Clinician engagement: Scoping paper

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Foreword

This scoping paper contains a detailed analysis of the state of clinician engagement in Victoria and ideas and opportunities for the Department of Health and Human Services (DHHS; the department) to improve this state. The focus of the recommendations is on actions that the department could take.

There are two reasons to seek staff engagement. The first is to obtain their participation in improvement activities designed to create better, safer care. This occurs at the service level, and for the department, good clinician engagement will improve the intent, effectiveness and acceptability of health service policy.

The second is to ensure that clinicians flourish. At the very least, their work needs to be sufficiently rewarding to allow them to maintain a state of wellness. Developing a suitable work environment to achieve this is largely a direct employer responsibility. However, the Department of Health and Human Services as system manager can also influence this.

Health care is increasingly complex, and the experience for patients can be unreliable and sometimes dangerous. Engaged staff create safer care. A rural medical clinician has even suggested that disasters are due to failure of clinical engagement. At the local level, engagement of clinicians in the redesign of care is critical, but also challenging. This respondent puts the issue elegantly:

> 'Clinicians are already heavily engaged in the welfare of their patients. The challenge for us is to harness their zeal in the continuous improvement of the broader system. To do this we must make the connection between system improvement and better care for their patients.' (regional public health service nurse)

A very large number of Victorian clinicians, managers and policy makers gave generously of their time and ideas to this scoping study.[1] The resultant scoping paper is long because I wanted to keep faith with the people I asked to contribute, and ensure there was adequate representation of their voices. It can serve as a basis for future public documents and as a reference source for the Department of Health and Human Services (and full data sets are also available).

Intent of the scoping paper

This work was undertaken so that the department could receive advice on ways to better engage clinicians in continuous improvement at the service and system level. This work will be used to inform the department's ongoing response to the recent review of hospital safety and quality assurance in Victoria, and also inform the department's broader reform work on quality and safety and the revitalisation of clinical networks. Objectives included:

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[1] I am also very grateful to the DHHS project control team: Peter Breadon, Anna Burgess, Juliette Begg and Bridget Weller who were very supportive. I am especially grateful to Danielle Romanes who undertook a huge amount of work supporting this investigation and in sourcing and analysing data and preparing visualisations

- developing an understanding of what clinician engagement is

- evaluating, at a high level, the current approaches to clinician engagement in Victoria

- reviewing the range of approaches and mechanisms used for clinician engagement in different jurisdictions, including best practice

- providing a range of recommended solutions to improve how clinician engagement is done in Victoria at both the system and health service level.

Navigating the scoping paper

Section A - Executive summary

Section B - The concept of clinician engagement – theory and literature contains chapters on the theoretical basis of the concept of clinician engagement, information on its measurement, its significance for patient care and some 'solutions' recommended by others.

Section C - System-level clinician engagement in Victoria describes the information available on the state of engagement across Victoria's health system.

Section D - Drilling down on engagement – what are the big issues? describes the thoughts of CEOs, nurse executives and lead clinicians in more detail – allied health, junior doctors and community sector are discussed.

Section E - Clinical communities of practice and clinical networks focuses the theoretical basis and evidence base for these bodies, together with views from outside and inside the networks on how their work could be improved and focused.

Section F - Engagement for policy development and implementation is centred on the department's staff experience of engagement. Can they access what they need? How are advisory groups working? There is also a small but telling survey of advisory member experiences.

Recommendations are made throughout the paper, and a full list of recommendations for action is provided in Appendix D. They are only included once in the body of the scoping paper, although for many, there are multiple places where this is requested by respondents, such as the request for better patient outcome data. In general, the recommendations are placed at the earliest possible point, not necessarily where the case is most compelling.

Methods

A mixed-methods approach was used to analyse the issue of clinician engagement in Victoria. This involved a literature review, stakeholder interviews, focus groups and site visits, analysis of existing datasets, and collection and analysis of new data. Conclusions were drawn and recommendations made on the basis of all material that was collected and analysed.

Literature review

The peer-reviewed and grey literature on clinician engagement was investigated at the start of the project, and then a further enquiry was undertaken in response to findings from the earlier interviews and surveys. A systematic literature review on the topic of 'clinician engagement' would have resulted in a limited set of literature. Engagement can only be searched as a keyword in Medline, and most references to it relate to the more established field of patient engagement (and clinicians are mentioned in most of these articles). There was a need to pursue the topic of work engagement and broader literature on change and improvement in health care, bodies of literature that would have been neglected by a narrow search, and included a number of non-clinical bodies of literature (for example, human resources). An overall approach to health care as a complex adaptive system was assumed (this is described further in the paper), and this influenced the recommendations made. Some highlights only pertaining to stakeholder involvement in policy making are included in the literature surveyed and summarised. Pre-existing authorial knowledge was supplemented by a snowball search strategy. Review of this literature allowed the proposal of a definition for clinician engagement, and served to support the design of survey and interview questions (and the recommendations).

Stakeholder interviews

An initial list of key internal and external informants was provided by the department, and extended as informants suggested others with relevant views. Most interviews were with public sector clinicians and managers. In terms of the private sector, interviews were only undertaken with representatives from the not-for-profit section, and only with managers. Most of the interviews were conducted by the author alone. Extensive hand-written notes were created and later coded.

Two hospital case studies were undertaken. These institutions arranged for staff to participate in focus groups, enabling a range of views from executives, managers and 'grassroots' clinicians to be collected. Some 'grassroots' participants had patient care concerns and personal frustrations that were in fact related to engagement issues, but appeared to have not considered how their interactions with 'the system' could be different.

Other data collection and analysis

Relevant existing quantitative data was analysed. This included an analysis of workforce data held by the department and primarily collected by the Australian Health Practitioner Regulation Agency, the Victorian Public Sector Commission's 2015 People Matter Survey, a new data collection formed from word analysis of health services' annual reports, and nine original surveys of health system stakeholders. These are discussed in detail below.

Surveys

Key informant interviews formed a framework to guide survey development by defining areas of interest for enquiry and allowing the proposal of solutions that could be rated by respondents. The nine surveys described in the table below were conducted using Survey Monkey. Participants were provided with the assurance of anonymity, and IP addresses were not collected. The full data sets are owned by the Department of Health and Human Services, and are available for use by others.

There is a problem of validity in relation to the assessment of the state of engagement by respondents. A definition was deliberately not provided, because individuals' native understandings were of interest (but focus group work was not undertaken to clarify such understandings and establish whether they differed between groups). However, most other questions were more specific, and there was also a wealth of information provided in the free text comments.

Surveys developed and administered

Group survey	Number of respondents	Estimated denominator (if known)	Response rate (if known)	Number of questions in survey	Total free text comments
Clinical leaders	192	-	-	17	501
Clinical leaders (private only)	46	-	-	21	78
Public health service CEOs	31	86	36per cent	6	73
Private health service and day procedure centre CEOs	67	171	39per cent	6	101
Departmental and ministerial advisory group members	66	-	-	22	84
Department staff (relevant branches)	105	~500	~21per cent	22	182
Nursing and midwifery leaders (public)	436	-	-	17	863
Nursing and midwifery leaders (private)	109	-	-	18	248
Clinical networks' mailing lists	770	5877	13per cent	18	619

It was not possible to determine the response rates with any accuracy for some of the large mailing lists used. Most contained multiple email addresses that were no longer active or were for staff that were on leave.

Much of the surveying was opportunistic (for example, the 'leading clinicians' survey was sent to a list of individuals known to the department and presumed likely to be interested and respond), or relied on initial survey recipients to distribute the survey to all intended respondents.[2] The samples are therefore not representative (for example, the private sector DONs appeared less likely to send the survey on to other nursing and midwifery managers). While private sector views were sought, they were more limited in number and kind of respondents, and any comparisons should be made with caution. Finally, it is unlikely that many survey respondents were grassroots clinicians (many would have been clinical leaders and managers).

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[2] Advisory group chairs were asked to distribute the survey to all members, private health service executives were asked to distribute the clinical leads survey to their heads of units, and Directors of Nursing (DONs) were asked to distribute to their assistant DON's and (assistant) midwifery and nurse unit managers.

Qualitative analysis of free text survey comments

Resources were not available to conduct a research quality evaluation of the qualitative data. Specifically, there was a lack of other experienced qualitative researchers able to immerse themselves independently in large amounts of rich qualitative material which was collected and then negotiate themes and subthemes with the principal researcher. However, this material was analysed in as scholarly manner as possible. The corpus of free text comments from each survey was coded as a whole (with colour coding across large Excel spreadsheets). This approach to whole qualitative sets is important when analysing survey responses, because respondents often put all their thoughts, relevant or not, in answer to the first question and then do not answer the others. Alternatively, respondents sometimes reach the third question and think of something else they want to emphasise about their answer to the first. Complexity theory was not used as a frame for the qualitative analysis; instead, an inductive approach was taken.

To reduce the risk of bias, coding was performed at the level of major themes only, where there was little opportunity for subjectivity in interpretation. Major themes are described with exemplars (direct quotes). These quotes typify respondent comments on the designated themes, or occasionally, creative recommendations for improvement are featured (because the aim of this work was to provide solutions for improving engagement). Some department staff raised queries about the lack of counts of the coded comments. This is not the place for a referenced treatise on qualitative methodology, but I will note that it is not valid to count *post hoc* where there was no specific query (that is, if a measure was not planned). For example, if clinicians were asked if leadership training is important (and the question is mandatory), it can be concluded, for example, that 52 per cent thought it was important. However, when respondents were simply asked to volunteer issues of importance to them, the same conclusion cannot be made. For instance, the topic of the previous question may have resulted in respondents writing more about data; however, they actually did think leadership training was important. If a theme occurred very frequently, it was a major theme, but the issue of *how* major was better gleaned from the substance of the comments made (their detail, their passion and so on) than their number.

The value of open-ended questions is that they allow investigators to find out about people's ideas and feelings without them being prefigured or prescribed. Interviews are better again, because queries and probes are employed to ensure shared understanding and to encourage subjects to reflect more deeply on issues. In the overall analysis and reporting in this scoping paper, evidence from interviews and surveys is at times interweaved where they together provide corroboration for a particular point. In all, there was a very rich set of data from multiple sources, allowing triangulation and confident identification of engagement problems and the creation of solutions for better clinician engagement in Victoria.

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Section A - Executive summary

Overview

The purpose of the scoping paper is to help the Department of Health and Human Services (DHHS; the department) develop a cohesive long-term strategy for strengthening clinician engagement in Victoria. It does this by defining clinician engagement, clarifying its purpose, identifying priority areas for improvement and recommending some useful first steps that can be taken those areas.

This executive summary provides a high-level overview of the scoping paper's key findings and recommendations.

What is clinical engagement?

There are varied interpretations of clinician engagement, and the terms 'engagement' and 'leadership' are often used almost interchangeably. The following definition is proposed:

> Clinician engagement is about the methods, extent and effectiveness of clinician involvement in the design, planning, decision making and evaluation of activities that impact the Victorian healthcare system.

Under this definition, engagement becomes a measurable organisational feature (of both health services and government bodies) which can be planned for and reported against.

Investigation process

This scoping paper provides detail about national and international clinician engagement practices and relevant theory and evidence. Extensive primary research informed this project, including interviews and small group meetings with more than 100 clinicians, executives and academics from the public and private hospital systems, community health and the Department of Health and Human Services. Over 1800 people responded to surveys.

Patient engagement was out of scope; however, the purpose of clinical engagement is to assure and improve the experience of patients and the safety of their care; thus, patients should be central to any improvement activity. Without patient involvement, just as without clinician involvement, plans are deficient. General practitioners were also out of scope, except through their interface with the hospital system as rural visiting medical officers. There is only a minor focus on mental and community health services.

While the experience of private clinicians and executives was canvassed and contrasted with their counterparts, it should be noted that direct consultation with private sector stakeholders was exclusively at the executive level, as was with not-for-profit services, whose perspectives are unlikely to be always representative of those of their for-profit peers.

The context for examining clinician engagement

The concept of clinician engagement comes in part from work engagement, a behavioural perspective on employee motivation. Job strain (burnout) and work engagement result from the balance between job demands and job resources. One benefit of engaged employees is discretionary effort outside the strict letter of an enforced job description; this creates better functioning and more successful organisations.

The situation for clinicians is different from many other employees because they have responsibilities to patients and clients that exist regardless of their relationship with an employing institution. Clinicians also may have stronger allegiances to professional groups than an employer (and many do not have a single employer).

Analysis of the People Matter Survey administered by the Victorian Public Service Commission (VPSC) for 2016 shows engagement index values below 75 (out of a possible score of 100) for 46 per cent of public health service and hospital employees and 49 per cent of community health service employees.[3] This means that just under half of those surveyed did not consistently agree with statements such as 'My organisation motivates me to help achieve its objectives'. Average organisational index values across the state were highly variable: from below 60 (relatively low engagement) to a high of 90 (very high engagement). Areas of strength and weakness were evident in both health services and community health, and across metropolitan, regional and rural areas.

Many health services in Victoria face significant challenges to engaging their employees. One of these is the difficulty of engaging fee for service medical clinicians who are not paid to participate in organisational initiatives or quality improvement. One in three rural public health service CEOs and one in six metropolitan CEOs volunteered problems with engagement of these clinicians, including in basic quality activities such as attending morbidity and mortality meetings. Some CEOs proposed more central support with visiting medical officer employment, such as standardised contract models 'so that they know they have to play by statewide rules'.

Part-time clinicians (most commonly in nursing and allied health) can also be difficult to engage. About 16 per cent of the total Victorian clinical workforce works less than half-time, with around four per cent working the equivalent of a single shift or less each week. These clinicians are less likely to be familiar with organisational policies, while weaker relationships with colleagues make it difficult for peers to influence them, and scheduling difficulties would often see them excluded from meetings and improvement work. All these problems also apply to medical officers such as surgeons, who work at multiple institutions.

The Victorian government currently has a substantial health system reform agenda and a significant increase in expectations of the safety and quality performance of service providers. Whether these reforms succeed or not is crucially dependent on clinicians engaging with, understanding the rationale for, and supporting implementation of the intended changes. This engagement cannot be taken for granted. In a complex system, where power is highly distributed and devolved, it is easy for government messages and policies to go unnoticed or be ignored by clinicians. In reality, chief executives and boards

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[3] The survey was completed by 28,132 health service and community health service staff respondents out of approximately 85,544 survey recipients.

have limited control over clinicians; thus clinicians also need to be empowered to work collectively to improve care for patients.

Encouragingly, the consultation conducted for this project revealed strong interest among clinicians and department staff in achieving deeper and more consistent engagement. The government's new Better, Safer Care policy will address many of the issues identified in this research, including:

- **Investment in clinical engagement structures and department capability** – such as the establishment of a Victorian Clinical Council and the revitalisation of the department's clinical networks, for which a new model is suggested in this scoping paper.

- **Strengthened accountability for quality and safety performance** – this will in turn spur health care providers to invest more effort in clinical engagement, because it is a necessary ingredient for performance improvement.

- **Open provision of meaningful performance information** – this will support clinician engagement in improvement work within health services and provide a foundation for productive discussion about broader system issues. Clinicians crave robust data about comparative performance (it is the 'life blood' of meaningful engagement) and it is something the department and new agencies will be equipped to provide.

- **A stronger focus on the private sector** – consultation found the not-for-profit health services had a strong interest in working more closely with the department and the public system to improve patient care.

Why is clinician engagement important?

There is high quality evidence that where clinicians are measurably engaged, there is lower staff turnover and absenteeism, decreased infection rates, increased patient satisfaction and lower patient mortality.[4] Further, there is evidence from the safety and quality movement that without clinician engagement, leadership and support, change does not happen or is not sustained.

