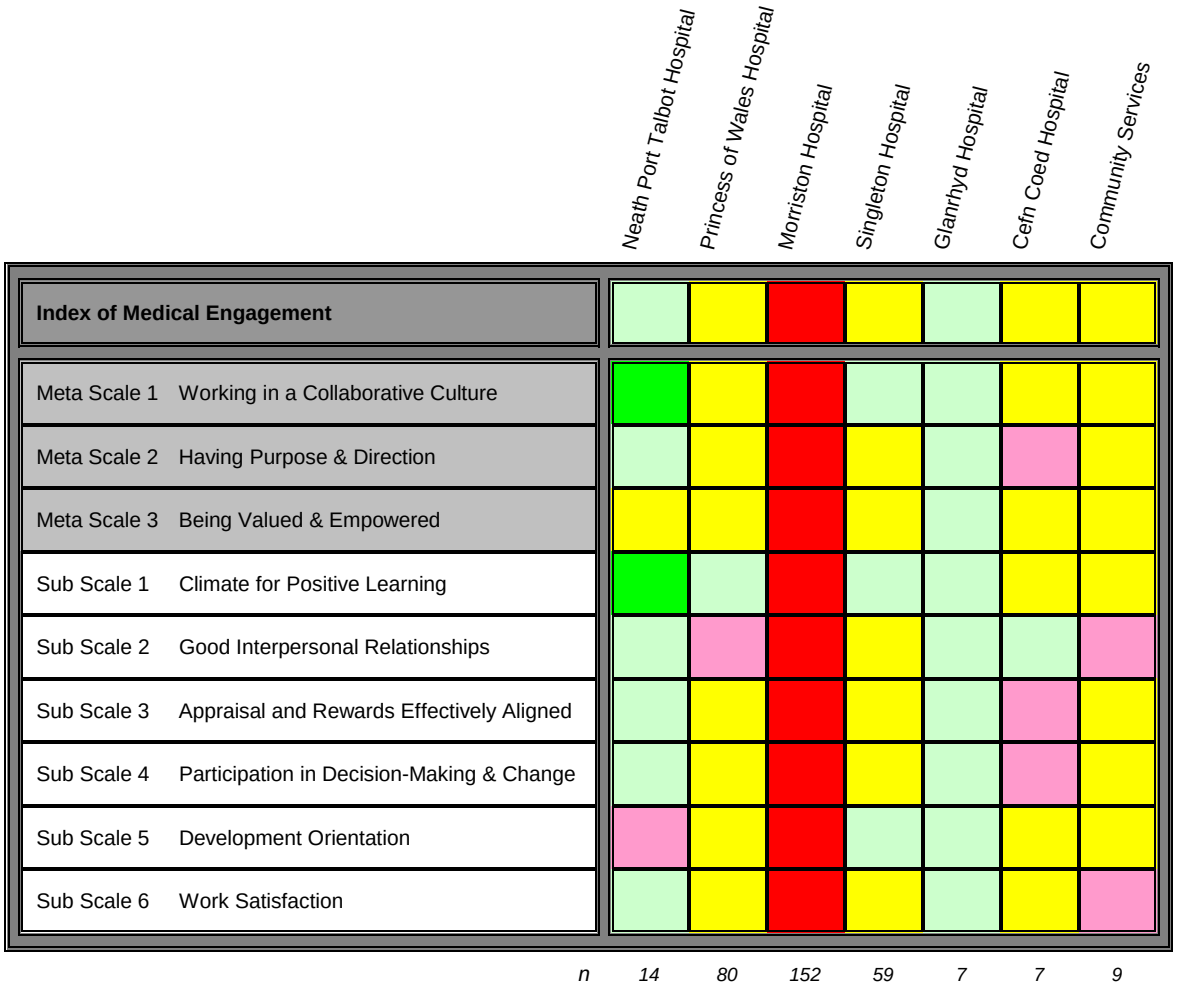
- ***Levels of Medical Engagement by Staff Group***

An inspection of the table below shows that, since the responding medical sample mainly comprised staff group ***'Consultants'*** (n = 300) their average levels of engagement paralleled the engagement profile for the ***'Whole Sample'*** (n = 340). Specifically, ***'Consultants'*** rated nine of the ten MES scales within the ***low*** relative engagement band compared to the external norms and one MES scale (i.e. **Sub-Scale 1: Climate for Positive Learning)** was rated a little more positively and fell within the ***medium*** relative engagement band compared to the external norms.

The table also shows that the other two staff groups both had a more 'mixed' engagement profile, although **Meta-Scale 3: Being Valued and Empowered** and it's two constituent subscales (i.e. **Sub-Scale 5: Development Orientation** and **Sub-Scale 6: Work Satisfaction**) were all rated in line with the ***lowest*** relative engagement band by both staff groups. Furthermore, although staff group ***'Associate Specialist'*** (n = 16) also rated **Sub-Scale 2: Good Interpersonal Relationships** in line with the ***lowest*** relative engagement band compared to the norms, they rated both **Meta-Scale 2: Having Purpose and Direction** and **Sub-Scale 4: Participation in Decision-Making and Change** the ***high*** relative engagement band

- ***Levels of Medical Engagement for Main Base***

In order to examine the levels and pattern of medical engagement within the seven ***Main Bases*** **i**n greater detail, the table below presents the levels of medical engagement associated with each of these locations.



It is apparent from the above table that when the aggregated medical engagement results are broken down to the finer-grain ***Main Base*** level, the engagement profiles of medical staff affiliated to each of these vary quite markedly.

Clearly, members of medical staff in affiliated to two ***Main Bases*** were, on average, predominantly ***highly engaged*** across most of the MES scales:-

Glanrhyd Hospital (n = 7) ***high*** engagement band on 10 MES scales

Neath Port Talbot Hospital (n = 14) ***highest*** engagement band on 2 MES scales
high engagement band on 6 MES scales

Members of medical staff affiliated to four ***Main Bases*** were, on average, predominantly ***moderately engaged*** across most of the MES scales:-

Community Services (n = 9) ***medium*** engagement band on 8 MES scales

Princess of Wales Hospital (n = 80) ***medium*** engagement band on 7 MES scales

Singleton Hospital (n = 59) ***medium*** engagement band on 7 MES scales

Cefn Coed Hospital (n = 7) ***medium*** engagement band on 6 MES scales

Members of medical staff affiliated to one ***Main Base*** were, on average, ***disengaged*** across all of the ten MES scales:-

Morriston Hospital (n = 152) ***lowest*** engagement band on 10 MES scales

It should be borne in mind that the dominance of the size of the medical staff sample affiliated to the Morriston Hospital (n = 152) has negatively influenced the overall organisation MES profile.

- ***Levels of Medical Engagement for Specialties***

In order to examine the levels and pattern of medical engagement within the ***Specialties*** in greater detail, the table shown overleaf presents the levels of medical engagement disaggregated by these categories.

As in the previous section, it is apparent from the table (overleaf) that when the aggregated medical engagement results are broken down to the finer-grain ***Specialty*** level, the engagement profiles of medical staff affiliated to the various specialties vary a great deal.