It is suggested that 'everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it'[5]. An engaged employee does just this: contributing to making health care safer and higher quality. Clinician engagement can result in:

- improvement of practices and quality at the micro (team) level

- improvement of practices and quality at the service system level

- better informed policy development

- support for effective policy implementation.

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[4] West M, Dawson J. Employee engagement and NHS performance. The King's Fund 2012:123.
Dromey J. Meeting the Challenge: Successful Employee Engagement in the NHS. London: IPA 2014.
Spurgeon P, Mazelan PM, Barwell F. Medical engagement: a crucial underpinning to organizational performance. Health Services Management Research 2011;**24**(3):114–20.

What does good engagement look like?

Investigations produced a clear picture of what engagement and disengagement look like (see table below). The desired state is where relationships between clinicians, managers and policy makers are characterised by mutual understanding and trust built through ongoing work together. Well-designed formal networks and organisational structures facilitate these collaborations, and vibrant informal networks feed into them. Rich and timely information on activities, priorities and potential changes flow across the system, and two-way communication is the norm. Clinicians feel they have a voice 'up' into policy making, and are not just the recipient of plans and directives. For policy makers and managers, clinician engagement results in better informed and more effective policy, and stronger support for policy implementation. For clinicians, the result is a sense of empowerment and belonging.

A disengaged state	An engaged state
In policy development	
Clinicians: • find the channels for providing advice to government inaccessible or exclusionary • consider consultation tokenistic; for rubber stamping policy, not improving it • feel policy makers do not understand the real problems and priorities in the system • find the department's policies make little sense (or do not reach them). Department staff: • feel unsure about the quality of the advice they receive • are unable to reach out for expertise • may be unsuccessful implementing reforms.	Clinicians: • feel their opinions and expertise are considered, and their participation is valued • can identify and access relevant department staff who will respond to them • recognise policies are rooted in shared priorities and cognisant of practice realities. Department staff: • receive advice that is expert, evidence based and representative • know their advisory processes are credible and respected by the health system • have relationships with a broad range of clinicians and understand their perspectives • engineer reforms that are understood, owned and widely implemented.
In the leadership of health services	
CEOs and the department have antagonistic relationships. CEOs protect their work and are reluctant to learn from peers.	CEOs and the department have supportive relationships. CEOs share their work and help other institutions to improve care.
In the work of clinical networks	
Relatively few clinicians pursue individual clinical interests. The network struggles to obtain data. The network has little overall influence on the health care sector.	Many clinicians are involved. Diverse membership enables a creative approach to hard health care problems. The networks are able to improve practice.
In the leadership of clinical units	
Managers feel they are battling alone. Clinicians are hostile to management requests.	Teams tackle problems and improve care. Implementation of required changes are a shared responsibility.
In the delivery of care	
Clinicians: • avoid participating in workplace activities they do not have to • are unaware of health service or statewide policy directives • are often absent and off sick due to depression and burnout.	Clinicians: • routinely go the 'extra mile' • initiate and support quality improvement • create a learning environment by sharing knowledge with all members of the team • know about and follow important health service and statewide policies.
The result of disengagement is that patients receive low quality care and report poor satisfaction with their experience of it.	The result of engagement is that patients receive safer, higher quality care and report higher satisfaction with it.

The need to set the agenda for engagement

For the department and health services to strengthen clinician engagement, there needs to be a common understanding of its importance and what the department's objectives, expectations and approaches towards it are. Currently, the department has set no expectations for clinician engagement – including both its own engagement and that within health services.

Internally, the department needs to be much clearer about its expectations of staff with regard to engagement and how it should be undertaken. A lack of time and deep connections with the health system mean that advice is often sought from a small group of clinicians and representative consultation with the broader clinical workforce does not occur. Clinicians working in community health, general practice and private health services – cumulatively over half of the total Victorian health workforce – are often left out altogether. More findings and recommendations on this issue are included below under the heading 'Involvement of clinicians needs better structures, processes and support for consultation and debate'.

Measurement to help health service leaders strengthen engagement

There is a potentially variable focus on clinician engagement by executives and health boards, with 48 per cent failing to comment on it in their annual reports. Clinician engagement requires an enabling work environment. Investment in human capital and skill enhancement, stimulating evidence and data, employee autonomy, strong supportive leadership, fairness and trust and good two-way communication all create happier and more engaged workers. Work hindrances and unreasonable job demands by contrast lead to disengagement and burnout. Creation of an enabling environment is rightfully the responsibility of health service providers and a matter for board oversight.

The People Matter Survey (the key resource public health services are given) currently has limitations. These include the fact that the survey is excessively long, in part because of the inclusion of sections with little perceived relevance to clinicians. This can contribute to low completion rates, making results unrepresentative and therefore misleading or unusable. Some health service providers wishing to measure clinician engagement more accurately, regularly, and with greater analytic support are choosing to invest in private survey products instead.

Currently, the department itself is not able to monitor engagement. Participating organisations receive useful benchmarked reports on their People Matter Survey results, but the department itself struggles to access this data and has no visibility at all into the results of commercial surveys. This means it is unable to monitor clinician engagement and identify providers in need of support.

The department needs to provide better information for clinicians

The easiest way to stimulate engagement is to provide clinicians with information about the outcomes and experiences of their patients. This draws them into conversation about quality improvement. Currently this information is missing in many parts of the health system.

Information to engage clinicians in quality improvement

Clinicians are clamoring for data to support their engagement in quality improvement within health services and clinical networks. Better data – timely benchmarked outcome data – was selected in the top three improvement priorities by clinical networks, clinical leaders and nursing and midwifery managers in the surveys of both the public and private sector.[6] Often it was the top priority.

> 'I can't tell you how excited I am about the new department information plans – it's important to provide data that doctors believe in – they say "Don't show me the results of some poxy little audit you did last week" '. (metro quality manager)

Clinicians also need information to help them resolve clinical care problems they identify. Hence there were widespread requests for accessible statewide policies and protocols for best practice care. Generating high quality, evidence-based resources of this kind is research intensive and beyond the capacity of most clinical units to do well or efficiently. However, as the Travis and Duckett Reviews highlight, the department has historically not done enough to identify and disseminate best practice guidance across the system. While health services can currently access some clinical protocols via PROMPT, access to the portal is variable, its coverage is not comprehensive and there is no guidance as to which protocols work best.

Information to engage clinicians in policy development

Second, clinicians who would otherwise be interested in learning about departmental outputs and initiatives often struggle to find any information on them. At the most basic level, the department provides too little public information about its work and priorities. It can be a herculean task to locate information on the website. Some initiatives have no website representation at all. Website links break and are not fixed. Contact numbers are not regularly updated. Clinicians seeking to learn more about, or get involved in, the department's work have difficulty.

> 'We don't know who's there, what they do; it's so hard to find the right person.' (allied health clinician)

Much information that would be of interest to clinicians is withheld. Non-endorsed material (including solid advisory work) is often not published, and respondents complained about results and resources of department-funded projects not being shared across the system. This may contribute to the apparently common practice of seeking advice interstate or internationally without investigating within Victoria.

Risk aversion characterises many of the deficiencies in the department's approach, but it ultimately hurts the department. Clinical network members would be more engaged if the networks were allowed to feature lively debates on their webpages with colourful and conflicting opinions. Lack of transparency means that opportunities for re-examination of policies and practices can be missed. Inhibition about discussing internal policy processes can reduce clinician's trust and engagement:

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[6] Improved access to guidelines would also support safety. A relative lack of statewide guidelines and protocols in Victoria is a particular risk to the quality of care provided by sessional clinicians, who are less likely to be familiar with the protocols at all the different health services they work at.

> 'Current department representatives are unable to speak candidly, thus their involvement feels Machiavellian and when changes occur the sector feels manipulated'. (community health service CEO)

A further issue with the department's communication is a lack of connection with the intended audience. The department often struggles to communicate information in ways that resonate with clinicians. Often these documents do not highlight the shared priorities and values of clinicians and policy makers in a manner that could increase support for reform.

> 'We are a black box to many clinicians – they don't understand why we are doing what we do or what drives us to reach out to them… we rarely make the effort to make it easy for clinicians to understand our processes, responsibilities and culture'. (departmental survey respondent)

Involvement of clinicians needs better structures, processes and support for consultation and debate

Consultation and cooperation with clinicians should be a core part of the department's engagement with the health system. While a number of groups currently exist to support this, many suffer from inadequate role clarity, representativeness and support. At the same time, the department lacks a strategy to ensure its own staff has the capability to engage effectively with clinicians.

Clinical networks and advisory groups

First, the department must address the key structures it has developed for ongoing engagement: the clinical networks and clinical advisory groups.

The role of statewide clinical networks needs to be clarified, and they should be structured and supported to maximise their reach. Currently, the official mandates of clinical networks are extremely broad, but in many cases their membership is limited, and the steering groups of each have developed quite different work programs.[7] It is currently unclear to the network steering committees, which of their many possible activities they should be prioritising, and whether they should be focusing on statewide or network-wide improvement. Many network members are frustrated by their inability to reliably influence practice system wide. There was a demand for the networks to be strengthened by the development of regional subgroups where clinicians could meet to discuss shared concerns regularly.

The department needs to address the deficiencies that were found in its clinical advisory groups (that is, the broad range of taskforces, reference groups, consultative councils and committees providing advice to the Minister for Health and the department). While clinicians bring significant goodwill and enthusiasm to these groups, only a quarter of departmental staff and a third of advisory group members currently think that the groups are achieving their potential. Departmental and advisory group respondents generally agree that advice is only 'sometimes' reflected or even considered in decision making, which can lead to a view that the groups are tokenistic.

> 'Sometimes it feels like our involvement is an afterthought or tick-box process. I do acknowledge that it is not intended to be so.' (advisory group survey respondent)

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[7] This may, in part, reflect the fact that data has not been consistently available to support a focus on statewide variation.

In part, these problems stem from a lack of role clarity: 15 per cent of advisory group respondents believe their group is unclear on its role or purpose, while in the department the proportion is 27 per cent. Some appear to have overlapping roles,[8] reflecting the fact that the department has not developed an overarching approach for the groups, and indeed does not even have a central list of the different groups and their memberships.

Some groups appear to have been established with inadequate consideration of the capabilities, resources, data and consultation processes their members will need to do their jobs well. Department liaison with the groups was considered deficient, with an excessive rotation of staff that were too junior.

> 'The impression of many clinicians… is that there is a lot of talk and many meetings, but what actually results bears little relation to their specific input… dealing with the department can be a 'talkfest' and a waste of precious time.' (advisory group survey respondent)

Finally, current engagement structures may not be sufficiently representative, putting the accuracy of advice at risk. Advisory group memberships can be duplicative and demographically skewed. For example, 90 per cent of survey respondents were aged over 40, half were currently serving on 2–12 advisory groups, and half had been serving on various advisory groups for 5–28 years. Clinical networks can be similarly unrepresentative: only 15 per cent of survey respondents were from the private sector or had been in practice for fewer than ten years. Some network steering groups lacked grass roots clinicians, patients and carers.

Consultation processes

The department's ongoing consultation with clinicians should not be limited to advisory groups and clinical networks. However, the department currently lacks processes for routinely engaging clinicians in debate about its priorities and activities, particularly emerging challenges and opportunities. It does not regularly release white papers as other jurisdictions do – a missed opportunity to create readiness for change and offer the chance to become involved and create solutions. The department's engagement instead tends to occur much later in the policy development process, often with consultation initiated too late for stakeholders to conduct research, consult within their own constituencies and significantly influence decisions.

Departmental capability for engagement

Department staff capability for clinician engagement is crucial to the creation of a state of effective clinician involvement and the department's effectiveness as system manager. For staff to consult on and develop policy in partnership with clinicians, or explain and promote policy to them, they need to be able to speak in a language clinicians understand and have a broader appreciation of the structures and cultures clinicians work within.

Experience in and contact with clinical settings appears to be low for many staff in health policy and program roles. The survey of department staff in branches with significant contact with the health system found that while the majority has a wealth of experience and frequent

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[8] For example, an excess of groups working in the maternity space was identified in stakeholder interviews.

contact with the health system, 38 per cent have never worked in the sector,[9] and 37 per cent do not undertake a substantive visit to a health service at least annually.

A quarter of department survey respondents reported that they never or rarely have enough access, for their role, to clinicians outside the department, and about one in six reported they never or rarely have enough access to advisory groups or clinicians who work within the department. A lack of relationships within the health system can then make it difficult for staff to seek out other sources of clinical advice. A lack of health system knowledge and exposure can make it difficult to interpret and assess that advice, or to interact with clinical stakeholders effectively.

Personal interactions are critical and currently appear limited in quantity. Staff in areas such as the private hospital unit, and the aged care branch lamented funding cuts that have resulted in them severely curtailing site visits. Community informants also volunteered that regular visits were greatly missed. In all there was a desire to:

> '…return to the good old days when DHHS personnel attended external meetings in person at, rather than engaged only via email with, health services… there's nothing like putting a face to an email address to break down barriers to information flow, and to pick up information as an 'incidental' by-product of a meeting/gathering.' (department survey respondent)

Where contacts and relationships do exist, they may be focused in certain areas, excluding non-medical clinicians, the private sector and regional and rural health services. For example, the survey found that it is rare for central office department staff to visit rural and regional health services: 64 and 70 per cent of survey respondents do not visit rural and regional health services at least once a year, respectively.[10] Perhaps partly as a result, the rural and private sectors felt poorly 'understood':

> 'There is not a lack of good will but pure ignorance – they think they know what the private sector is like.' (not-for-profit CEO)

A number of clinical and departmental survey respondents reported a need for more clinicians to work within the department:

> 'It would be great if senior clinicians and department managers could also hold joint positions at the DHHS so as to accurately inform the government what is actually happening at the "coalface".' (clinical network member)

Empower clinicians to lead change

In order for engagement to be most effective in achieving improved quality and safety of care for patients, clinicians need to be equipped with the skills and opportunities they need to lead change.

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[9] Approximately a quarter of surveyed staff in Health Service Performance and Programs, half in Regulation, Health Protection and Emergency Management and three quarters in Priority Health Projects.
[10] Defined as a substantive site visit. For metropolitan the figure is 45 per cent. The geographic discrepancy reflects, in part, the fact that regulators of metropolitan (but not regional and rural) health services were included in the survey.

Training in quality improvement and system influence

A fully engaged health system requires a good proportion of clinicians to have expertise and experience that goes beyond delivery of care. For example, the ability to undertake quality improvement requires specialist training, including skills in change management and leadership as well as improvement science. Contributing to policy requires an understanding of policy settings, design, constraints and implementation.

Many survey respondents reported that they need more skills in quality improvement. A third of nursing and midwifery leaders from public and private health services disagreed or strongly disagreed that they have adequate training and development in quality improvement. The broader survey of clinical (including medical and allied health) leaders found that of 11 interventions to strengthen clinician engagement in their organisation, increased training and development was the second most important among public sector respondents and third most important for private sector respondents.

Many department stakeholders and survey respondents also identified a need for development and support for existing clinical leaders in clinical networks and advisory groups, including skills for systems thinking, system leadership and policy design.

> 'One thing the department doesn't often appreciate is the variability in the skills, bias and experiences of clinicians [on advisory groups].' (department survey respondent and doctor by background)

> 'More training about big picture issues would help people in my position better exercise leadership.' (clinical networks survey respondent)

Insufficient investment in these skills may be contributing to reliance on the same clinicians across a number of advisory groups and in consultation (the 'usual suspects' problem).[11] This is further exacerbated by the lack of a systematic 'pipeline' for the development of future system leaders. There is a subset of junior clinicians eager to be involved in system improvement work who may also be a good group to target as they 'are often able to identify the gaps and inefficiencies in the system, before they become indoctrinated as part of the system'.[12] In other settings, health professional students have been successfully enlisted.

Opportunities to exercise leadership

There are some fine examples of clinician engagement practices in the Victorian system that should be shared and promoted. Health service executives who have laboured to create engaged workplaces deserve public recognition for their achievements and the chance to inspire others.

Clinical networks need the lateral space and freedom to exercise leadership. They would benefit from being able to develop a better brand identity and being able to propose regulatory or performance accountability measures when necessary to ensure that guidelines and improvements reach the whole sector.

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[11] See the section on engagement structures for statistics on clinicians who serve on multiple groups and/or over many years, and on the diversity and representativeness of these clinicians.

[12] Department survey respondent.

Clinicians also need to be able to *apply* the quality improvement training they receive. One way to achieve this on a broader scale is through increasing opportunities to participate in well-designed and large-scale quality improvement initiatives. There is opportunity to develop statewide collaboratives (with associated improvement training) to allow the Victorian system to take a great leap forward in terms of system improvement capability.

Remove hindrances and inefficiencies

It is also vital that the department creates space for clinicians to engage in these initiatives, rather than simply asking them to do more in addition to their existing workloads. Many clinicians identified a lack of paid time / protected time as a significant barrier to participation in quality improvement. Clinical leaders and nursing managers in both public and private practice suggested lack of time was the major obstacle to engagement in quality improvement in their organisations.

In part, this is due to the perceived necessity for each health service to individually reinvent clinical protocols, practice guidelines and data collections:

> 'Of all possible changes to improve quality improvement, strong statewide communication to enable sharing of challenges and solutions will enable me to minimise reinventing the wheel.' (clinical leaders survey respondent)

Some executives stated that they are busy in part because of departmental requirements. A metropolitan CEO reported being 'tired of petty and time-consuming data checking and auditing by the department' and begged for restructure of separate funding programs that all have their own reporting requirements. Some spoke about the way this flows onto clinicians:

> 'So much time is spent filling out surveys and providing facts and figures from our client management systems to provide DHHS with something to talk about.' (clinical leaders survey respondent)

> '[Appropriateness work] is a journey that needs to start by decompressing the box-ticking-non-value-adding that is paralysing the frontline teams. Pull it apart and decide what is important – decompress the tasks at the frontline.' (Metro hospital unit head, medical)

Summary of proposed actions to strengthen clinician engagement

Many of problems described in this scoping paper can be ameliorated and some resolved altogether. Solutions are varied in nature, audience and scale. They are designed to influence clinician engagement at multiple levels as befits an issue central to the complex system of health care delivery. All are explored in greater detail in the body of this scoping paper, with the proposed solutions summarised in the table below and also provided in detail Appendix D. They are not prioritised, and while the quality of engagement is important, there are nearly 130,000 registered clinicians in Victoria and some solutions are more likely to reach many more of these clinicians, increasing their involvement in improvement of their work.

SET THE AGENDA Develop objectives, expectations and good measures	INFORM Provide information and data to support engagement	INVOLVE Improve structures, processes and support for consultation and debate	EMPOWER Invest in skills, capabilities and opportunities to lead change
1. State the definition, objectives and principles of clinician engagement, possibly as a compact describing roles and expectations. 2. Set standards for clinician involvement in safety and quality. 3. Set minimum responsibilities for health service boards in regard to clinician engagement. 4. Improve data collection on clinician engagement. 5. Use data to monitor clinician engagement and give underperforming organisations targeted support to improve. 6. Engage with private providers and clinicians to explore development of a strategy for their sector. 7. Engage with community-based providers to explore development of a strategy for their sector.	8. Provide better patient outcomes data to inform and motivate clinician engagement. 9. Expand access to and improve navigability of the PROMPT portal, and use it to share agreed statewide guidelines and local protocols with clinicians and provider organisations. 10. Develop a clinician-focused communications strategy. 11. Make department information, reports and contact information easy for clinicians to find and use. 12. Publish analysis, advice and reports developed through clinician engagement structures. 13. Share improvement project findings and resources to drive peer-to-peer engagement.	14. Clarify the role of statewide clinical networks. 15. Structure statewide clinical networks to maximise reach and involvement of clinicians. 16. Provide clinical advisory groups with clearer roles and best practices for operation. 17. Adopt a white paper process to engage clinicians in policy debates. 18. Ensure clinicians have multiple ways to voice system concerns to the department. 19. Develop a strategy to build the department's clinical engagement capability. 20. Develop and standardise the use of contemporary approaches to departmental engagement with clinicians. 21. Improve access to department staff, consultation and engagement for rural stakeholders with multi-site videoconferencing facilities.	22. Empower clinical networks with tools, resources and policy influence. 23. Promote best practices in clinician engagement in the workplace. 24. Increase the availability of training in quality improvement for clinicians. 25. Build the capability of clinicians already engaged with the department. 26. Expose junior clinicians to the department's work. 27. Create pipelines to develop the skills of clinical experts in system and policy influence. 28. Investigate a systematic approach to engaging health professional students in improvement. 29. Conduct statewide quality improvement collaboratives involving all services and the private sector. 30. Identify and address barriers to engagement caused by workplace and system inefficiencies, freeing up clinician time for engagement.

Section B - The concept of clinician engagement – theory and literature

Understanding clinician engagement – introduction

The term clinician engagement is used variably and meaning is very much determined by the perspective of the user. In particular, it is often misrepresented as a quality to be sought from clinicians by management, rather than a shared state to be achieved. There is also an overlap with literature on change, and calls for 'clinician leadership' and 'clinician engagement' are largely interchangeable and usually associated with safety and quality improvement.

Patient engagement is also crucial for safety and quality improvement, but is out of scope for this work. Engagement with patient problems, whether by consideration of qualitative data or collected patient stories or via the participation of patients in design and evaluation processes, is at the heart of clinician engagement.

Due to their widely varying cultural contexts and diverse health system design and funding arrangements, policy documents and research findings from other health systems are only of limited relevance for Victoria. It is often forgotten that UK documents (for example, Kings Fund) have been developed for a system in which all clinicians, including medical practitioners, are salaried National Health Service employees. Large US institutions (for example, the Mayo Clinic, Virginia Mason Health Centre, Veteran's Health Administration) also have salaried doctors. In Victoria the majority of medical practitioners work as private contractors for at least part of their working week.[13]

Some Australian doctors in this circumstance describe a very deficient relationship with the hospital in which they work:

> 'I don't think they would care if I was there or not, to be honest. I think that applies to just about every doctor in the hospital (cardiologist).' [1, p. 152]

The nature of employment and career progression for staff within the Victorian health system potentially makes a great deal of difference to the likelihood of engagement. For instance, imagine a request for participation in a quality improvement project being received by:

- a public hospital staff specialist versus a private hospital visiting medical officer

- a doctor in specialty training with a three-year contract with the same institution versus a one-year contract or on a loosely arranged rotational scheme involving many institutions

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[13] 7627 medical practitioners only work in the public sector, 4701 work in both the public and private sectors, and 9154 work in the private sector only. *Source: National Health Workforce Data Set (2015)*

- a nursing unit manager versus an acting nursing unit manager

- a staff physiotherapist versus a locum or casual physiotherapist.

A clinician can be dedicated to patient care, but be disengaged from system activities associated with their work due to too many workplaces, competing allegiances (for example, to professional organisations), competing demands (for example, work/life), or limited incentives. Command and control management practices may give clinicians little voice and limit their autonomy outside prescribed roles. Additionally, clinicians do not like to feel incompetent – and may feel that way with regard to involvement in managerial or organisational activities.[1]

The concept of clinician engagement derives in part from study of work and employee engagement that is relevant to all industries and jobs and also from the literature on prosocial behaviours, especially organisational citizenship behaviour. It has been of special interest in health care because of the evidence from the safety and quality movement that without clinician engagement/leadership/support/involvement, change does not happen or is not sustained.[2] The cooperation of medical clinicians has been especially troublesome to ensure.[3] Improving engagement has thus been seen as a critical underpinning for safety and quality improvement. Understanding the foundational concepts of work engagement is of utility before considering clinician engagement and its definition.

The investigations described in this paper are presented in two parts. First, clinician engagement at the system level is discussed and consideration given to how the Department of Health and Human Services could support it, and in particular, the work of the clinical networks. For the department to undertake work in managing and monitoring health care it needs a range of connections with the sector and with clinicians. The chief executives are a major point of contact. The devolved structure of the Victorian system means that clinicians' concerns may be promoted by the CEOs to the department and the CEOs also form a conduit and effector for implementation of policy. Quite often, though, the department needs to seek advice directly from clinicians. Sometimes it needs to directly influence clinicians.

The second part of this paper focuses on the department and how it is engaging with the system and with clinicians. The research findings suggest that there is a capability issue on both sides – but one that is entirely remediable.

Work engagement

The original concept of employee engagement was a behavioural perspective on employee motivation.[4] Thus the literature is limited in its relevance to contract workers, whether physiotherapists or doctors. Work engagement is defined as:

> 'A positive, fulfilling work-related state of mind that is characterised by vigour, dedication and absorption' (Schaufeli, cited in [5]).

It is relevant to *employees* in the health care system and the concept is explored in more detail in Appendix A. Here a few things are worth noting. First, that some of the desired behaviours performed by engaged employees are those that are discretionary, pro-social or voluntary – that is outside the strict letter of an enforced job description.

Second, the job demands–resources (JD-R) model[6] describes how job strain (burnout) and work engagement are produced by a balance between: job demands and job resources. Job demands are the physical, social or organisational aspects of the job that require sustained physical and psychological (that is, cognitive or emotional) effort. Job resources refer to those physical, social, or organisational aspects of the job that may: 1) reduce job demands, 2) be functional for achieving work goals, or 3) stimulate personal growth, learning, and development (these include both autonomy and feedback). Too many demands and too few resources predict burnout[7, 8] and thus illness and absences[9, 10] and result in employees working less safely.[8] Burnout is a well-recognised problem for health care workers,[11, 12] and unsafe work practices in health care can result in harm to patients as well as staff themselves. Engaged workers redesign and improve their jobs (including for example how they work with others, thus also potentially increasing resources available to others).[7] Those with higher levels of self-esteem and self-efficacy are better able to do this,[13] and those who have traits of proactivity and conscientiousness are more likely to do so.[5]

Third, employees will be more engaged in performing some job tasks than others. Job demands have been differentiated into challenge and hindrance stressors. Challenges such as a high workload, time pressure, and high levels of job responsibility are often perceived as opportunities to learn, achieve, and demonstrate competence (possibly for reward). People 'may work very passionately to respond to challenge demands because they believe doing so is meaningful and important, even though they simultaneously recognise that doing so may also leave them feeling exhausted'.[14] This sounds like much clinical work. Hindrances, however, are stressful demands that have the potential to thwart personal growth, learning and goal attainment; for example, role conflict, organisational politics and 'red tape'. Hindrance demands are considered exhausting and at times impossible to address. Much organisational or system improvement work involves wrestling with hindrances.

Improving work engagement

A detailed list of suggestions to enhance engagement has been developed.[5] Many derive from the literature on 'high involvement work practices' – which has four main attributes:

- power – employees have the power to make decisions and/or to participate in the decision-making process
- information – information is shared among employees
- reward – employees are rewarded for their good performance
- knowledge – employees are provided with the necessary training to do their work.[15]

Ten suggestions for enhancing work engagement[5]

1) Select staff with a propensity for engagement. This might mean the use of personality measures such as 'conscientiousness', 'proactivity' and 'optimism'.

2) Train staff for engagement. This includes the socialisation of newly appointed staff and efforts to promote self-efficacy through careful feedback and coaching.

3) Invest in human capital and skill enhancement. This gives confidence to employees and enhances the sense of reciprocity encouraging employees to give something back to the organisation.

4) (Re)design jobs to maximise employee autonomy, challenge, variety, skill utilisation and scope for learning and development. Power is important for engagement; this refers to the authority to fulfil job responsibilities, participation in decision making, freedom over how to do one's own job, authority to make decisions about one's own work.[15]

5) Provide strong supportive leadership.

6) Reward and promote managers using their ability to engage employees as a key criterion. Reward is important for all employees, this includes recognition and praise, financial rewards and promotion.[15]

7) Ensure fairness of treatment and trust in management, using a range of voice mechanisms to achieve this. It is important for employees to understand the reasons behind critical decisions.[15] Fairness and trust are key factors in ensuring a positive psychological contract.

8) Ensure extensive and effective two-way communication. There can be extensive downward communication associated with engagement; however, upward communication concerning work issues is also important. This builds trust, but also should result in better strategy, policy and performance as when 'transformational engagement' occurs:

> 'Employees are at the heart of strategy development and of delivery… The insights and ideas of employees, wherever they work, about how products and services can be improved, are harnessed, listened to and acted on.'[16]

9) Create a context that reinforces job security and supports flexible working.

10) Adopt a strategic human resource strategy that reflects the values of engagement and recognises the need to have an integrated engagement strategy and engagement system.

How is clinician engagement different?

Most of the engagement literature is focused on business enterprises, where maximising profit is the ultimate organisational aim. In health care, maximising profit is not usually the major aim. Patient satisfaction and patient safety have been considered as surrogates for the productivity and profitability measures used in business, but what constitutes good or adequate results in these domains is far more contestable than a balance sheet is. There are special issues in applying the general work engagement literature to the work of clinicians.

First, clinicians have moral/ethical/professional responsibilities to patients and clients and most of their work is client facing. These client relationships exist regardless of employee relationships with an employing institution. For instance, a nurse may love their job, help their colleagues with their work, and stay back to talk to patients, but be hostile or indifferent to management, especially above their nursing unit manager (NUM). When their help is needed supporting a system-level change in an infection control practice benefiting unseen patients it may be difficult to obtain. Our nurse's NUM may also consciously or unconsciously create a happy and stable work environment by either filtering/shielding staff from system issues or by encouraging a within-unit tribalism; such practices limit systemic change. The situation is described in health care institutions where team members pull together 'not because of targets but in spite of them, and as a form of resistance to governance'.[17]

Second, while employee engagement has been summarised as being the emotional commitment an employee has to the organisation and its goals, for clinicians there are often multiple workplaces and multiple 'organisations' and allegiances to professional groups and unions. Priorities in this 'pluralist'[5] organisational life may not preference any employing organisation. Independent clinicians may consider themselves highly accountable to their profession and their patients, but not really to the organisation in which they work. Clinicians imbued with a certain view on the social contract may even see their fundamental allegiance as being broadly to society,[18] or alternatively, to social goods they can create by their work with individual patients.

The comment 'Clearly, a purely individualistic approach to professionalism does not resonate with contemporary, team-based healthcare' has been made recently by UK surgeons.[19] Yet, the very existence of exclusive occupationally-centred medical colleges with their focus on professional standards, steep entry requirements (and 'turf protection') may be antagonistic to development of a broader more system-based approach to professionalism.[20] Doctors' insecurity (and competitiveness) means that they suffer anxiety about potentially criticising a colleague.[1] Robust examination of the processes and outcomes of care creates this potential, and the support and respect of doctors' colleagues is extremely important to them.[1] Some brave clinician leaders are able to work comfortably in the space of system accountability, but they are a minority.

The purpose of clinician engagement

The ultimate purpose of clinician engagement is to improve the quality and safety of health care. This includes:

- improvement of practices and quality at the micro (team) level

- improvement of practices and quality at the service system level

- enabling informed decision making and policy development

- achieving support for effective implementation of policy.

It is disputable whether clinician engagement is discretionary or not. There is a famous quality improvement quote: 'everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it'.[21] This sounds great, but one of those two jobs is well defined, staff have been elaborately trained to undertake the work and their performance is clearly rewarded. The other not so much!