Clearly, members of medical staff in six ***Specialties*** were predominantly ***highly engaged*** (i.e. ***high*** or ***highest*** relative engagement bands compared to the external norms) across most of the MES scales: -

Pathology (n = 10) ***highest*** engagement band on 8 MES scales
high engagement band on 2 MES scales

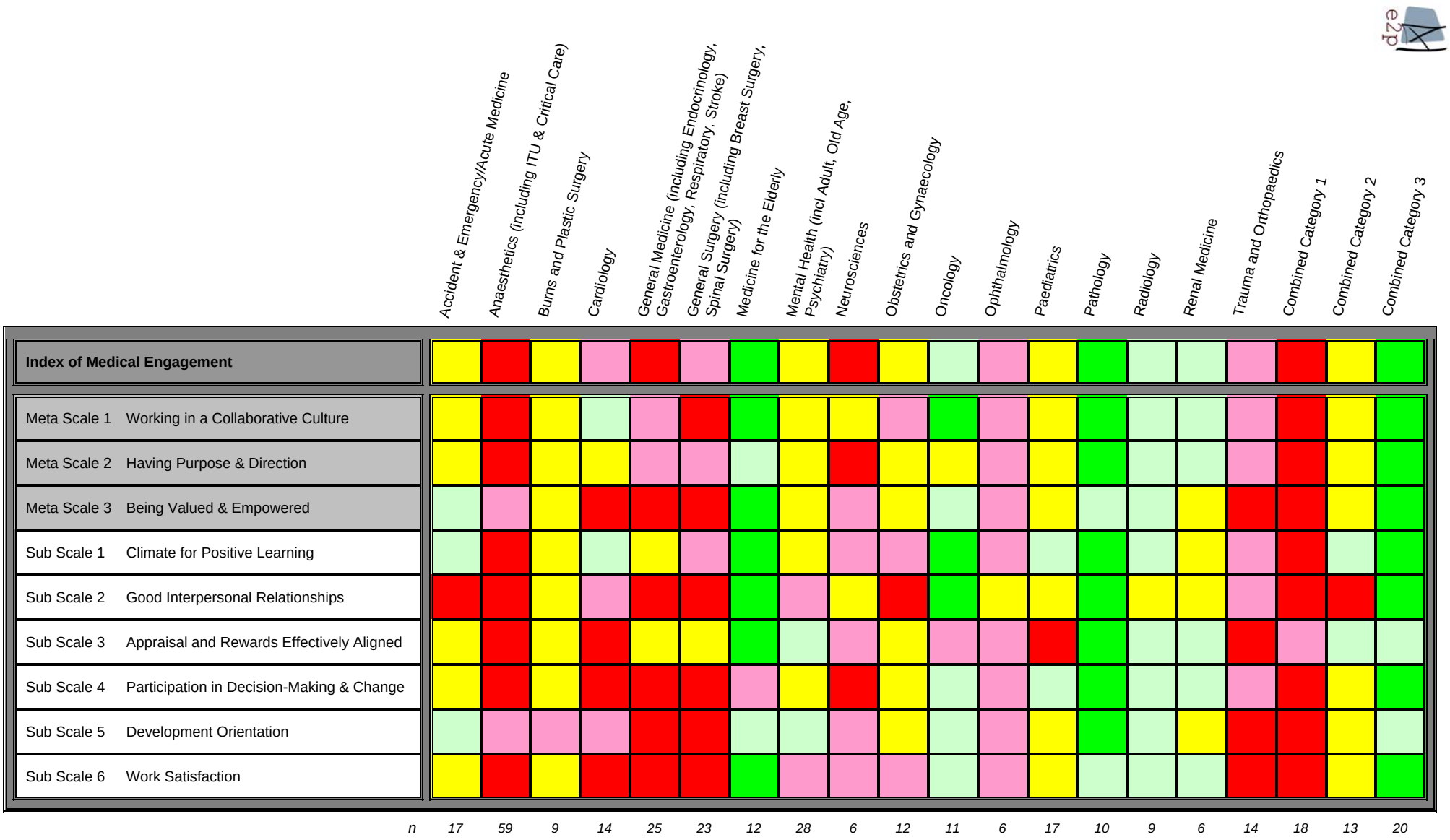
Combined Category 3 (n = 20) ***highest*** engagement band on 8 MES scales
high engagement band on 2 MES scales

Medicine for the Elderly (n = 12) ***highest*** engagement band on 7 MES scales
high engagement band on 2 MES scales

Oncology (n = 11) ***highest*** engagement band on 3 MES scales
high engagement band on 5 MES scales

Radiology (n = 9) ***high*** engagement band on 9 MES scales

Renal Medicine (n = 6) ***high*** engagement band on 6 MES scales


Accident & Emergency/Acute Medicine
Anaesthetics (including ITU & Critical Care)
Burns and Plastic Surgery
Cardiology
General Medicine (including Endocrinology, Gastroenterology, Respiratory, Stroke)
General Surgery (including Breast Surgery, Spinal Surgery)
Medicine for the Elderly
Mental Health (incl Adult, Old Age, Psychiatry)
Neurosciences
Obstetrics and Gynaecology
Oncology
Ophthalmology
Paediatrics
Pathology
Radiology
Renal Medicine
Trauma and Orthopaedics
Combined Category 1
Combined Category 2
Combined Category 3
Index of Medical Engagement
Meta Scale 1 Working in a Collaborative Culture
Meta Scale 2 Having Purpose & Direction
Meta Scale 3 Being Valued & Empowered
Sub Scale 1 Climate for Positive Learning
Sub Scale 2 Good Interpersonal Relationships
Sub Scale 3 Appraisal and Rewards Effectively Aligned
Sub Scale 4 Participation in Decision-Making & Change
Sub Scale 5 Development Orientation
Sub Scale 6 Work Satisfaction
n 17 59 9 14 25 23 12 28 6 12 11 6 17 10 9 6 14 18 13 20

Members of medical staff in six other ***Specialties*** were predominantly ***moderately engaged*** (i.e. ***medium*** relative engagement bands compared to the external norms) across most of the MES scales: -

Burns & Plastic Surgery (n = 9)	***medium*** engagement band on 9 MES scales
Paediatrics (n = 17)	***medium*** engagement band on 7 MES scales
Combined Category 2 (n = 13)	***medium*** engagement band on 7 MES scales
Obstetrics & Gynaecology (n = 12)	***medium*** engagement band on 6 MES scales
A & E /Acute Medicine (n = 17)	***medium*** engagement band on 6 MES scales
Mental Health (n = 28)	***medium*** engagement band on 6 MES scales

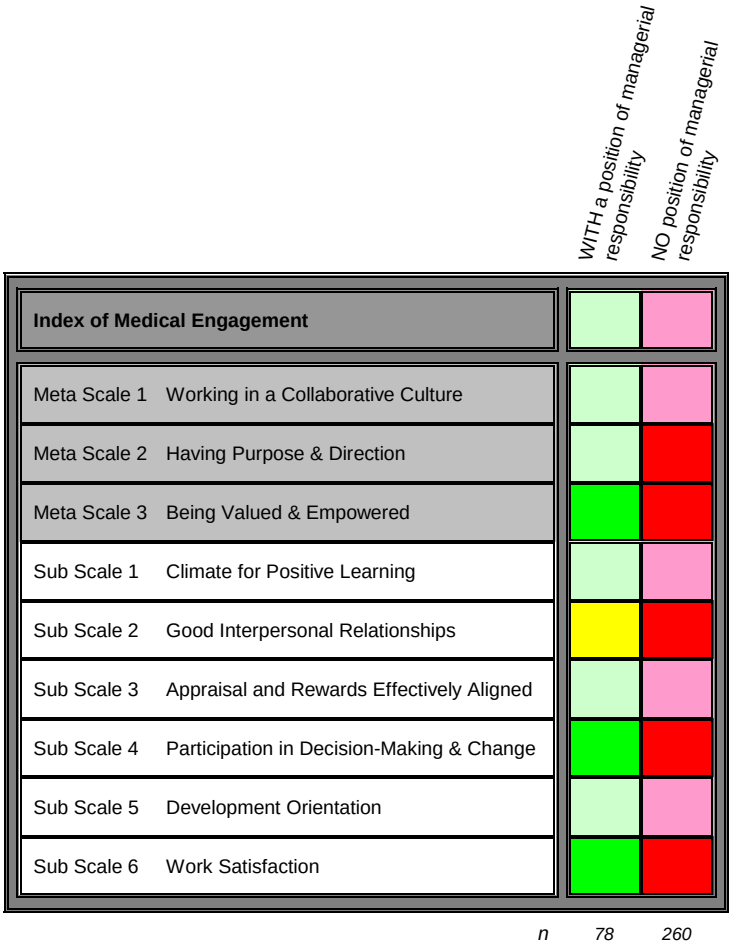
Finally, members of medical staff affiliated to eight ***Specialties*** were associated with a predominantly ***disengaged*** profile (i.e. ***low*** or ***lowest*** relative engagement bands compared to the external norms) across most of the MES scales: -