The quest for clinician leadership / clinician engagement is sometimes an expectation that they take responsibility for change with minimal organisational support and to do so as volunteers (uncompensated extra work). In regard to this it has been suggested that:

> 'Managers and policy makers need to come clean. If independent practitioners are meant to assist with reforming the system, this should be included within their job descriptions and adequately rewarded.'[22]

However, engagement is a concept that bridges the system/individual distinction that has unhelpfully dominated patient safety debates. While professional clinical practice entails an individual moral responsibility for actions:

> 'Opportunities to 'be good' are institutionally organised and structured and individuals make a crucial contribution towards the creation and reproduction of the normative conditions and criteria by which they and their actions are to be held to account.'[23]

In essence, individuals create the system that they engage with.

Defining clinician engagement

The definitions offered for clinician engagement are diverse and complex, sometimes including wellbeing and with a varied focus on the workplace itself (rather than the individual). Major definitions are summarised in the table that follows.

Comparison of published definitions of clinician engagement

Definition	Comment
'[A] workplace approach designed to ensure that employees are committed to their organisation's goals and values, motivated to contribute to organisational success, and are able at the same time to enhance their own sense of wellbeing.'[16]	Starts with 'a workplace approach', rather than focusing on individuals.
'[M]edical (clinician) engagement is the active and positive contribution of doctors (clinicians) 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.'[24]	Used in the Medical Engagement Scale (MES). This definition is individual focused, 'an intra-individual concept, involving a motivational state or level of commitment that exists within the individual'.[25] The MES tool itself includes organisational measures.
'A positive attitude held by the employee towards the organisation and its values. An engaged employee is aware of business context, and works with colleagues to improve performance within the job for the benefit of the organisation. The organisation must work to develop and nurture engagement, which requires a two-way relationship between employer and employee' (UK Institute of Employment Studies[26]).	Again a positive attitude is required, but the two-way nature of engagement is specified.
'[E]ngaged staff think and act in a positive way about the work they do, the people they work with, and the organisation they work for… when at work engaged staff will experience a blend of job satisfaction and commitment, involvement in the direction of their own job and a feeling of empowerment. They will be advocates of their organisation and what it does, desire to improve the way things are done in their organisation, both for themselves, their colleagues and the outcomes for the team. They will work in teams and want to work for positive outcomes.'[27]	This definition also includes positivity and has a mixed organisational – individual focus. It includes within in it a confusing range of other elements: for example, 'involvement in direction of job' is a high involvement management practice.
The cognitive, emotional and physical contribution of health professionals to their jobs and to improving their organisation and their health system within their working roles in their employing health service.[22]	Developed by Victorian academics, closely related to the original definition of work engagement, but specifies improvement as the aim.
Clinician engagement is the involvement of clinicians in the planning, delivery, improvement and evaluation of health services, utilising clinicians' clinical skills, knowledge and experience.	This definition and variations of it come from NHRC/lead clinicians group and is used widely in Queensland where health services make this part of their strategy and report against it.

The definition that is proposed for Victoria is based on the definition(s) currently used in Queensland. An example of one is provided in the last box of the table; all are slightly different, but have involvement as their central concept. The Queensland definitions are free of the 'preachy' overtones of the UK work, where positivity is an invariable component and also omit wellbeing. This work is not so much concerned with positivity, but that the clinicians are there – in the room and participating in a co-creation process with regard to design, planning and evaluation, and being full participants in decisions that concern them and their patients. On the part of clinicians, such involvement may be a prescribed part of their paid role with protected time allowed, or partially or entirely discretionary. However, for managers ensuring such involvement occurs is central to proper performance of their paid role. Furthermore, participation by angry, disenfranchised burnt-out employees is unlikely; hence attention to high involvement work practices and workload by managers will determine the likelihood of clinicians becoming involved.

Delivery of care has been removed from the Queensland definitions as that is clinicians' primary work and also including it distracts from the issue of engagement for improvement. The words, methods, extent and effectiveness have been added to help create a framework for describing and measuring clinician engagement. Any definition of clinician or work engagement aside, it is important to remember that word engagement has an existing meaning for health service employees and policy makers. This meaning relates to its uses referring to actions (particularly positive participatory communication events) and connection (derived from its use referring to a formal agreement to get married).

Proposed definition

Clinician engagement is about the methods, extent and effectiveness of clinician involvement in the design, planning, decision making and evaluation of activities that impact the Victorian health care system.

Evidence that clinician engagement improves outcomes

There are many papers comparing measures of burnout with clinical performance and patient safety. Clinical leadership has been demonstrated to have a positive impact on patient outcome measures.[28] Leadership and engagement are tightly linked – if senior clinicians are given leadership roles, they will become engaged and then become central drivers of reform.[29] Medical clinicians have been demonstrated to be somewhat resistant to systems thinking and involvement in improvement.[1, 30, 31, 32] Without their involvement, improvement fails or is not sustained.[33] Clinician engagement is one of the ten challenges to improving quality in health care that were determined from analysis of the UK Health Foundation's program evaluations.[34]

The large number of National Health Service (NHS) trusts and the substantial amount of survey and performance data available about each trust means that the strongest work is from the UK.[35, 36] Findings, using engagement measures from the NHS staff survey include:

- Patient satisfaction is significantly higher in trusts with higher levels of engagement.

- Engagement is significantly linked to patient mortality in acute trusts, both when mortality is measured in the same year as engagement, and when measured in the subsequent year.

- High levels of engagement are associated with much lower absenteeism.

- Staff turnover rates are approximately 0.6 per cent lower in trusts that have an engagement score one standard deviation higher than the mean.

- Engagement is significantly related to trust quality ratings.

- In trusts where a large percentage of staff felt they could contribute towards improvements at work, infection rates decreased, reinforcing the value of staff involvement in service improvements.

Positive results on the UK Medical Engagement Scale have been linked to improved mortality, fewer reported incidents and higher levels of service provision (determined by Care Quality Commission ratings).[37]

There is also a growing body of research about the effect of clinicians on health service boards. Again, the size of the NHS and the number of boards and publicly available performance measures have enabled quantitative research.[38] Quality ratings of service providers, derived from information in hospital trust annual reports, and publicly available performance measures (from the Healthcare Commission and Dr Foster) over a three-year period were positively associated with a higher percentage of doctors on boards. This influence also applied to lower morbidity rates and withstood tests to exclude the possibility of reverse causality (doctors joining boards of already successful organisations). It was also associated with improved patient experience.[39] Nurses and allied health professions did not have this effect, and the qualifications of the CEO were not important.[39] Even a small increase in the number of doctors on boards (10per cent) was found to have marked consequences for hospital level outputs and outcomes.

It is theorised that the participation of clinicians on boards focuses more attention on safety and quality issues.[28] A study of US and UK hospitals examining relationships between management practices and quality of care found hospitals with boards that paid greater attention to clinical quality had management that better monitored quality performance.[40]

Measuring clinician engagement

Frequently engagement items are included within a more comprehensive staff survey (which may include items from the Utrecht Work Engagement Scale[41]). The overall culture of any organisation can be assessed by tools such as the well-established competing values framework.[42] However, whatever approach is taken it is important to note units *within* hospitals have quite distinct cultures[43, 44] and engagement data needs to be made available at work unit level. Additionally, questions that begin with 'My organisation…' that work in US or UK contexts may not work well for Australian medical practitioners whose organisational

allegiances may be both multilayered and tenuous – involving hospital(s), health region, private practice group, craft group and so on.

NHS staff survey

The authors of the UK work that examined the relationship between engagement and NHS performance used items from the staff survey that related to three different dimensions: psychological engagement, advocacy and involvement,[35] the latter being the focus of the definition proposed in this paper. Psychological engagement included three questions probing dedication, vigour and absorption: 'I look forward to going to work', 'I am enthusiastic about my job', and 'Time passes quickly when I am working'. Advocacy was measured using two questions: 'I would recommend my trust as a place to work', and 'If a friend or relative needed treatment, I would be happy with the standard of care provided by this trust'. Involvement was measured using three questions: 'I am able to make suggestions to improve the work of my team/department', 'There are frequent opportunities for me to show initiative in my role', and 'I am able to make improvements happen in my area of work'. For antecedents of engagement, they focused on two aspects of people management that previous NHS work suggested are particularly linked with engagement: appraisal and team working.

Medical engagement scale (MES)

The medical engagement scale was developed as part of UK work on medical leadership and has been validated using a large sample of NHS doctors (more than 20,000).[24] The scales and subscales[37] include: 'Working in a collaborative culture', 'Having purpose and direction' and 'Feeling valued and empowered'. Measures assessing the organisation as well as the perceptions of doctors are a strength of this scale and workers are able to be placed on the following grid and response to organisational changes tracked. This scale has only been validated for medical practitioners. The tool is publically available, but the benchmarking data for the MES are held by a private consultancy. Its utility for the Australian employment context is unclear because no Australian data have been released.

Advisory Board Nurse Engagement Survey

An international group offers this survey specifically designed to meet the needs of nurse executives and a range of solutions are then suggested in response to the results, including high visibility leadership interventions, motivational narratives, building a unit-level infrastructure and so on. It is used in Victoria – in at least one very large metropolitan health service. Costings have not been investigated. Some sample items are available, the full scale is not publically available and the benchmarking data privately held. As an example, questions in the autonomy category include: 'I have an appropriate level of independence in caring for my patients', 'I have sufficient input on my patient's care plans' and 'Nurses on my unit take an active role in contributing to decisions that affect our work'. The role specificity of the questions is notable. There is new attention to nurse engagement/satisfaction surveys as part of requirements for application for 'magnet' status in the US. This defines a culture that encourages the nurse to flourish as a professional, focuses on professional autonomy,

decision making at the bedside, involves nursing in determining the nurse work environment, provides professional education and promotes leadership. Collaborative working relationships are fostered, with teamwork and positive relationships among different departments and disciplines demonstrated. The idea is that the 'magnet' name helps patients identify hospitals where they can find satisfied nurses and expect to receive a higher level of care. Only about six per cent of US hospitals achieve magnet designation.

Best Practice Australia

A number of public and private not-for-profit metropolitan and regional health services in Victoria have paid Best Practice Australia (BPA) to undertake staff engagement surveys, which are then benchmarked against other clients of BPA.[14] Neither the scale nor the benchmarking data is publically available. A hospital CEO who had used this survey over several years was interviewed. It cost about $50,000 per administration. With results being available at unit level, the organisation is able to assess and strengthen their middle management (improving their performance, including planning and staff management.) Problem units receive six-monthly follow-up surveys after institution of improvements. It was considered value for money, especially because of the accompanying benchmarking data available.

NSW – Australian Medical Association – Australian Salaried Medical Officers Federation Survey

This joint AMA/ASMOF report was recently released.[15] Overall response rate was thought to be about 33 per cent, but it was quite low for some regions. The publicly available results are broken down by local health districts, and there are striking differences between areas. For instance, in response to the question: 'The chief executive and senior management team at my LHD/network consults doctors about issues that affect them', 41 per cent agreed or strongly agreed in one area, but only 22 per cent in another. In response to 'The chief executive and senior management team at my LHD/network can be trusted to tell things the way they are', agreement ranged from 74 per cent to 35 per cent. In response to: 'I consider that my work is aligned to the wider organisational goals and mission of my LHD/network', agreement ranged from four per cent to 29 per cent. In response to: 'I feel motivated to contribute above and beyond what is normally required at work', agreement ranged from 12 per cent to 44 per cent. Overall, doctors felt valued by patients, coworkers and other clinicians, but not by the LHD or ministry. This locally created scale is publically available, but has not had full psychometric development.

OECD

The OECD has recently taken quite a different approach, measuring the *participation* of leading clinicians (doctors and nurses) in clinical management functions. Views of 'No involvement', 'Giving an opinion', 'Shared decision making' and 'Final decision-making responsibility' were sought on a range of subjects from budget to hospital decoration to

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[14] See client list here: http://www.bpanz.com/page/About_Us/Our_Experience/

[15] http://asmofnsw.worldsecuresystems.com/pdf/0267_AMAASMOF_EngagementReport_v5.pdf

choosing protocols.[45] This approach seems to have some potential utility for the Department of Health and Human Services if the proposed definition is accepted. Items could be added to the People Matter Survey for health services.

The most representative and comprehensive data on clinician engagement in Victoria is collected through the People Matter Survey run by the Victorian Public Sector Commission (VPSC). This is a valuable resource which should be used widely, both within health services and the department.

However, a few factors limit its use. First, although the option to identify respondents' clinical unit is made available to health service CEOs, this is not always taken up, reducing the actionability of the results. Second, response rates (for which health service CEOs are responsible) are sometimes low, which can compromise the usefulness of the data (especially for small rural health services) and make it easy to dismiss the results. Finally, it is difficult for the Department of Health and Human Services staff to access the data or for the department to procure VPSC analysis of the results. This locally created scale is publically available. The survey uses just five questions used to create the engagement index: 'my organisation motivates me to help achieve its objectives', 'my organisation inspires me to do the best in my job', 'I would recommend my organisation as a good place to work', 'I feel a strong personal attachment to my organisation' and 'I am proud to tell others I work for my organisation'.

As an illustration of the complexity of the choice of survey and survey questions, in the table below the MES scales are contrasted with items in People Matter Survey. Note that the People Matter Survey has a range of relevant questions, not full overlap, but most importantly, the five-item 'engagement measure' provided by People Matter is quite narrow (the five items are shown in bold). That is, a scale such as MES would use many more items to construct an engagement score.

MES scale domains compared with People Matter Survey items

MES scale	Scale definition – concerned with the extent to which…	Closest People Matter Survey equivalent
Index: Medical engagement	…doctors adopt a broad organisational perspective with respect to their clinical responsibilities and accountability	8D: My organisation motivates me to help achieve its objectives
Meta scale 1: Working in an open culture	…doctors have opportunities to authentically discuss issues and problems at work with all staff groups in an open and honest way	3C: People in my workgroup are honest, open and transparent in their dealings 3E: My workgroup always tries to improve its performance 7C: I am encouraged by my colleagues to report any patient safety concerns I may have
Meta scale 2:	…medical staff share a sense of	5A: Senior managers provide clear strategy and

MES scale	Scale definition – concerned with the extent to which…	Closest People Matter Survey equivalent
Having purpose and direction	common purpose and agreed direction with others at work particularly with respect to planning, designing and delivering services	direction 5C. In times of change, senior managers provide sufficient information about the purpose of the change 5D. Communications about change from senior managers are timely
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	2F: I receive adequate recognition for my contributions and accomplishments
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	7D: The culture in my work area makes it easy to learn from the errors of others
Sub scale 2: [I] Good interpersonal relationships	…all staff are friendly towards doctors and are sympathetic to their workload and work priorities.	3H: People in my workgroup treat each other with respect
Sub scale 3: [O] Appraisal and rewards effectively aligned	…doctors consider that their work is aligned to the wider organisational goals and mission	2H: I have a clear understanding of how my own job contributes to my workgroup's role 3F: I have a clear understanding of how my workgroup's role contributes to my organisation's stated outcomes
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	4B: My manager listens to what I have to say 4C: My manager involves me in decisions about my work
Sub scale 5: [O] Development orientation	…doctors feel that they are encouraged to develop their skills and progress their career	8K: In my organisation, there are opportunities for me to develop my skills and knowledge
Sub scale 6: [I] Commitment and work satisfaction	…doctors feel satisfied with their working conditions and feel a real sense of attachment and reward from belonging to the organisation	9D: Considering everything, how satisfied are you with your current job? 9E: Considering everything, how would you rate your overall satisfaction with your organisation as an employer? **7O: I would recommend my organisation as a good place to work** **7P: I am proud to tell others I work for my organisation** **8C: I feel a strong personal attachment to my organisation** **8E: My organisation inspires me to do the best in my job**

Improving clinician engagement – what does the literature offer?

Clinician engagement is an issue that must be considered within a complex socio-political contextual web. There are longstanding tensions between clinical work and management work and between managers and clinicians. These are most pronounced for medical clinicians, who have been leading participants in an ongoing struggle for control of health care. Appendix B summarises some of the literature on this subject. Solutions include the attempt to circumvent requests for structural power by the widespread application of the word 'leader'. Doctors have been integrated into formal management structures, but not always as budget holders. Indeed, controlling cost and managing budgets often sits ill with their identity as patient-focused practitioners. One of the interesting current ideas is that creation of an intermediate space in health care systems is needed to allow clinicians to participate in transformation and improvement – the suggestion is:

> '…to search for strategies to locate clinical/medical practice at a more collective level and also to install medical leadership and engagement in so-called less structured systems like networks.'[46]

Viewing health care as a complex adaptive system provides an overarching framing for considering solutions. Complexity theory has been extensively applied to investigation of health care systems and institutions over the last 20 years, particularly to the study of change and improvement. This approach focuses on the interactions between system components 'as the foundation from which the properties of a system emerge'.[47] Complex systems are energised by diversity and characterised by nesting and self-organisation. Nesting refers to larger complex systems that surround the system under examination, and it has component parts that are themselves complex systems. Broader social systems and societal structures surround health care, and within health care nesting continues down to the level of the clinical micro-system. Self-organising describes the capability of the various interconnected elements in a system to adapt or learn from experience.

> 'If we recognize that health care organisations are complex adaptive systems operating in a professional milieu then we focus on different things and arrive at different conclusions than if we believe that they are professional bureaucracies begging to be run more effectively and efficiently according to traditional rules of administrative behavior.'[18]

For instance, considerable attention has been given to clinicians' roles via job descriptions, task analysis and redesign processes in an attempt to improve care. Complex adaptive systems, though, are defined by interdependencies between people, so 'attention to the management of relationships is more important than attention to the management of roles'.[18] In health, shared value systems and shared expertise facilitate some relationships and make others more difficult (for example, when there is tension over 'turf' between professions).

At the level beyond the bedside, there is even more need to engage diverse thinking to meet the strategic and operational challenges of modern health care. When widespread participation in decision making is enabled, 'many parts of the system (not just the top) are using their view of events, their knowledge of the organisation, and their knowledge of

themselves in order to discover or create a successful organisational adaptation.'[48] Participation itself creates and improves self-organising abilities. When people are brought together to exchange and process information, they learn more about the system and each other. This social process leads to personal and organisational learning.

> 'Participative decision making will enhance and make denser the organisation's web of relationships, and at the same time set free a broad range of ideas and strategies which can lead to the organisation developing a larger behavioural repertoire. These factors may make the management of participation messy, but in the long run the results will be worth the effort.'[48]

Tips for improving clinician engagement

There are voluminous UK publications which are somewhat self-referential and closely linked to the UK context and NHS politics, challenges and strengths. There is limited evidence (case study verging on anecdote) provided for suggested solutions. These are often very general, not easily measured and there is little sense of what prudent investment for engagement might look like.

Ways to promote clinician engagement derived from study of the best organisations following application of the MES:[49]

1. Leadership – stable, top-level leadership that promotes and fosters relationships, sets expectations and leads by example.

2. Developing a future-focused and outward-looking culture – encouraging and engaging in best practice, and promoting and contributing at regional and national level.

3. Selecting and appointing the right doctors to leadership and management roles – open competition and appointment based on ability, attitude, leadership aptitude and potential.

4. Promotion of understanding, trust and respect between doctors and managers – developing an acknowledgement and acceptance of professional differences.

5. Clarity of roles and responsibilities and empowerment – ensuring doctors and managers work together, are accountable and empowered to shape and develop the organization.

6. Effective communication – building trust and developing relationships through open, honest communication that is persistent, widespread and inclusive.

7. Setting expectations, enforcing professional behaviour and firm decision making – (issues relating to unprofessional behaviour and patient safety are dealt with quickly and decisively).

8. Providing support, development and leadership opportunities to doctors at all levels.

UK work using the NHS staff survey[35] found engagement to be associated with aspects of job design: working in teams, getting good support and appraisal from an immediate manager, having clear job content and the opportunity to be involved in decision making.

Organisational features considered important in study of Trusts that were highly successful or improving on engagement measures in the NHS staff survey:[36]

1. Organisational values that emphasise the centrality of patient care – with frontline staff involved in developing the values and managers re-enforcing their centrality through their actions (including embedding them in human relations processes). One of their respondents noted that as many health care workers see their job as a vocation, 'it's important to have absolute synergy between your personal values and your organisational values'.[36]

2. Senior leaders who value engagement, communicate effectively (being very visible) and have some stability and experience.

3. Engaging managers, these line managers play a pivotal role in appraisal, in supporting team working and staff involvement. Training for this group is important.

4. Employee voice and involvement – being able to raise concerns, offer suggestions for improvement, and be involved in organisational decision making. Case study trusts focused on encouraging strong clinical leadership and devolving power and responsibility to clinicians (different to the previous NHS command and control or 'pace setting' approach).

5. Working in partnership with unions.

6. Giving special attention to involving staff in challenging times when resources are stretched.

The US literature offers rather more transactional or pragmatic solutions. The topic of clinician engagement overall has been of less interest in the US.

Strategies used to engage providers in US hospital quality initiatives:[50]

1. Financial – for example, personal payment for specific quality outcomes or protected salaried time.

2. Private reporting – that is, feedback to the provider that is timely and may contain comparative data, such as utilisation, cost and clinical outcomes benchmarked with the work of others.

3. Provider leadership – entrusting providers to formally lead initiatives.

4. Alignment strategies –include professional service agreements and physician compacts (for example, at Ottawa[51] and Royal Children's Hospital Melbourne).

5. Employment replacing contractor arrangements.

6. 'Removal of barriers' – assumes providers have the desire to participate, but are hindered by: shortage of time, lack of methodological knowledge or competency or poor psychological safety (an environment where speaking up and making mistakes is risky, this inhibits learning).[52] Barriers can be removed by: making projects more feasible, administrative support (personnel, data, experts), training, communication – including use of multiple approaches and creation of multiple opportunities to be involved.

A US study involving interviews with the executives of ten high-performing hospitals where physicians were mainly salaried employees, placed emphasis on 'engaged leadership' with quality as a shared goal. This requires finding ways to reward scholarly safety and quality activities and adequate compensation: 'Too many hospital leaders believe that physicians can do quality at tea time and between surgical cases…'[53]

While the cost of medical engagement is a potential barrier, it is suggested that as doctors have the most influence on variation in health care outcomes it is not possible to reduce variation without investing.[53] Researchers have suggested that:

> 'Any serious and enduring medical engagement and leadership development strategy will require some innovative policy for physician compensation and performance management, to take into account the time that physicians are dedicated to extra-clinical roles and to move from local initiatives to broader changes in the system.'[46]

It has also been noted that engagement 'activities may be more challenging to implement when physicians are self-employed or employed independently of the hospital'.[53] Victorian researchers also found that the part-time employment of senior medical practitioners limited their level of clinical engagement with the institution.[54]

Junior medical clinicians and health professional students

In the case of medicine, there have been convincing arguments made for the negative effects of frequent junior doctor rotations on the quality of care delivered and on professional development.[55] Currently, junior doctors undertake four to five rotations per year. This means they will work in different clinical units and in different sites. They do this in an environment where patient complexity is increasing, yet there is also rapid throughput of patients. Additionally, working hours are restricted – an inevitable consequence of reduced hours is more shift work, more handovers and an even more fragmented work experience. Reducing working hours has not been as effective as expected in reducing psychological distress and burnout in junior doctors.[56, 12]

Rotational patterns of employment are associated with personal isolation, dysfunction workarounds and poor patient care.[57] Doctors fail to develop crucial interprofessional teamwork competencies and receive reinforcement of: 'the "trainee as tourist" mentality in the critical learning activities of quality improvement, patient safety and systems change'.[55] Junior doctors are currently socialised to cope, but 'given little or no guidance about how to fix the broken system'.[58] It is not known what strain this causes for nursing staff, who are forced into an even more vital continuity role, with respect not just to individual patients but in carriage of 'how things are done here'. More modern approaches to education focus on competency. Time to trust is necessary to realise competency-based education.[59] The UK has undertaken considerable work attempting to improve the experience of foundation doctors, including longer rotations.

While some junior medical staff are enthusiastic about quality improvement (QI)[60], others may have poor understanding of QI activities and consider it extra work and without value.[61]

Quality improvement can be successfully taught to students from all health professions and trainees and has been attempted at scale[62] and local changes in care delivery implemented. The US Institute of Medicine (IOM) has recommended involving students in team-based quality improvement and patient safety activities.[63p53] They note that many effective interventions combine team training with 'taskwork' training related to best practices for a specific patient population (for example, diabetes patients).[63p68] However, ensuring sufficient faculty to support this work and limiting competing demands on trainees can be a problem.[64] It has been suggested that alignment of education and practice at the community clinic (or micro) level could be achieved by increasing the value, and lowering the costs of students in practice settings by engaging students in organisational improvement.

The potential value of students at the community clinic level

'To begin with, students need to learn and demonstrate [interprofessional] competencies before entering the clinical environment and come to it with the ability to contribute, even in small peripheral ways… Longitudinal rotations can… allow the learners to become a part of the practice rather than just 'tourists' passing through.

In a planned system, students can also add considerable value to practices. They can gather data on practice performance and processes and analyse care flow. They can research care processes and guidelines and bring this information into the practice for consideration. If appropriately prepared and supervised, students can be more active liaisons between the practice, their patients, and the community. However, this can only be achieved if the students have enough continuity with the practice to accomplish the work and a supervisory structure that links their learning with the practice's improvement goals.' [65p48]

Conclusion

Clinician engagement is not a unitary and agreed concept. Clinicians may or may not work as salaried employees, but even when they do, may still identify as independent professionals. Their engagement results in better safer care, but their anomalous status may make it more difficult to achieve. Setting a definition for clinician engagement that is focused on involvement seems to offer the potential for measurable increases in engagement, essential for sustainable change in health care. In the sections that follow, a range of opportunities to improve engagement in Victoria that are supported by local research are suggested.

Section C - System-level clinician engagement in Victoria

System-level clinician engagement was assessed by collection of relevant workforce data, detailed analysis of the 2016 People Matter Survey, speaking to and surveying CEOs, clinical leaders, clinical network members, nursing unit managers and frontline clinicians. Engagement, by region, by sector and by stakeholder viewpoint was varied. More senior stakeholders had a rosier view than those lower in the organisational hierarchy. There were pleas at all levels for site visits and face-to-face meetings – from the Department of Health and Human Services, from board members and CEOs. Everyone wanted more personalised engagement and consideration of their concerns about clinical care.

What does the People Matter Survey tell us?

The best available statewide data on engagement – the Victorian Public Sector Commission's 2015 People Matter Survey – sent to over 100,000 people – indicates that there may be significant room for improvement in many parts of the health system. Results for both organisations and professions in the public hospital and community health services sectors show a high level of variability, with areas of both excellence and weakness.

The Victorian Public Sector Commission conducts the People Matter Survey of employees in most public hospitals and health services and community health services every year. The survey contains five questions on engagement that are combined to form a total score out of 100 (known as the 'engagement index'). An index value of 100 indicates that the employee 'strongly agrees' with all five engagement statements. These are:

- 'my organisation motivates me to help achieve its objectives'
- 'my organisation inspires me to do the best in my job'
- 'I would recommend my organisation as a good place to work'
- 'I feel a strong personal attachment to my organisation'
- 'I am proud to tell others I work for my organisation'.

An index value of 75 indicates weaker agreement with these statements, on average, while an index of 50 indicates the respondent neither disagreed nor agreed with them. An index of 25 or 0 indicates the respondent disagreed or strongly disagreed with the questions, respectively.

As discussed earlier, the engagement index is constituted from a narrow set of items (although the People Matter Survey does contain a range of other items also relevant to engagement, which are not analysed here, but could be fruitfully investigated). It is also not

focused on the clinician involvement or on engagement in quality improvement which are the foci for this paper, but does provide information about attitudes that will reflect past involvement and potentially predict future likelihood.

As Figure 1 below shows, employees' engagement index values are highly variable across Victoria, although remarkably similar across the hospital and community health sectors. About half of all respondents (54 per cent of hospital staff and 51 per cent of community health service staff) provided an engagement index value of 75, indicating that on average, half agree or strongly agreed with the questions assessing their engagement. Encouragingly, a significant proportion of employees are highly engaged: 15 and 18 per cent of public hospital and community employees reported engagement values of 100, indicating perfect agreement with the questions.

Figure 1 Distribution of respondent engagement scores in hospitals and community health services
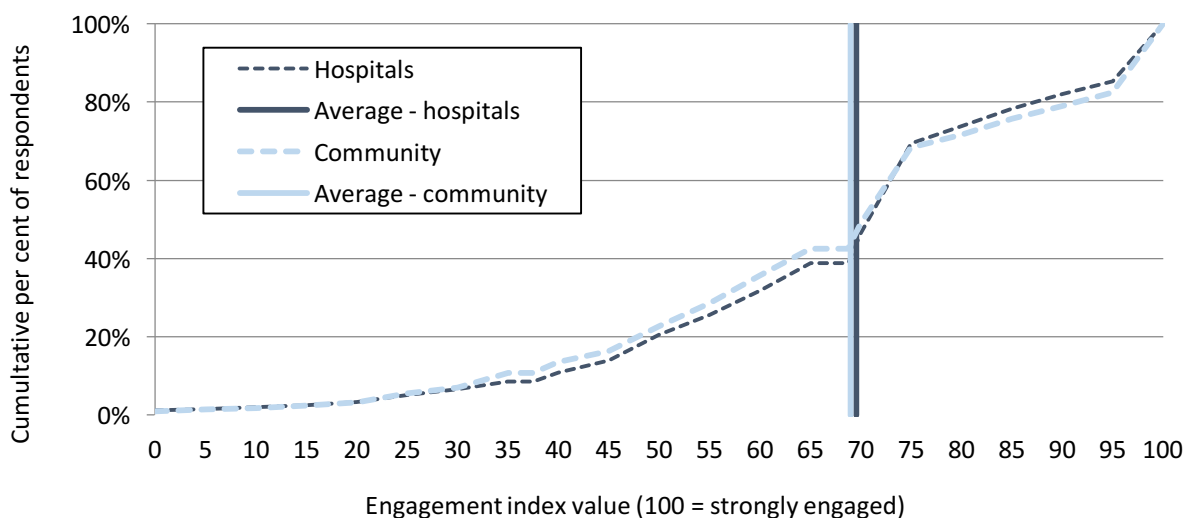
Source: analysis of 2014–15 People Matter Survey data provided by the Victorian Public Sector Commission.

Notes: Indices are calculated from the average of all employees' individual average agreement with five Likert scale questions concerning their engagement in the 2015 People Matter Survey. Clinician and non-clinician respondents were not differentiated in the data provided, and other analyses show that non-clinician (particularly executive) respondents report higher engagement, potentially skewing the results. The People Matter Surveys were distributed to 85,544 employees, with 28,132 responses (n = 1160 in community health and 28,126 in health services). Survey responses rates varied by organisation (and likely also by background, position and employment status), and data may not be perfectly representative. It was not possible to conduct tests of significance using the summary data provided.

However, many respondents were much less engaged. About one in six (14per cent of hospital staff and 16per cent of community health service staff) reported index values under 50, indicating that on average they felt disengaged or strongly disengaged. For all public hospitals and community health services respondents, the average engagement values were 70 and 69, indicating that on average, respondents did not routinely agree or strongly agree that they felt engaged in the ways canvassed.

As Figure 2 shows, while many health service providers do have highly engaged staff, there is significant variation across the state, with areas of strength and weakness in both hospitals and community health services across metropolitan, regional and rural areas.

Average organisational engagement was similar across the community and hospital sectors, with sector-wide organisational average scores of 71.4 and 71.3, respectively.