Combined Category 1 (n = 18)	***lowest*** engagement band on 9 MES scales ***low*** engagement band on 1 MES scale
Anaesthetics (n = 10)	***lowest*** engagement band on 8 MES scales ***low*** engagement band on 2 MES scales
General Surgery (n = 23)	***lowest*** engagement band on 6 MES scales ***low*** engagement band on 3 MES scales
General Medicine (n = 25)	***lowest*** engagement band on 6 MES scales ***low*** engagement band on 2 MES scales
Trauma & Orthopaedics (n = 14)	***lowest*** engagement band on 4 MES scales ***low*** engagement band on 6 MES scales
Cardiology (n = 14)	***lowest*** engagement band on 4 MES scales ***low*** engagement band on 3 MES scales
Neuroscience (n = 6)	***lowest*** engagement band on 3 MES scales ***low*** engagement band on 5 MES scales
Ophthalmology (n = 6)	***low*** engagement band on 5 MES scales

As with the previous data disaggregation by ***Main Bases***, the reasons for these ***Speciality*** fluctuations in medical engagement are not evident from inspecting the MES results in isolation from an understanding of 'on-the-ground' medical working conditions. Further probing at the local level should uncover the causes and consequences of identified low levels of engagement and point to ways in which these threats to optimal performance may be reduced.

- ***Levels of Medical Engagement and Managerial Responsibility***

A comparison of levels of engagement between those members of medical staff ***with*** a position of managerial responsibility (n = 78) compared to those medical staff ***without*** a position of managerial responsibility (n = 260) is summarised in the table below.



An examination of the table above shows that those members of medical staff ***with*** a position of managerial responsibility were more engaged with respect to all ten MES scales compared to their colleagues ***without*** a position of managerial responsibility. Medical staff respondents ***with*** a position of managerial responsibility were strongly engaged on all MES scales apart from **Sub-Scale2: Good Interpersonal Relationships**, which was rated a little less positively but was still within the ***medium*** relative engagement band compared to the norms. It may be that for some members of medical staff the demands of management are not always compatible with maintaining good working relationships with others.

In contrast to these findings, medical staff respondents ***without a*** position of managerial responsibility were disengaged on all MES scales and the biggest differences between the two medical staff groups occurred for the following three MES scales: -

- **Meta-Scale 3: Having Purpose & Direction**
- **Sub-Scale 4: Participation in Decision-Making & Change**
- **Sub-Scale 6: Work Satisfaction**

These scale differences highlight the key areas that characterise those members of medical staff who take on positions of managerial responsibility. Although the question of whether or not these aspects of engagement are the causes or consequences of medical staff assuming these expanded managerial roles is a moot point, nevertheless these results do suggest that these three engagement areas are very influential in maintaining high levels of medical engagement at ***'ABMU UHB'.***

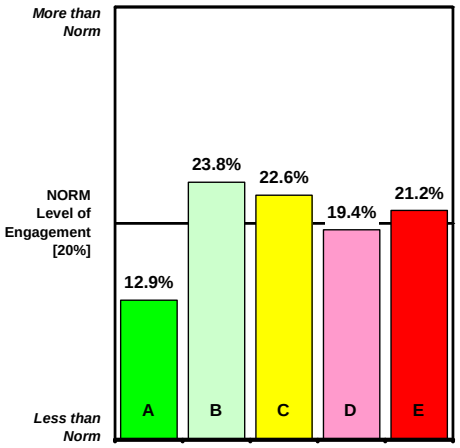
c) Distribution Profiles of Medical Engagement

We have seen in ***Section b)*** above that average scores can provide a useful summary of how all members of medical staff who participated in the engagement survey have rated all of the MES scales compared to the norms. Of course, averages only tell part of the story since similar averages may conceal very different underlying distributions of scores. Knowing the shape of these distributions is sometimes important in identifying the proportion of medical respondents who may be either strongly or weakly engaged with service design and delivery. In other words, it may be useful to identify 'clusters' of medical staff that are associated with relatively high or relatively low levels of engagement.

For each of the ten medical engagement scales in turn, the distribution of scores for all medical staff in the normative database (i.e. currently over 12,500 medical staff) were split into five bands of scores (labelled A to E) - the upper and lower limits of each band being adjusted so that 20% of doctors in the norms fell into each one. A set of histograms detailing the expected and observed frequency of members of medical staff affiliated to ***'ABMU UHB'*** is shown overleaf.

The interpretation of these histograms centres on examining the percentage deviation of the observed frequency distributions of the doctors' ratings (above or below) from the expected 20% norm line. If any of the doctors' histogram bars (i.e. A to E) fall above the 20% norm line, then they are rating above the level that we would expect from the external thresholds. Conversely, if any of the histogram bars (i.e. A to E) falls below the 20% norm line then this shows that there are a fewer number of doctors rating at this level than we would expect from the normative bandwidths. For this particular Trust, the ten histograms (shown overleaf) highlight the percentage of doctors who fell into each of these five bands of scores and this enables a comparison to be made between the profiles of medical engagement scores within this Trust compared to the group norm. Clearly, organisational efforts to enhance medical engagement should focus on areas where there are more relatively disengaged groups of medical staff.

Medical Engagement Index



AMBU UHB:

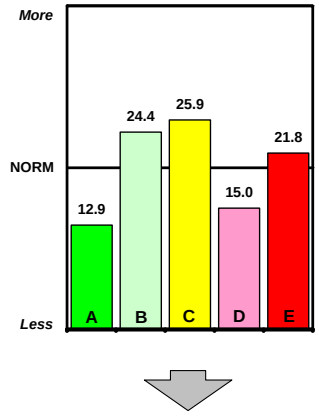
[Sample n = 340]

Relative Levels of Medical Engagement [Percentage of Medical Staff in 5 Bandwidths A - E]

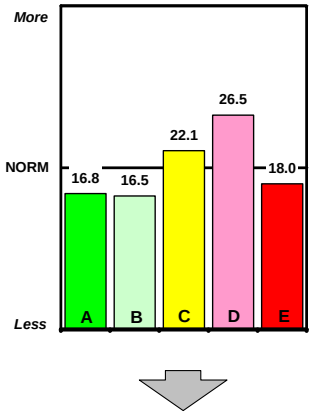
BANDS

A = Most Strongly Engaged Medical Staff
B = Strongly Engaged Medical Staff
C = Moderately Engaged Medical Staff
D = Weakly Engaged Medical Staff
E = Most Weakly Engaged Medical Staff

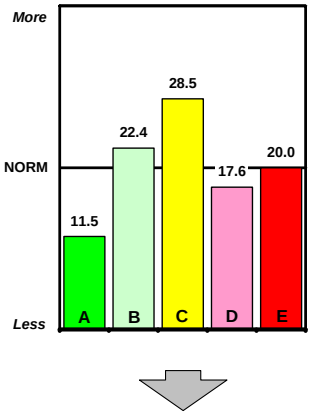
Meta 1: Working in a Collaborative Culture



Meta 2: Having Purpose & Direction

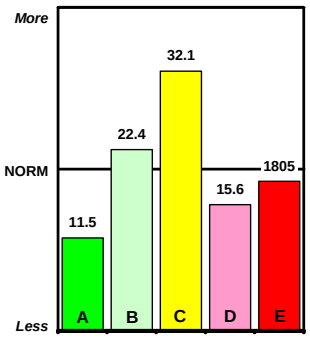


Meta 3: Being Valued & Empowered

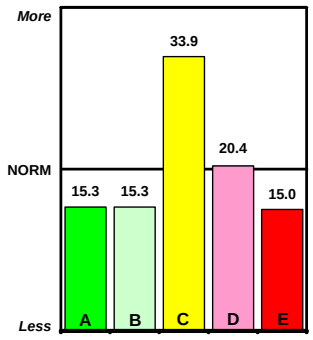


Sub-Scales

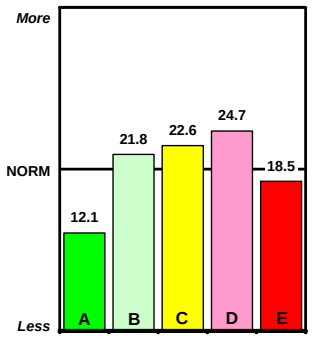
1: Climate for Positive Learning



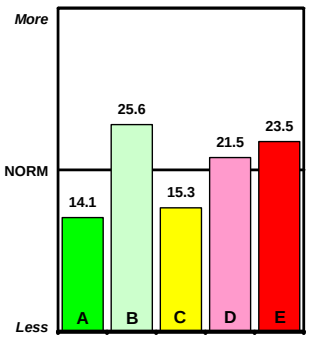
3: Appraisal & Rewards Effectively Aligned



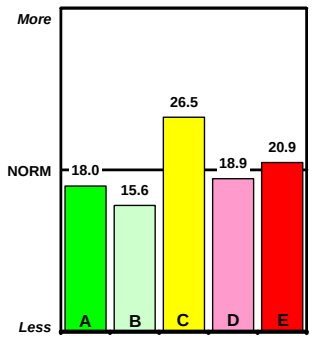
5: Development Orientation



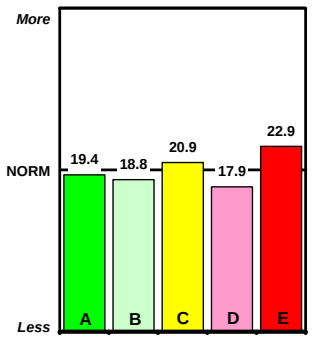
2: Good Interpersonal Relationships



4: Participation in Decision Making & Change



6: Work Satisfaction



The table below summarises percentages of all medical staff respondents who were the ***most engaged*** (i.e. Bands A and B) and the ***least engaged*** (i.e. Bands D and E) for each of the ten MES scales.

		Percentage Most Engaged (Bands A & B)	Percentage Least Engaged (Bands D & E)
MEI:	**Medical Engagement Index**	**37**	**41**
Meta-Scale 1:	**Working in a collaborative culture**	**37**	**37**
Meta-Scale 2:	**Having purpose and direction**	**33**	**45**
Meta-Scale 3:	**Feeling valued and empowered**	**34**	**38**
Sub-Scale 1:	**Climate for positive learning**	**34**	**34**
Sub-Scale 2:	**Good Interpersonal relationships**	**40**	**45**
Sub-Scale 3:	**Appraisal and rewards effectively aligned**	**31**	**35**
Sub-Scale 4:	**Participation in decision-making & change**	**34**	**40**
Sub-Scale 5:	**Development orientation**	**34**	**43**
Sub-Scale 6:	**Work satisfaction**	**38**	**41**

Although an examination of the above table shows that the profiles of medical engagement vary across the MES scales, it is also apparent that within each scale there are some variations in the frequency of medical staff reporting high and low levels of medical engagement. For example, 40% of all medical staff respondents were either ***'most strongly engaged'*** or ***'strongly engaged'*** (i.e. their ratings fell either in Band A or in Band B) with respect to **Sub-Scale2: Good Interpersonal Relationships.**

The frequency of medical staff respondents who were either ***'most weakly engaged'*** or ***'weakly engaged'*** (i.e. their ratings fell either in Band E or in Band D) was highest for **Meta-Scale 2: Having Purpose & Direction** (45%) and **Sub-Scale 2: Good Interpersonal Relationships** (45%) indicating the particular importance of sharing a common purpose with others and working in a supportive climate to sustaining medical engagement.

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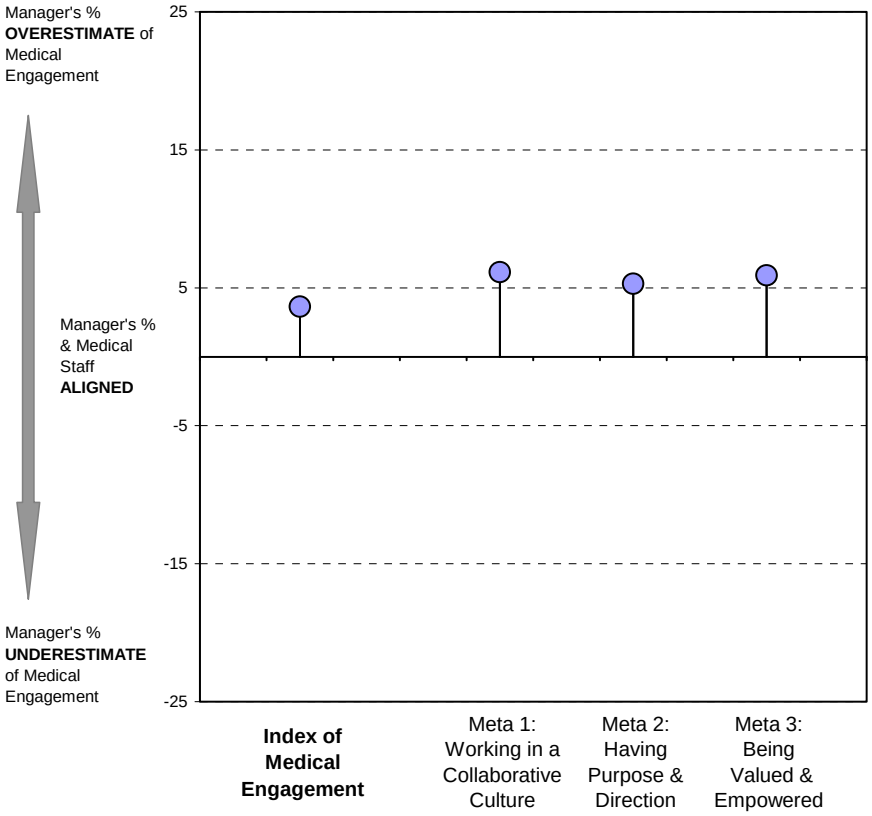
d) Alignment of Medical Ratings and Managerial Perceptions

In addition to medical staff completing the MES, a small sample of senior mangers (n = 6 in all) were asked to make an estimate of the percentage of engaged medical staff on each of the ten medical engagement scales. Differences between these estimates and actual percentages of engaged medical staff in this Trust were calculated and they indicate the extent to which managers and medical staff are aligned in their perceptions.