Figure 2 Staff-reported engagement in Victorian hospitals and community services
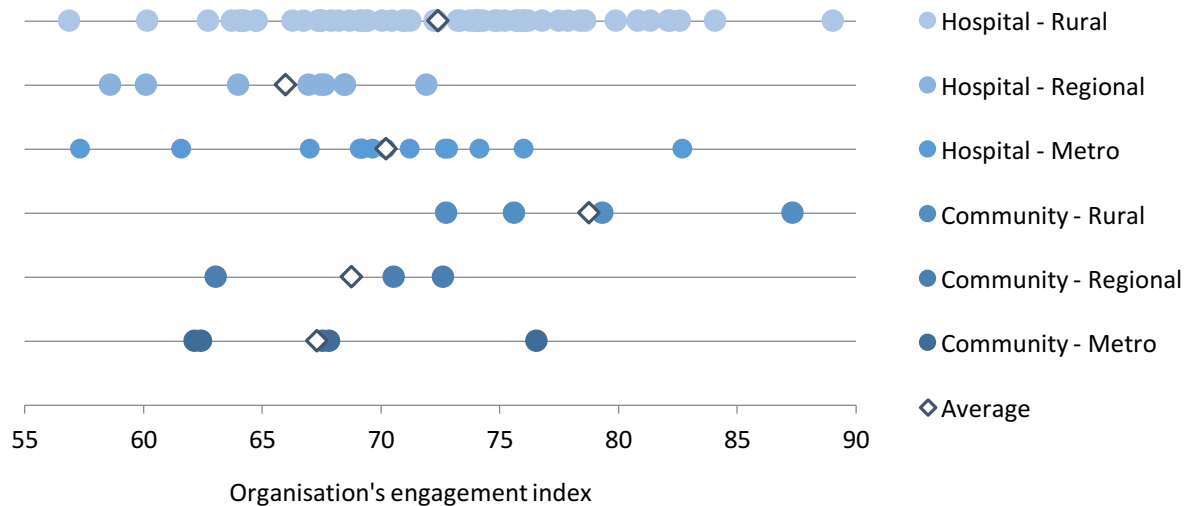
Source: analysis of 2014–15 People Matter Survey data provided by the Victorian Public Sector Commission.

Notes: n = 12 community health services and 82 hospitals. Survey responses rates varied by organisation and data may not be perfectly representative. It was not possible to conduct tests of significance using the summary data provided.

Engagement varies across professions. As Figure 3 shows, medical respondents reported feeling more engaged with their organisation than allied health workers or nursing staff did, on average. This was common across both hospitals and the community health sector, although the differences are unlikely to be significant in community health.

Figure 3 Variation in average reported engagement across health professional groups

Source: analysis of 2014–15 People Matter Survey data provided by the Victorian Public Sector Commission.

Notes: It was not possible to conduct tests of significance using the summary data provided. Response rates are likely to vary significantly by professional group and results may not be representative, even in groups with large sample sizes. Sample sizes are as follows: for community health services only: community development (66), counselling (76), oral health (65) and social

worker (92). For both community health services and hospitals: management, administration and corporate support (298 and 6537, respectively), support services (68 and 2507), personal service workers (24 and 508), other health professional (39 and 1731), medical employees (20 and 1745), nursing employees (97 and 10,566) and allied health professional (179 and 4512).

Reported engagement also varies somewhat for respondents with different employment conditions. As Figure 4 shows, across both hospital and community health services, respondents on executive contracts were most likely to report a strong sense of engagement with their organisation. With the exception of sessional community health workers, ongoing staff were less likely to feel engaged than casual, fixed-term and sessional staff.

Figure 4 Variation in average reported engagement by employment status

Source: analysis of 2014–15 People Matter Survey data provided by the Victorian Public Sector Commission.

Notes: the engagement value for sessional staff in community health services was suppressed, because there was only one respondent in that category. Response rates are likely to vary significantly by professional group and results may not be representative, even in groups with large sample sizes. Sample sizes for both community health services and hospitals are as follows: executive contract (12 and 213, respectively), casual (34 and 1154), fixed-term temporary (213 and 4270), sessional (1 (suppressed) and 247) and ongoing (870 and 21823). An additional 30 community service and 417 hospital staff reported they 'didn't know' their employment status; their engagement values are not reported here. It was not possible to conduct tests of significance using the summary data provided.

Reported engagement also varies for survey respondents with different levels of organisational seniority. Executives are much more engaged than managers and employees; a trend that is consistent across the two sectors examined. Figure 5 demonstrates this. Two of these results are surprising and at variance from the literature and the interview data that follows in this paper. The first is the higher engagement of doctors. The second is the suggestion that more enduring employment in an organisation may be associated with slightly weaker engagement. Doctors are generally dismissive of organisational emails, and while most surveys attract polarised participants, perhaps in the case of disenfranchised doctors 'delete' occurred more often. The enduring employment finding is hard to interpret without unit-level data. As discussed earlier, many staff feel their strongest engagement at the work unit level, and may be negative about the overall organisation. This difference in views may be more pronounced for those who have been there longer, or longer-term staff may be less engaged at both unit and institution level. However, this is just speculation, more representative, comprehensive and granular data would provide greater intelligence.

Figure 5 Variation in average reported engagement by organisational seniority
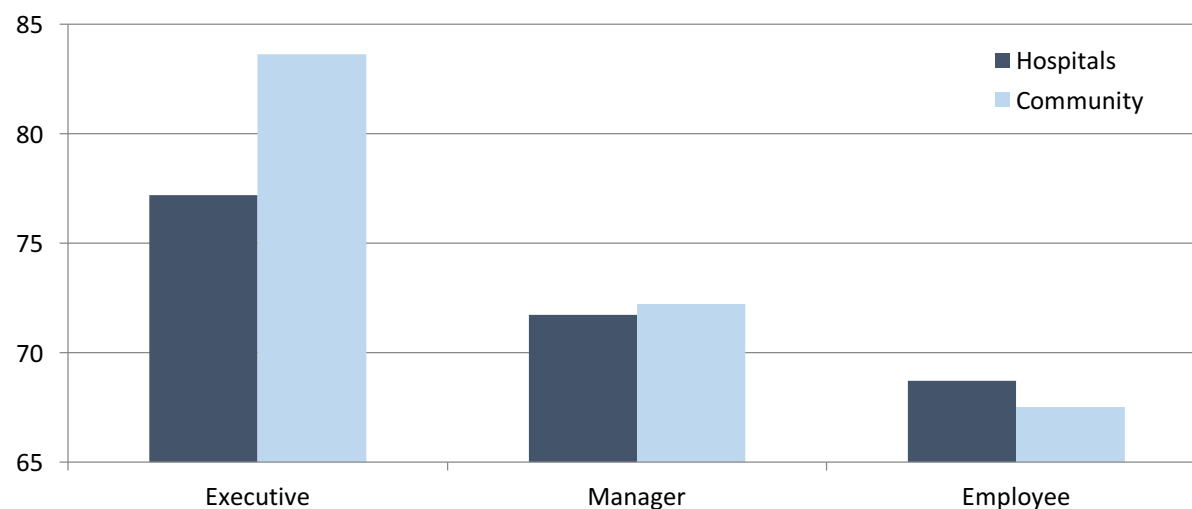
Source: analysis of 2014–15 People Matter Survey data provided by the Victorian Public Sector Commission.

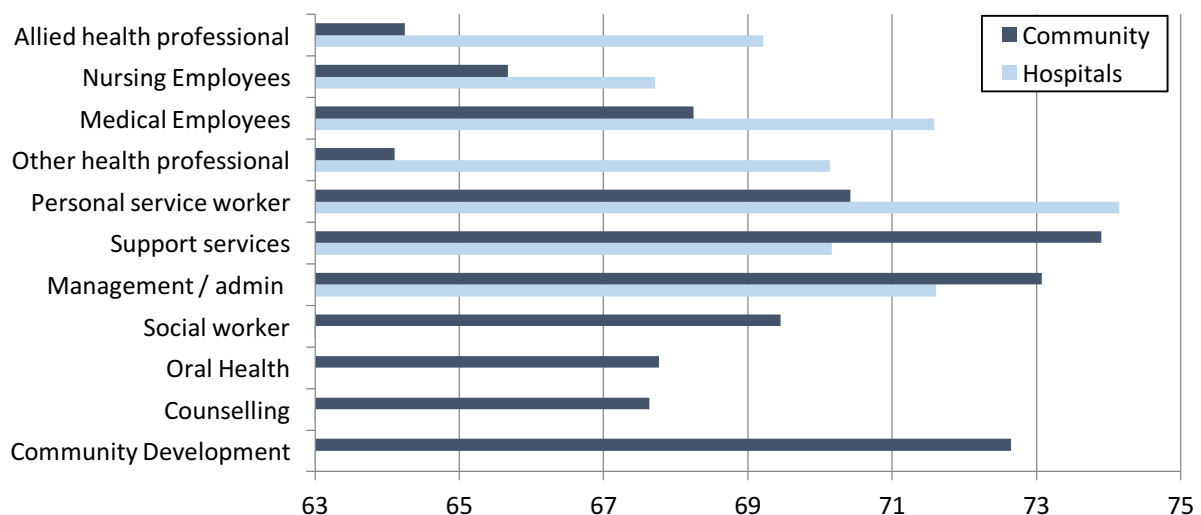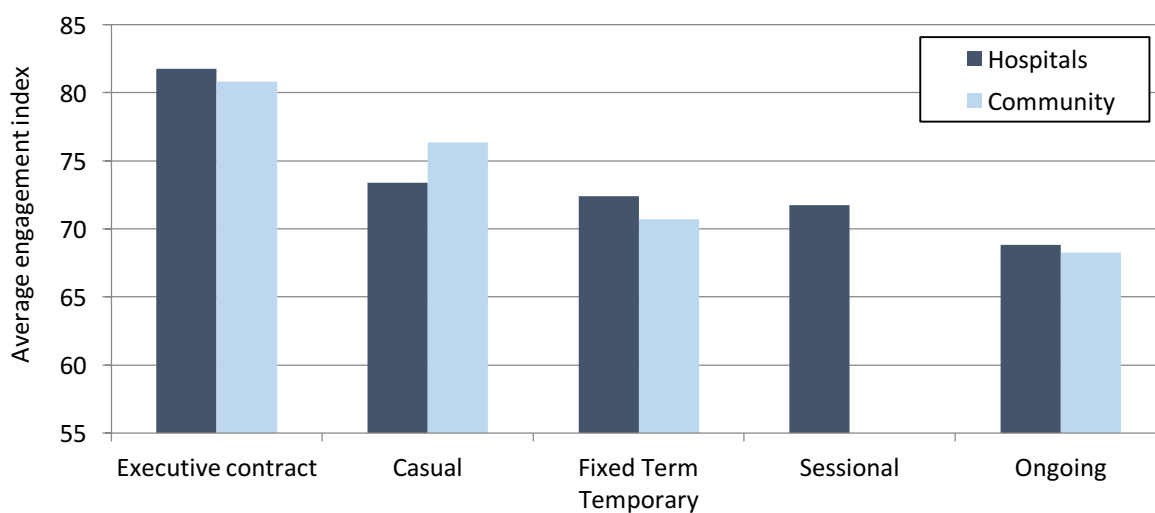Notes: Response rates are likely to vary significantly by professional group and results may not be representative, even in groups with large sample sizes. Sample sizes for both community health services and hospitals are as follows: executive (65 and 1418, respectively), manager (152 and 4133) employee (943 and 22,581). It was not possible to conduct tests of significance using the summary data provided.

Recommendations

Improve data collection on clinician engagement – *the People Matter Survey's data collection process is improved so it is a better fit for the purposes of health service providers. This would include:*

- *removing irrelevant sections from the survey in order to decrease its length and increase response rate*

- *developing a much shorter and engagement-focused 'pulse check' version to allow organisations to monitor and address the effect of organisational change when they feel they need to*

- *promoting the opportunity to collect the service unit of respondents, which would permit more granular and actionable analysis of survey results*

- *the VPSC consulting with public and private health services using commercial survey products (such as Best Practice Australia's) instead of the People Matter Survey in order to better understand perceived gaps in the survey and reporting*

- *permission for the private sector to use the redeveloped survey(s) on a cost-recovery basis, and promotion of participation.*

Use data to monitor clinician engagement and give underperformers targeted support – *The department s People Matter Survey data to monitor clinician engagement in health services and identify underperformers for targeted support from Safer Care Victoria. If a health service uses a different survey, it should be invited to supply the results of that to the department instead.*

Are health service boards concerned with engagement?

Victoria public health service and hospital boards were comprehensively surveyed in 2012. This survey had a quality and consumer focus. At that time only just over two-thirds of boards had quality as a standing agenda item.[66] About two-thirds of board members believed that the quality of care delivered by their health service was better or much better than a typical Victorian health service, presumably due to a lack of benchmarking and the confusing nature of the available quality metrics.[67] Hence, this group was not surveyed again, but instead their annual reports were reviewed. These revealed significant variation in mention of clinician engagement. This suggests (but may not necessarily entail) variation in executive and board focus on clinician engagement. In total, almost half of all annual reports did not mention clinician engagement. There was no neat link between health service size or geography and their propensity to mention engagement; for example, small rural health services were less likely than major (mostly metropolitan) health services to mention engagement, but more likely than outer metropolitan and large regional health services.

Figure 6 Per cent of health service annual reports that do not mention clinician engagement
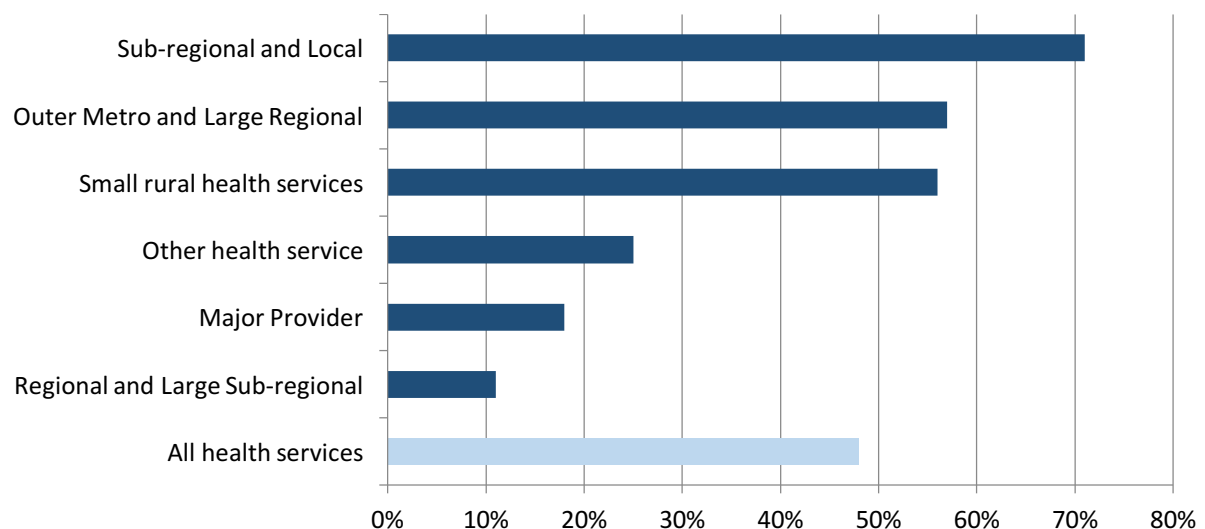
Source: analysis of health services' annual reports for 2014-15 (or the most recent year available)

Notes: Patient safety culture results from the People Matter Survey have not been considered as mention of engagement here, because they are not directly about engagement and are required within the statement of priorities, rather than being discretionary. Total n = 81 of 89 eligible services, including subregional and local health services (n = 14), outer metropolitan and large regional (7), small rural (36), other health service providers (4), major providers (11), and regional and large subregional (9).