The figure below shows that, on average, senior managers appeared to ***slightly overestimate*** the overall **Index of Medical Engagement** on all three Meta-Scales (i.e. **Meta-Scale 1: Working in a Collaborative Culture, Meta-Scale 2: Having Purpose & Direction** and **Meta-Scale 3: Feeling Valued and Empowered**).

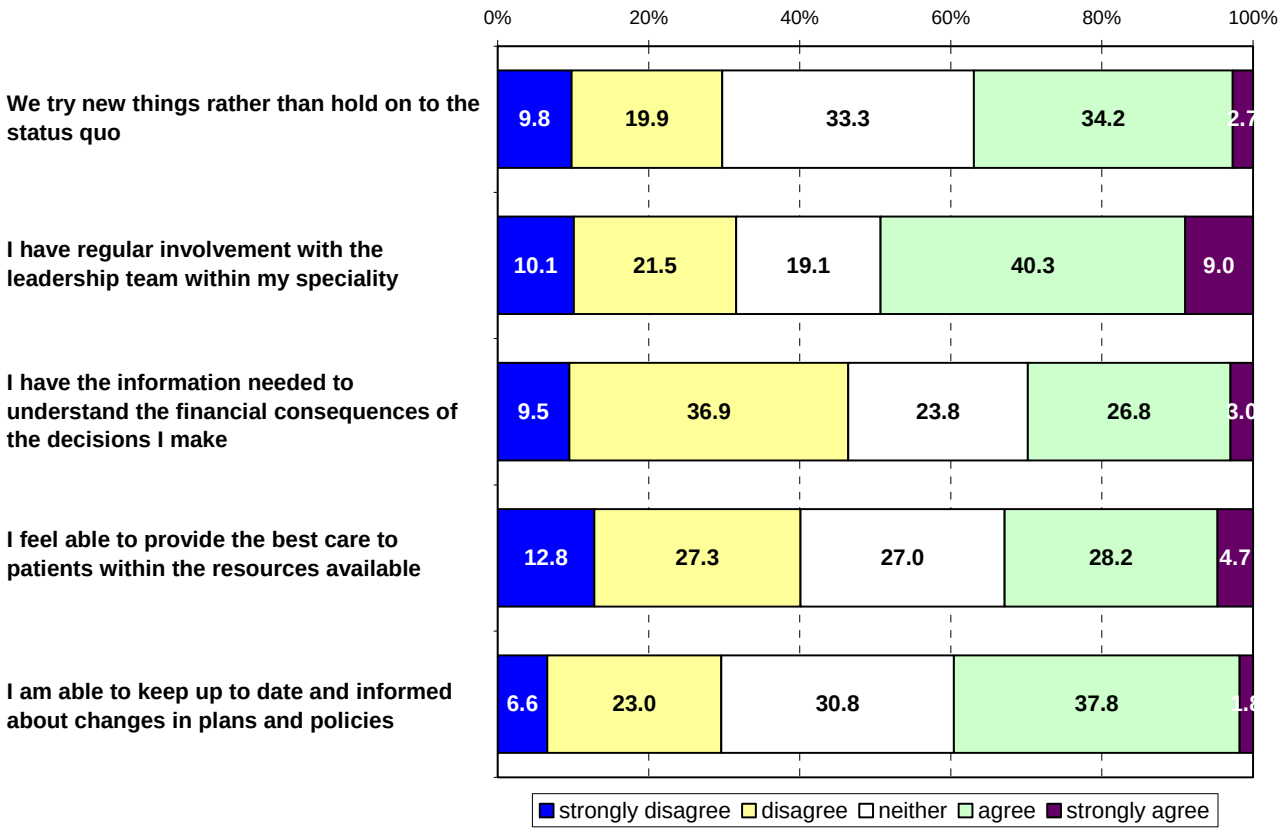


In this instance, the consistent tendency for managers to ***overestimate*** levels of medical engagement may reflect a managerial belief that some members of medical staff are more positively engaged than they actually consider themselves to be. Since, the survey results have confirmed that there are several 'pockets' of disengaged medical staff, this rather optimistic managerial perception may reflect low levels of management motivation to provide more facilitative opportunities for encouraging the development of medical staff engagement at ***'ABMU UHB'***. However, it must be remembered that the small sample of managers (n = 6) on which the results are derived are affiliated to a range of ***ABMU UHB*** organisations.

3) LOCAL QUESTIONS

Representatives of ***'ABMU UHB'*** had identified a number of local issues and these were included as two rating sections within the MES survey questionnaire in order to provide additional information about medical engagement. Respondents were asked to rate each item using a five-point level of agreement scale. The two stacked histograms shown below summarise the ranked ratings (i.e. the average level of item scores) of all respondents to each section.

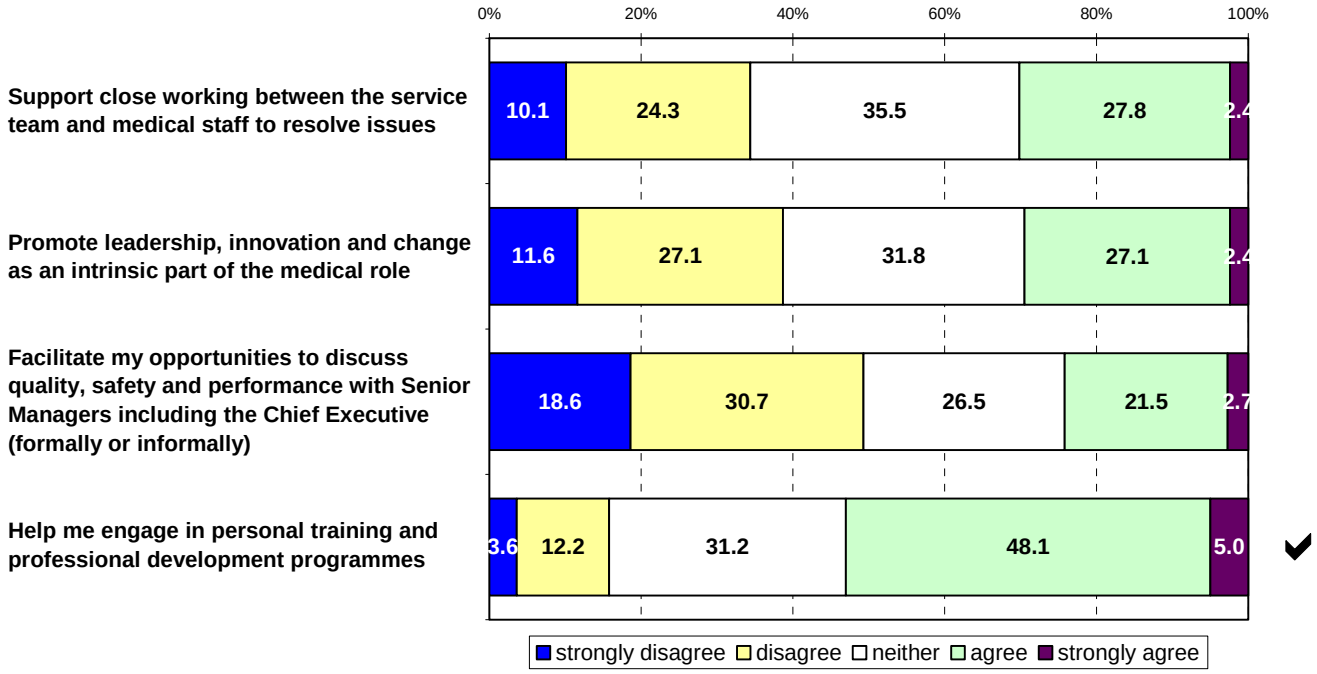
Generally, in this organisation....



The medical staff rating of these sections provided a 'mixed' picture of working in ***'ABMU UHB'***. For example**,** an examination of the ranked histograms shown above reveals that 49% endorsed (i.e. either ***'agreed'*** or ***'strongly agreed')*** that they have regular contact with the leadership team within their speciality but only 33% endorsed the statement that ***'I feel able to provide the best care to patients within the resources available'.***

Similarly, 53% endorsed (i.e. either ***'agreed'*** or ***'strongly agreed')*** that the working arrangements in the organisation helps them engage in personal training and professional development programs, whereas only 24% endorsed the statement that '***Working arrangements in this organisation facilitate my opportunities to discuss quality, safety and performance with Senior Managers including the Chief Executive (formally or informally).'*** (see histogram overleaf)

The working arrangements in this organisation….



The stacked histograms shown above summarise the level of endorsement (in percentages) of all medical staff respondents who rated these two sets of local questions. An examination of these histograms shows that some items were associated with a level of acceptance of 50% or more (i.e. these items had been rated either ***agree*** or ***strongly agree*** by a majority of medical staff respondents) whereas some items were associated with a level of rejection of 50% or more (i.e. these items had been rated either ***disagree*** or ***strongly disagree*** by a majority medical staff respondents).

To assist rapid interpretation, these ***'majority acceptance'*** and ***'majority rejection'*** items are identified on the stacked histograms using a tick or a cross where appropriate and highlight the broad pattern of medical opinion in the organisation. (Please note that there are no ***'majority rejection'*** items for this organisation).

4) OPEN ITEMS

Three additional items were included within the ***'ABMU UHB'*** MES survey questionnaire in order to provide further information about medical engagement within the organisation. The three open items were as follows:

- ***Open Item 1:*** ***'Please suggest ways that the organisation could promote better working arrangements to support care across the integrated care pathway.'***

- ***Open Item 2:*** ***'Please suggest ways in which the service could enable you to keep up to date about changes in plans and policies.'***

- ***Open Item 3:*** ***'Please suggest ways in which the service could enable you to become more involved in influencing decision-making about services.'***

The responses to each open item were analysed independently although for some medical staff respondents there was a deal of overlap in the issues that were mentioned in response to each of the three items. Overall, 42 % of the total medical sample commented on Open ***Item 1***, 36 % responded to ***Open Item 2***, and 38 % provided comments in response to ***Open Item 3***.

- ***Content Analysis of Open Item 1*** ***– 'Please suggest ways that the organisation could promote better working arrangements to support care across the integrated care pathway.'***

Content analysis of the aggregated open comments for this item revealed that there were three main themes which conveyed the key ideas in the combined collection of responses.

(a) Good Care
(b) Care Pathway
(c) Management Issues

In order to present the most central issues as described by the medical staff themselves and to enable the reader to rapidly get the gist of current medical concerns, a sample of representative comments made with respect to each of the identified key themes are shown below:-

Theme (a) Good Care

"Staff need to be models of good care, with hand washing, picking up rubbish, taking action where there is dirt and rubbish, not tolerating poor aspects of care."

"The clinicians genuinely try to work together to provide good care, it is the facilities and infrastructure that prevent us from doing so."

"There is no simple mechanism to abolish the waste into something more constructive that adds value to health care"

"Good care cannot be provided when patients are treated in ambulances outside A&E. Good care cannot be provided when patients wait 23 hours in A&E for a ward bed prior to surgery."

"There is lot of overlap in care and there is room for streamlining."

“Delayed transfer of care or delayed discharges need to be dealt with more strongly, possibly with legislation, as it prevents others in need of care from being admitted"

“For starters I'm not convinced that we have integrated care pathways except, in some cases, in name which is ironic because the name is the least useful feature of 'integrated care pathway’."

“Care delivered by this sort of service will not be integrated”

Theme (b) Care Pathway

“Clear pathway for who is responsible for the care of the patient.”

“Decrease the fragmented care patient receives and give a holistic care approach to the patient.”

“Care pathways are best kept simple with named people roles who are meant to be responsible at particular points in the care pathway and time targets should be stated too.”

“Two pathways have been sent to me this year after they were completed and the department I work in is pivotal within the pathway but were never consulted in its development.”

“Allow staff to follow patient journey through the whole pathway so they see how they play a part in the overall standard and experience of care.”

“Clear pathway for decision making when patient is being looked after more than one specialty”

“Opportunities for development and innovation are limited by time and resource constraints, and reluctance from other links in the pathway due to the same pressures on their services.”

“Clinicians have become operatives in a poorly managed clinical process where tier upon tier of incompetent management has been imposed to control, measure and ultimately destroy clinical care pathways"

"Complex care pathways help no one as they are difficult to stick to and do not achieve the targeted goal.”

“Better information to see the whole pathway.”

Theme (c) Management Issues

"Managers are all tied up with the micromanagement of daily crises due to lack of beds and staff not surprisingly, there is minimal strategic planning.”

"Employ clinical managers who actually engage with, and appreciate the staff, care about the important issues instead of irrelevant nonsense, listen to ideas instead of either doing the minimum, or concentrating on petty issues."

“Simply saying, we've put x staff through IQT is helpful but without the foundations of continuous transparent measurement it's not enough.”

“There is a poor link between activity and personal reward, both professionally and financially for many members of staff.”

"Management in allowing staff to work in a poor environment are allowing standards to drop."

"The changes in the 'role of the personnel department' that occurred about 15 years ago when 'HR' appeared has contributed to the gradual change that has taken place in our ability to attract and retain staff."

- ***Analysis of Open Item 2 – 'Please suggest ways in which the service could enable you to keep up to date about changes in plans and policies.'***

Content analysis of the aggregated open comments for this item revealed that three main themes were evident.

(a) Communicating Change
(b) Staff Involvement
(c) Effective Meetings

The sub-sets of open comments most applicable to each of the themes were identified in turn and verbatim examples of the most representative comments are shown below.

Theme (a) Communicating Change

"Inform anaesthetic dept of changes in surgical list allocation in a timely fashion, both for long term permanent changes which impact on anaesthetic job plans, and the short term daily changes."

"The other thing that would assist most in helping staff keep up to date with changes in plans is to get the staff involved assisting in making the decisions and measuring the impact of the changes."

"The intranet page is an excellent means of keeping up to date about changes including regular updates in clinical governance meetings."

"Too many 50 page documents of expensive management jargon emailed to everybody - this is not a good way of informing staff of 'developments'."

"Frequent short bulletins about change and why it is necessary i.e. whim of politicians etc."

"Only change what is broken and prioritise the fixing to reduce the tsunami of changes."

"Many changes have no evidence to back them and appear to be a whim of management."

"Ensure mailing lists are up to date so that whoever needs to know is informed about planned policy changes as they occur."

Theme (b) Staff Involvement

"The other thing that would assist most in helping staff keep up to date with changes in plans is to get the staff involved assisting in making the decisions and measuring the impact of the changes."

There will always be a disenfranchisement if staff feel plans and changes are being imposed on them, that fundamentally those plans and policies are not that likely to work because they have been designed not by those affected."

"Many changes have no evidence to back them and appear to be a whim of management."

"Staff fail to engage with the service, e.g. at MSAC meetings because the general feeling is that their views are ignored anyway"

"Involve senior medical staff in decisions re: change."

Theme (c) Effective Meetings

"Have regular meetings with medical staff to plan services."

"There is no longer a regular consultants or directorate meeting within Medicine"

"By coming to audit/directorate meetings to discuss potential changes, rather than bringing them in as a fait accompli."