Research suggests that improving board and management practices may be an important and previously underappreciated component of systems level change.[40] One of the three mechanisms for board effectiveness suggested by the NHS is 'Giving priority to engagement with stakeholders and opinion formers within and beyond the organisation; the emphasis here is on building a healthy dialogue with, and being accountable to, patients, the public, and staff… [funders] and regulators'.[68]

However, review of annual reports for Victorian health services suggests varied formal board attention to staff engagement. Staff may be engaged, management may be instituting high involvement work practices and collaborative improvement proceeding apace, but

engagement is not, in general, a board focus. There were comments made by survey respondents about the Department and local boards needing to provide 'listening ears' to clinicians; for example, about the effect of patient throughput imperatives. One respondent understood the literature around board composition:

> 'Clinical engagement is a nonsense. It involves the most informed coal face worker too late in the decision making process. Clinicians must be INCLUDED around the executive and board table BEFORE money is wasted… As per Kings Fund – quality care at hospital level is proportionate to the number of HOSPITAL DOCTORS you have on the board.'

Nurse executives had also not noticed board attention to engagement. This is shown in Figure 7. However, it is not clear to what extent clinical managers are aware of board scrutiny and direction in other areas, so this data is hard to interpret. A rural interviewee suggested:

> 'Respecting local governance is a false barrier – the department is the regulator. Have to change system so that boards govern the structure the regulator wants.' (rural doctor)

In the case of engagement, the focus by boards could be improved.

Figure 7 Nurse views on board focus and executive effects on engagement
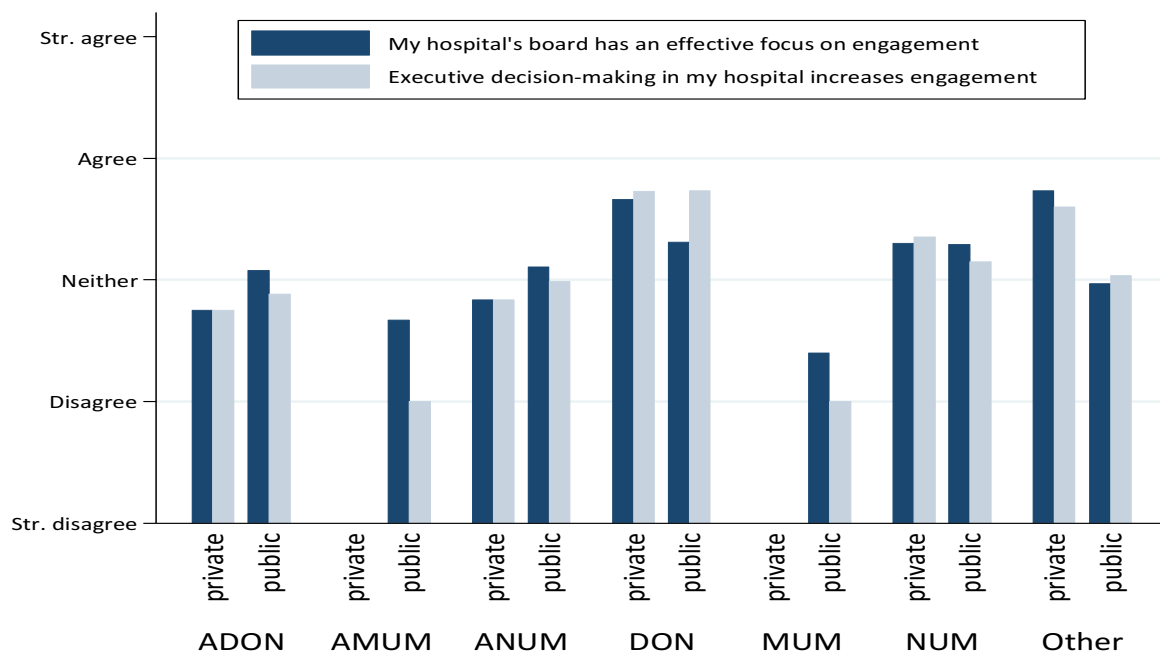
Source: survey of nursing and midwifery leaders in the public and private hospital sectors.

Notes: N = 348 public and 100 private respondents. Survey responses relied on directors of nursing circulating the survey, and so are unlikely to be representative and unbiased. DON & ADON = director and assistant director of nursing; MUM & AMUM = manager and assistant midwifery unit manager. NUM & ANUM = manager and assistant nurse unit manager.

> **Recommendations**
>
> ***Set minimum responsibilities for health service boards in regard to clinician engagement****. These may include:*
>
> - *a minimum response rate to the improved People Matter Survey or consider using another tool that offers sufficient granularity*
>
> - *reporting their engagement survey results together with their planned response*
>
> - *review of the membership of their senior executive to ensure that there is appropriate multidisciplinary representation*
>
> - *developing an annual schedule of visits so that they can hear concerns from all parts of their organisation*
>
> - *considering whether the structural preconditions for engagement are being met by:*
>
>   - *minimising very part time employment arrangements*
>
>   - *supporting high involvement work practices (people and culture)*
>
>   - *ensuring management structures that support engagement are in place (for example, clinical directorates)*
>
>   - *considering amending statements of priorities to incorporate minimum requirements.*

Are structural preconditions for clinician engagement in Victoria in place?

The management literature is clear that 'engagement is a social practice that requires repeated interactions over time',[22] and thus it is considered by some unrealistic to 'invest hopes for system reform in the engagement of independent practitioners'.[22] Salaried employment, where there is one employer and one workplace quite simply engages doctors.[69] Thus, by implication, it should be more difficult to engage clinicians who work part time in the health system or who have a number of part-time fractional appointments with different employers.

As Figure 8 shows, a significant proportion of clinicians work part time in the Victorian health system. In 2015, when the data was collected, about a quarter of nurses and allied health clinicians, and an eighth of medical clinicians, worked the equivalent of three shifts or less (24 hours or less) per week across the entire health system.[16] Nurses were the most likely to

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[16] Analysis of the National Health Workforce Data Set NHWDS (2015, 2014). This dataset is a combination of data collected through the registration renewal process each year both through the information required to register and a survey administered at the time of registration. Survey response rates are approximately 90 per cent and so are highly indicative. However, the survey has not been weighted and so will have minor inaccuracies in its representation of workforce conditions.

work part time (28per cent work 24 hours per week or less), followed by allied health (24per cent) and then doctors (12per cent).

Figure 8 Clinicians working part time in the Victorian health system
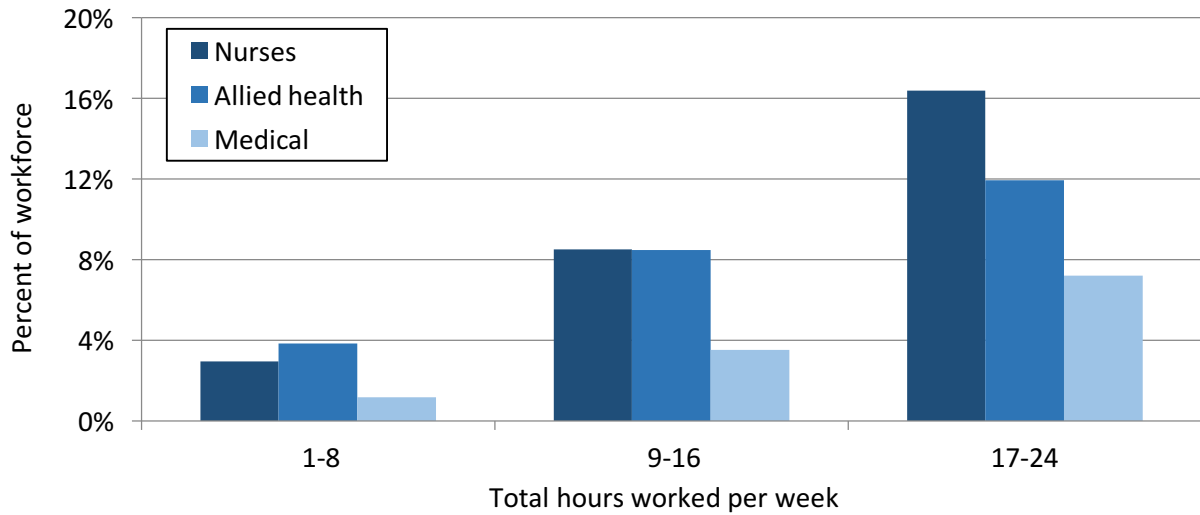
Source: National Health Workforce Data Set (2015).

Notes: The NHWDS is a combination of data collected through the registration renewal process each year both through the information required to register and a survey administered at the time of registration, with the latter making up the bulk of the data collection. Due to the high response rate (89.7per cent for nursing, 92.6per cent for medical and 83.3–95.8per cent across allied health professions), no imputation or estimation for item non-response has been taken. The results presented should thus be seen as indicative rather than absolute. N = 127,776 respondents, including 76,637 nursing, 21,482 medical and 29,657 allied health.

Fractional appointments are also a commonly cited obstacle to engagement. Currently, the department does not have access to data showing the number of clinicians working for multiple employers, or the number of employers per clinician. However, the number of clinicians working across different sectors (which implies a minimum of two employers) can provide a lower minimum estimate of this phenomenon. As Figure 9 shows, approximately eight per cent of all clinicians, including 22 per cent of all doctors, are currently working in both the public and private sectors.

Figure 9 Distribution of the Victorian clinical workforce across the public and private sectors
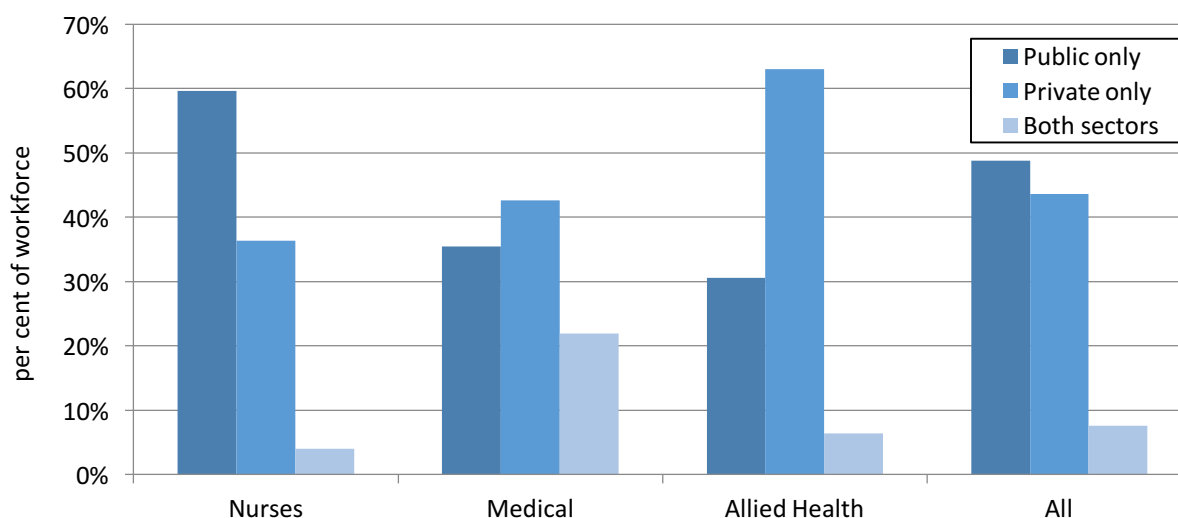
Source: National Health Workforce Data Set (2015).

Notes: N = 127,776 respondents, including 76,637 nursing, 21,482 medical and 29,657 allied health.

In an ideal world health services would report payroll data (in defined format) so that the Department of Health and Human Services can analyse the fractional appointment issue more accurately (and even potentially compare it with the results of an improved statewide engagement survey). The original request was to find out about staff working small numbers of shifts or sessions by area. This was not possible.

It may not be desirable for the department to significantly alter the proportion of part-time and fractional clinical appointments in the health system. Flexible work arrangements will be necessary for the retention of ageing members of the workforce, and should be encouraged in professions in which family commitments have historically been barriers to the progression of women. Some fractional work arrangements may be reducible through service consolidation in metropolitan,[17] but are likely to remain an integral feature of the rural health system, in which few services can provide full- or even half-time work to many clinical specialties.

Nevertheless, engagement of these clinicians will remain crucial. This is because fractional and part-time workers are both less likely to be familiar with organisational policies and procedures, and part-time clinicians are less likely to be maintaining skills or adopting new clinical practices. However, the minimal time they spend within a single organisation makes it difficult for health services to change this; for example, a presumably lower sense of organisational belonging would make it difficult to survey them, weaker relationships with colleagues would make it difficult for peers to influence them, and scheduling difficulties alone would often see them excluded from meetings and projects. As described later in this paper, NUMs and allied health clinicians volunteered part-time clinicians as being difficult to engage. Improvement potential aside, it was difficult to provide them with in-service

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[17] This would encourage hospitals to specialise in a higher volume and narrower range of clinical services, which would require them to adjust their employment arrangements accordingly.

education and some clinical managers were keen to have a minimum established for fractional appointments.

A further structural issue in Victoria is the difficulty of achieving engagement (and engagement in quality improvement in particular) from fee-for-service clinicians. This issue affects metropolitan hospitals (where surgeons are often paid on a fee-for-service basis), small rural health services (with VMO difficulties highlighted as a major issue in the survey of public hospital CEOs and by some private hospital CEOs). As one private hospital CEO commented:

> 'Clinicians in public practice attend to some of these [engagement] activities while drawing a salary. Clinicians in private practice are forgoing an income every time they participate.'

One option to reform this is to offer sessional payment arrangements for engagement activities (a CEO suggested there was a need for department funding to provide greater support for safety and quality to allow for this). Alternatively, the department could centralise appointments of fee for service clinicians and use the resultant monopoly power to negotiate fee-for-service contract terms and conditions that are more conducive to engagement (as one public CEO suggested).

Recent publication of a national analysis of the National Health Workforce data focused on eight medical and surgical specialties[70] created some controversy in Victoria. It was found that on average less than 30 per cent of clinical time was spent in the public sector.[70] Media discussion on the findings corroborated the argument that has been made here about fractional appointments limiting medical engagement.[71] *The Age* reporter quoted the president of the Australian Medical Association as saying: 'while he did not have data to show it, he believed many doctors were leaving the public system altogether because of unnecessary bureaucratic intervention'.

> 'There are quite burdensome continuing education requirements. For example, every year in the public system, even as someone who works there part time, I have to pass education modules on dealing with violent patients, hand washing modules, cultural competence modules.'[71]

The study author pointed out:

> 'Doctors who spend half a week in the public system are unlikely to be working on quality improvement programs in the same way they are dedicated to their private patients.'[71]

A related point made by a department employee and clinician was that the medical specialties with more full time appointments (for example, anaesthesia, intensive care, emergency, radiology, rehabilitation) should be a focus for engagement. Junior doctors should be a target too, but the focus of many on improving their curriculum vitae and the effects of the college-based rotational programs may limit their interest and availability.

Finally, there is a structural issue of a lack of roles providing experiences in leadership and management for non-nursing clinicians. Some senior medical clinicians involved in the clinical networks discussed the difficulty they had in accessing leadership positions, and

developing skills. This issue applies equally to allied health professionals. The heads of department in some institutions seemed to be rusted in place. There seemed to be need for more regular turnover of leadership positions. This builds the bank of skills among clinicians, but probably even more importantly enables the development of followership, which is a key element when leading relatively autonomous professionals. Physicians who have been leaders tend to become more willing to support their colleagues who are currently in leadership positions.[29]

What do chief executives think?