"Team briefs are helpful but we do not always have the time to attend meetings in person. Better communications from directorate and face-to-face meeting with stimulations to senior medical staff to attend interactive sessions built into their job plan."

"Circulate directorate meeting minutes to all the staff have open the possibility for suggestions and/or participation to the meetings."

"Do not make the times of these meetings unrealistic and do not destroy every lunch time."

"Pre-empt the meetings with circulars and ask for opinions on those circulars BEFORE the meetings to be discussed."

"There should be meetings to update consultants and their view points should be sought."

- ***Analysis of Open Item 3 – 'Please suggest ways in which the service could enable you to become more involved in influencing decision-making about services.'***

Content analysis of the aggregated open comments for this item revealed that three main themes were evident.

(a) Closer Management Contact
(b) Consultation and Decision-Making
(c) Medical Role

The sub-sets of open comments most applicable to each of the themes were identified in turn and verbatim examples of the most representative comments are shown below.

.

Theme (a) Closer Management Contact

"A major concern shared by many is the additional layer of management between senior managers and the executive, created by development of the managed units."

"There is a feeling that senior management have no idea of the day to day stresses of working 'on the shop floor'."

"There is no visibility of senior management."

“Middle management seen to live in terror of upsetting senior management in any way such as disagreeing with policy or change and if anything goes wrong.”

“Clinical directors take orders from senior management and impose them irrespective of the services requirements.”

“Management I feel NEEDS TO MEET regularly with the clinicians to exchange ideas and understand our concerns.”

“Is it a constant refrain from the more junior staff that they wouldn't know who some of the senior management were if they passed them in the corridor.”

“I have no enthusiasm to become involved with more senior management.”

Theme (b) Consultation and Decision-Making

“It is regular occurrence that the staff become aware of changes on the day they are implemented, specially at middle and junior grade levels, without having any idea what those decisions were based on and why they are being implemented.”

"Recognising that as clinicians we have a very patient focused view and that our input to decisions is paramount, supporting us as clinicians to develop our leadership skills at multiple levels according to how involved we are with leadership.”

“Although consultations occur it is largely the feeling that the decisions have been made and that no matter what people think the changes will occur anyway.”

"A major concern shared by many is the additional layer of management between senior managers and the executive, created by development of the managed units."

“The message is that of being a supportive caring trust to work in, but at the top it is vicious/cut throat/intimidating/bullying which puts staff off aspiring to management roles"

"It’s all very well asking us to get involved, but more often than not the individual consultant on the shop floor is just told what is happening to their service rather than their voice being listened to.”

“Invite SAS doctors to the forums (if there are any). I get the impression in General adult mental health that everyone is working flat out to keep up to speed with the outpatient demand and there is little time to influence/bring about change.”

“Although consultations occur it is largely the feeling that the decisions have been made and that no matter what people think the changes will occur anyway.”

Theme (c) Medical Role

“Asking and taking into account relevant medical staff's opinions PRIOR to instituting changes which may impact on their roles.”

“It's clear that the main reason to appoint clinicians to managerial roles is for them to shoulder the responsibility without giving them the power to make change.”

“Be allowed to take managerial roles.”

"A change of Management culture: to listen and understand professional ethics and duty to patients and team is the clinicians primary focus.”

5) SUGGESTED INTERVENTIONS

The MES methodology is based upon a model of medical engagement that differentiates organisational conditions from individual motivations in facilitating or inhibiting doctors to assume more proactive roles in shaping the organisations in which they work. In other words, the MES approach not only focuses on how individual doctors may become involved in a wider agenda but also takes account of organisational conditions that may impact upon perceived medical opportunities to become more engaged. Since less than optimal 'up-stream' organisational characteristics (in the cultural, structural and managerial control domains) impact upon medical staff at the 'sharp end', in this section of the report, some tentative suggestions are made about where management might best focus its attention in order to promote medical engagement at ***'ABMU UHB'***.

On the one hand, management interventions may be large-scale, Trust or Hospital-wide programmes directed at large groups of medical staff or, on the other hand, interventions may be small-scale, specific and focused on small clusters of staff. To ensure relative stability of the intervention recommendations for both large and small groups of doctors, the reference norms used to identify suggested intervention strategies for large groups (i.e. medical groups comprising more than approx. 15 - 20 members) are based on average scale scores for Trusts (currently over 100 Trusts in all). In contrast, the reference norms used to identify suggested intervention strategies for small groups (i.e. medical groups comprising less than approx. 15 - 20 members) are based on average scale scores for individual doctors (currently 12,500 doctors in all).

For both types of normative comparison, the aim is to view the MES results from an ***action priority perspective*** where engagement levels correspond to three levels of management intervention priorities. In order of priority, these potential management intervention strategies have been labelled as follows:

M = Monitor & Maintain Effectiveness – (i.e. high average engagement)

I = Scope for Improvement - (i.e. medium average engagement)

P = Priority for Development – (i.e. low average engagement)

It is clear from an examination of the three figures overleaf that there are numerous areas that have been highlighted as a ***Priority for Development***. In this first table, the MES results are presented at the ***Whole Sample*** and disaggregated at the ***Staff Group level***. In the second table, the MES results are presented disaggregated by ***Main Base level*** and in the third table, the MES results are disaggregated at the ***Specialty*** level. In all three tables, suggested interventions are presented as relative priorities in order to highlight where focussed management efforts may best be directed.

For example, at the ***Main Base*** level, the low engagement levels for members of staff in ***Morriston Hospital*** suggests that urgent intervention is necessary across all of the scales of the MES. Similarly, at the Specialty level, urgent intervention across all MES scale areas is also indicated for medical staff affiliated to ***Anaesthetics.***

However, the intervention tables identify a wide range of priority areas for greater management attention and these clearly require further careful investigation at the local level to fully understand the reasons for lack of medical engagement and to identify and target feasible cost-effective enhancements.

Suggested Strategies for Promoting Medical Engagement at Staff Group Levels

KEY: Action Priority

- P — Priority for Development
- I — Scope for Improvement
- M — Monitor & Maintain Effectiveness

	Whole Sample	Consultant	Specialty Grade Doctor / Staff Grade	Associate Specialist	
Meta-Scale 1: Working in a collaborative culture	I	I	I	P	**Ensure all staff are willing and able to work together productively and effectively** Provide support for all staff to collaborate effectively in shaping service change Improve the competence of all staff to build friendly and productive joint working relationships Ensure open discussion and equitable sharing of information, power and resources
Meta-Scale 2: Having purpose and direction	P	P	P	I	**Ensure all staff share a strong commitment to service quality as a core concern** Ensure committment to service quality is the key concern for both individuals and the organisation Demonstrate improving patient services and outcomes are a shared committment of all staff Encourage all medical staff to actively commit to planning, designing and delivering change
Meta-Scale 3: Feeling valued and empowered	P	I	P	P	**Ensure all staff understand that their contribution is understood and valued** Explore and promote the importance of shared values and beliefs between all staff groups Ensure that all staff are aware of how their contribution is appreciated and valued Match job duties and roles to individual staff skills so that staff time and efforts are not wasted
Sub-Scale 1: Climate for positive learning	I	I	I	I	**Promote a collaborative culture which supports multi-disciplinary working and learning** Establish interdisciplinary teams who work together to facilitate operational or strategic change Promote a climate of mutual support and joint learning to discuss organisational issues Publicise successful collaboration schemes as examples of good working practices
Sub-Scale 2: Good Interpersonal relationships	P	P	I	P	**Encourage open and honest communication with a trusting and cooperative work style** Encourage all medical staff to adopt collaborative and and cooperative working roles Promote a climate of trust where talk and action are coherent and consistent Develop communication channels that support effective cooperative working
Sub-Scale 3: Appraisal and rewards effectively aligned	I	I	P	I	**Recognise and reward doctors' commitment to achieving organisational goals** Assess individual doctor's performance and committment to achieving organisational goals Develop activities in which both managers and medics are keen to see succeed Introduce incentive schemes to recognise and reward doctors' committment to pursuing change
Sub-Scale 4: Participation in decision-making & change	P	P	I	M	**Develop doctors' roles to enhance participation in organisational decision-making** Identify and support work roles that organisationally-committed medical staff should perform Promote joint responsibility and committment to organisational decisions by all staff Develop structures and processes whereby medical staff can take a full part in decision-making
Sub-Scale 5: Development orientation	P	I	P	P	**Facilitate greater opportunities for the professional development of medical staff** Train all medical staff in project leadership and change management skills Support medical staff to achieve their personal and professional goals Provide facilities for medical staff to update and keep abreast of professional developments
Sub-Scale 6: Work satisfaction	I	I	P	P	**Provide working conditions and structures for medical staff to become involved in change** Promote a climate and culture for medical staff to feel supported and valued Incorporate work improvements for medical staff within service change initiatives Ensure all medical staff feel able to have a voice in the futrue direction of the organisation

Suggested Strategies for Promoting Medical Engagement at Base Level

KEY: Action Priority

- P — Priority for Development
- I — Scope for Improvement
- M — Monitor & Maintain Effectiveness

	Neath Port Talbot Hospital	Princess of Wales Hospital	Morriston Hospital	Singleton Hospital	Glanrhyd Hospital	Cefn Coed Hospital	Community Services	
Meta-Scale 1: Working in a collaborative culture	M	I	P	I	M	I	I	**Ensure all staff are willing and able to work together productively and effectively** Provide support for all staff to collaborate effectively in shaping service change Improve the competence of all staff to build friendly and productive joint working relationships Ensure open discussion and equitable sharing of information, power and resources
Meta-Scale 2: Having purpose and direction	M	I	P	I	M	P	I	**Ensure all staff share a strong commitment to service quality as a core concern** Ensure committment to service quality is the key concern for both individuals and the organisation Demonstrate improving patient services and outcomes are a shared committment of all staff Encourage all medical staff to actively commit to planning, designing and delivering change
Meta-Scale 3: Feeling valued and empowered	I	I	P	I	I	I	I	**Ensure all staff understand that their contribution is understood and valued** Explore and promote the importance of shared values and beliefs between all staff groups Ensure that all staff are aware of how their contribution is appreciated and valued Match job duties and roles to individual staff skills so that staff time and efforts are not wasted
Sub-Scale 1: Climate for positive learning	M	I	P	M	M	I	I	**Promote a collaborative culture which supports multi-disciplinary working and learning** Establish interdisciplinary teams who work together to facilitate operational or strategic change Promote a climate of mutual support and joint learning to discuss organisational issues Publicise successful collaboration schemes as examples of good working practices
Sub-Scale 2: Good Interpersonal relationships	M	P	P	I	I	M	P	**Encourage open and honest communication with a trusting and cooperative work style** Encourage all medical staff to adopt collaborative and and cooperative working roles Promote a climate of trust where talk and action are coherent and consistent Develop communication channels that support effective cooperative working
Sub-Scale 3: Appraisal and rewards effectively aligned	M	I	P	I	M	I	I	**Recognise and reward doctors' commitment to achieving organisational goals** Assess individual doctor's performance and committment to achieving organisational goals Develop activities in which both managers and medics are keen to see succeed Introduce incentive schemes to recognise and reward doctors' committment to pursuing change
Sub-Scale 4: Participation in decision-making & change	M	I	P	I	M	P	I	**Develop doctors' roles to enhance participation in organisational decision-making** Identify and support work roles that organisationally-committed medical staff should perform Promote joint responsibility and committment to organisational decisions by all staff Develop structures and processes whereby medical staff can take a full part in decision-making
Sub-Scale 5: Development orientation	P	I	P	M	M	I	I	**Facilitate greater opportunities for the professional development of medical staff** Train all medical staff in project leadership and change management skills Support medical staff to achieve their personal and professional goals Provide facilities for medical staff to update and keep abreast of professional developments
Sub-Scale 6: Work satisfaction	M	I	P	I	M	I	P	**Provide working conditions and structures for medical staff to become involved in change** Promote a climate and culture for medical staff to feel supported and valued Incorporate work improvements for medical staff within service change initiatives Ensure all medical staff feel able to have a voice in the futrue direction of the organisation

Suggested Strategies for Promoting Medical Engagement at Specialty Level

	Accident & Emergency/Acute Medicine	Anaesthetics	Burns and Plastic Surgery	Cardiology	General Medicine	General Surgery	Medicine for the Elderly	Mental Health	Neurosciences	Obstetrics and Gynaecology	Oncology	Ophthalmology	Paediatrics	Pathology	Radiology	Renal Medicine	Trauma and Orthopaedics	Combined Category 1	Combined Category 2	Combined Category 3	
Meta-Scale 1: Working in a collaborative culture	I	P	I	I	P	P	M	I	I	P	M	I	I	M	M	I	I	P	I	M	**Ensure all staff are willing and able to work together productively and effectively**
Meta-Scale 2: Having purpose and direction	I	P	I	P	P	P	M	I	P	I	I	P	I	M	M	M	P	P	I	M	**Ensure all staff share a strong commitment to service quality as a core concern**
Meta-Scale 3: Feeling valued and empowered	I	P	I	P	P	P	M	I	P	I	M	P	I	M	M	I	P	P	I	M	**Ensure all staff understand that their contribution is understood and valued**
Sub-Scale 1: Climate for positive learning	M	P	I	M	I	I	M	I	P	I	M	P	I	M	M	I	I	P	I	M	**Promote a collaborative culture which supports multi-disciplinary working and learning**
Sub-Scale 2: Good Interpersonal relationships	P	P	I	P	P	P	M	P	I	P	M	I	I	M	I	I	P	P	P	M	**Encourage open and honest communication with a trusting and cooperative work style**
Sub-Scale 3: Appraisal and rewards effectively aligned	I	P	I	P	I	I	M	I	P	I	I	P	I	M	M	M	P	P	I	M	**Recognise and reward doctors' commitment to achieving organisational goals**
Sub-Scale 4: Participation in decision-making & change	I	P	I	P	P	P	I	I	P	I	M	P	M	M	M	M	P	P	I	M	**Develop doctors' roles to enhance participation in organisational decision-making**
Sub-Scale 5: Development orientation	M	P	P	P	P	P	M	I	P	I	M	P	I	M	M	I	P	P	I	M	**Facilitate greater opportunities for the professional development of medical staff**
Sub-Scale 6: Work satisfaction	I	P	I	P	P	P	M	I	P	I	M	P	I	M	M	M	P	P	I	M	**Provide working conditions and structures for medical staff to become involved in change**

KEY: Action Priority

- P — Priority for Development
- I — Scope for Improvement
- M — Monitor & Maintain Effectiveness

6) THE WELSH PERSPECTIVE

The purpose of this report was to present the findings of the recent MES Survey at ***'ABMU UHB'***. The current results have been benchmarked against our established MES database comprising over 100 NHS Trusts and a sample of over 12,500 members of medical staff.

The survey data from ***'ABMU UHB'*** has been combined with the survey data from all of the other participating Welsh Health Boards and a Welsh normative database has been established. The 'Pan-Wales' medical engagement report will present the comparative medical engagement profiles for health organisations, medical staff groups and common specialties.