The views of public hospital chief executive officers (CEOs) were gauged through a short survey to which 29 CEOs responded. The survey was primarily focused on assessing their views on the clinical networks. However, it also asked them to provide suggestions for how clinical leaders and hospital executives could better inform and influence the department, and how the department could help them improve clinician engagement. It also asked them to nominate the areas of their health services in which clinical engagement is a problem.

Twenty-five CEOs responded to this question, with four (all from metropolitan and regional areas) stating that they did not have any particular problems. Nominated problems were relatively diffuse, reflecting the differing workforces and service challenges across the different organisations. The most commonly nominated problem was engagement of visiting medical officers (VMOs), which was cited by a third of all respondents – most of them rural respondents struggling with general practitioners and (to a lesser extent) metropolitan respondents with problems engaging VMO surgeons. Many other CEOs mentioned similar problems with engaging clinicians in quality improvement work, forums and conferences when these tend to be unpaid.

A further three CEOs (all from rural areas) talked about problems in residential aged care, while two CEOs (both from metropolitan areas) talked about their organisations having worked hard, or experiencing challenges in, engaging senior medical staff. Other problems cited included engagement in after-hours services when there is less management oversight, urgent care and maternity services and regional health services working together.

When private hospital and day procedure CEOs were surveyed (n = 67), of the 33 who answered the question, 'In what areas of your organisation is clinical engagement a problem?', 39 per cent claimed it was not a problem for them at all. The rest either said it was not a problem confined to any specific area, or nominated a wide range of engagement issues, including, for example, challenges engaging medical and older clinical staff, and organisational tensions around managerial prioritisation of operations over quality and safety.

What do clinician leaders think?

An opportunistic surveying technique was used to gauge the view of leading clinicians. This involved emailing the survey to clinicians who participated in the Review of Hospital Safety and Quality Assurance in Victoria (the Duckett Review) consultation process (these clinicians were nominated by public health services as leaders within their organisations),

along with graduates of the LINK and Clinicians in Redesign program and a departmental advisory group of quality managers.

As Figure 10 shows, only a minority of clinical leader respondents saw engagement as strong or very strong in their health services. Almost a quarter (12per cent) felt it was weak or very weak, and about half (45per cent) thought that it was only moderate. Views varied somewhat across different parts of the state, but may not be representative and (with the exception of metropolitan clinicians) sample sizes were small and the differences are unlikely to be significant.

Figure 10 Clinical leaders' views on the strength of clinician engagement in their health services
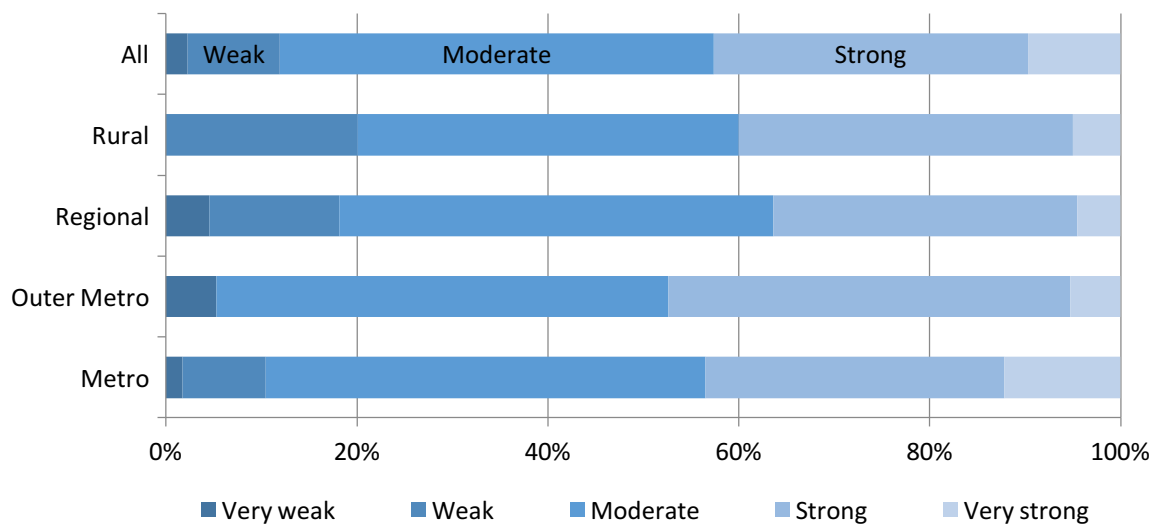
Source: survey of clinician leaders. Respondents encompassed lead clinicians whose contact details were already known to the department either through their participation in leadership development programs (namely, participation in the Executive LINK, Critical LINK and clinicians in redesign programs), their membership in a departmental quality and safety advisory group of quality managers, and through their being nominated by their chief executives to represent their hospitals in the Duckett Review's consultation with clinical leaders.

Notes: n = 176, encompassing metropolitan (n = 115), outer metropolitan (19), regional (22) and rural (20). Respondents were opportunistically selected and response rates varied. The responses reported here are unlikely to be representative. Sector was not assessed in the survey. It is likely that most, but not all, the respondents work in the public sector.

These groups views are unlikely to be representative of other clinicians. The results suffer from selection bias arising from the fact that they were mostly managers and executives (who in the People Matter survey tended to report a higher sense of engagement), and they were included in the survey on the basis of being already engaged, in one way or another.

The majority of recipients of this survey were public health service employees, although this was not assessed and confirmed through survey responses. An attempt was made to solicit the views of private clinician leaders via a survey sent directly to private health service CEOs, who were asked to circulate it to their craft group leads. Unfortunately, the response rate (n = 46) was ultimately too low for inter-sectoral comparisons, despite reminders and a recirculation of the survey to a non-representative list of private quality managers.

What do nursing and midwifery leaders think?

As Figure 11 shows, nursing and midwifery executives and managers were considerably less positive than CEOs, especially ANUMs and MUMs. The midwifery results were alarming, but relatively few midwives completed the survey (12 ANUMs and five MUMs and few from the private sector who have not been included in the graph).

Figure 11 Public nursing and midwifery executives and managers' assessments of the strength of engagement in their own organisations
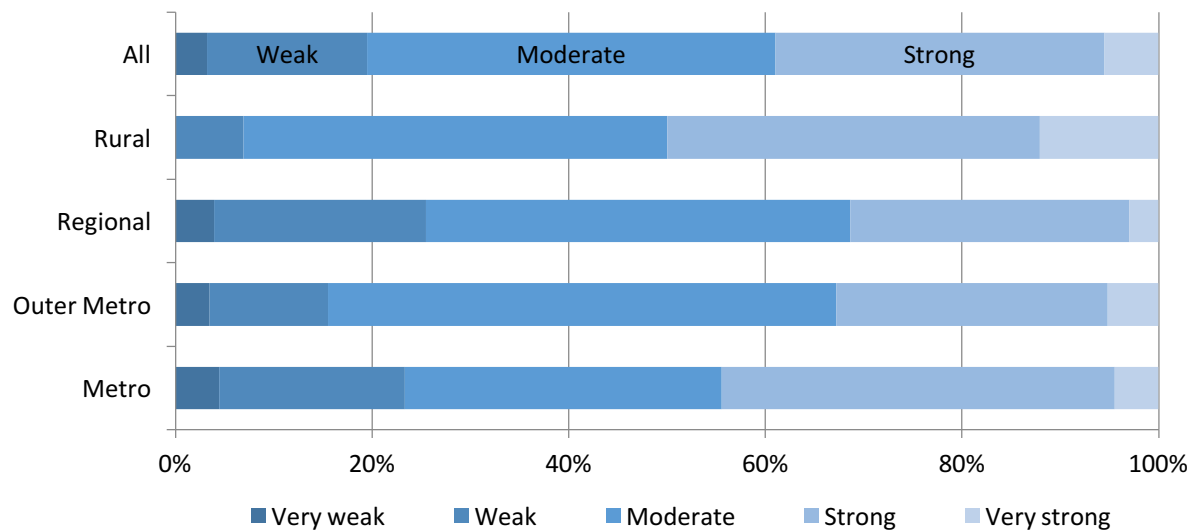
Source: survey of nursing and midwifery leaders in public health services.

Notes: Survey responses relied on directors of nursing circulating the survey, and so are unlikely to be perfectly representative and unbiased. N = 308 respondents, encompassing metropolitan (n = 90), outer metropolitan (n =58), regional (n = 102) and rural (n = 58).

Nursing and midwifery executives and manager views were surveyed using a slightly more representative method than those of the clinician leaders. The directors of nursing (DONs) in all public and private hospitals were sent the survey and asked to complete it and forward it to their assistant director of nursing (ADON) and all (assistant) nursing and midwifery unit managers ((A)NUMs and (A)MUMs)) in their hospital. This ensured inclusion of all interested DONs, with inclusion of others dependent on the DONs' readiness to circulate the survey. This varied considerably across sectors; DONs ultimately made up 43 per cent of private sector respondents, compared with seven per cent of public sector respondents. This suggests that circulation was much wider among public sector respondents than in private.

Conclusion

The limited benchmarking data available (poor completion of People Matter, no access to private sector results) means that it is not possible to be sure of the absolute state of engagement. CEOs, who are by definition highly engaged with their organisations were most positive, clinician leaders, by definition a selected and engaged group were also quite positive. The views of the large number of NUMs are considerably more concerning. Additionally, the positive view of private hospital CEOs reported via this survey versus perceptions given by their number in interviews (data following) re-enforces the need to be

cautious about the survey responses. There is undoubtedly limited medical engagement in private hospital improvement processes.

It is unfortunate more is not known about clinicians who have multiple employers; certainly, the number of very part-time employees is concerning. Respondents nominate this as a major barrier to engagement for improvement. Whatever the overall baseline state, clinician engagement in the Victorian health system is variable and is in parts deficient. The investigations that follow explore this in more detail. There are solutions too, clinician engagement can be improved, and is worth improving, to enable the provision of safer more high quality care.

Recommendation

State the definition, objectives and principles of clinician engagement, possibly as a compact describing roles and expectations.

Section D - Drilling down on engagement – what are the big issues?

In this section the views of CEOs are examined in more detail. This is followed by results of a survey completed by nurse executives, and focused on engagement for quality improvement. This is complemented by comments from a diverse range of 'leading clinicians' and members of the statewide clinical networks. Interview findings are described alongside survey results.

Public sector chief executive perspectives

Chief executives are uniquely placed, having a clear picture of how the whole system works, an overview over their organisation and, in the case of public sector CEOs, a close relationship with the Department of Health and Human Services. They were thus able to provide information about how the department at a policy level could help with clinical engagement. A large-scale analysis of UK NHS culture found that 'Consistent achievement of high-quality care was challenged by unclear goals, overlapping priorities that distracted attention, and compliance-oriented bureaucratized management.'[72] Victoria has a more devolved system than the NHS, but funders and regulators still make many demands of services. CEOs are the health system staff that have to confront demands from many quarters and organise work for others. They need clinician engagement to achieve organisational goals and to ensure safe, high quality care. Interviews were undertaken with five CEOs and 32 public sector CEOs and 60 private health service CEOs completed a brief survey.

One CEO (metro public) interviewed focused on medical staff, considering: their engagement a tricky issue as many think 'doing my best for the patient in front of me is doing a good job' and also believe that 'healthcare shouldn't play by the economic rules of the rest of life. Engagement is hard 'when they believe their time is so precious they are too busy to take part in things they do not value' – such as reading policies.

Another CEO (metro public) was confident about the correct approach to clinician improvement at the local level. He had an elegant schema considering what clinicians wanted was: first, to express their view; second, to be heard; third, be considered; fourth, engage in discussion about what is reasonable; and finally, to see change if reasonableness is agreed. He felt that the capacity of managers to listen to clinicians was generally poor, and commented:

> 'Medical staff have fabulous energy and commitment to health but give up if it's all too hard. Doctors are damaged by never getting to sit down, have conversations and be allowed to influence. When they are allowed to influence, there is no manager–clinician dichotomy'.

In addition to the nomination of VMOs as a problem, it was suggested that underexplored opportunities lay elsewhere: 'the junior clinicians and nurses know what the safety and quality issues are – there needs to be greater engagement at this level'. In regards to the

question of how the department could help CEOs, public survey respondents stated a range of potential improvements, including:

- **Workforce reforms**: 'DHHS centrally appoint clinicians and negotiate FFS contract terms/conditions.'

- **Funding** to support GP/VMO attendance at safety and quality workshops/meetings and allow organisations to prioritise safety and quality: 'We have an efficient WIES18 price in Victoria partly because we provide very little financial support to organisations to improve quality and improvement systems.'

- **Incentive realignment**: 'Most DHHS data requirements focus on financial and activity indicators and fail to include clinical indicators to assist health services improve their clinical practice.' 'It would also be a significant benefit if DHHS put clinical care and safety as the overriding performance measure for health services, rather than financial viability. This would allow health services to provide ongoing quality support and staff training / professional development at the levels required rather than pulling back in these areas to meet financial targets.'

- **Guidelines**: 'DHHS could provide templates and guidelines for a multitude of clinical and management matters rather than have every health service beavering away developing guidelines and policies in isolation from scratch.' 'Focus on computer software enhancements (including decision support systems) that ensure staff always have a focus on clinical engagement.'

- **Leadership**: Invest in clinical leadership development and ensure that larger health services are providing clinical leadership and oversight to smaller health services. One CEO interviewed, though, suggested that 'vanilla' leadership programs delivered centrally won't meet need – they can do better locally. However, the best time to influence doctors was suggested to be when they are advanced trainees.

- **Data provision**: 'DHHS to provide the rural sector with consistent data and information. All health services should be looking at consistent data. The latest surgical readmission reports are excellent and this should be expanded on.' 'Clinicians respond well to evidence of their own practice.'

Recommendation

Expand access to and improve navigability of the PROMPT portal, and use it to share agreed statewide guidelines and local protocols with clinicians and provider organisations.

CEOs discussed their relationship with the Department of Health and Human Services. It was considered that the WIES made it hard to innovate and that the department needed to broaden its activity / elective surgery / finance focus and balance with more quality and safety measures. The performance branch was singled out for comment by several. One was tired of data checking/auditing by the department, who they felt should have more trust

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[18] Weighted inlier equivalent separation (WIES).

and should rather invest energy in re-structuring some separate funding programs (with separate reporting requirements), for example, HARP funding. Another called for a more improvement focused engagement with the department (an internal department informant also suggested 'the performance branch uses some measures that should be used to support improvement, not for compliance').

Examples of good clinician engagement practices in the system

Many outstanding executives were interviewed (CEOs, DMS, DONs). Some of the practices they describe were exemplary. They have created structures and processes to ensure in-role participation and mechanisms to encourage, recognise and reward extra role participation.[22] Four diverse case studies focusing on doctors – the most difficult group to engage – are provided below:.

Investing in active governance/engagement structures and leadership training – regional public hospital

The DMS described the aim as: 'respecting and supporting clinicians' interests and passion, and giving them the tools and leadership skills to provide input'. Things that had contributed to their good engagement culture were a stable executive leadership team who made an effort to be on the floor (including the DON wearing uniform once a month), and an executive who valued and respected clinician input: 'it's not just pulling clinicians in to give input, but valuing their input that is essential'. Elements included:

- Craft leads appointed for potential, not seniority.

- Leads are mentored, supported to attend management for clinician workshops and some are doing the Royal Australasian College of Medical Administrators (RACMA) associate diploma.

- Regular meetings between the craft leads and the executive (and of the leads together).

- A six-member medical advisory council of senior staff chosen for their commitment to the organisation (not representing craft group) who meet with the DMS and CEO bimonthly.

- Clinical governance committees are multidisciplinary and include medical clinicians.

- The board quality subcommittee has senior medical, nursing and allied health clinicians.

- The department's investment in benchmarking with Dr Foster has enabled the hospital to investigate and address outlier results with clinician-led improvement projects.

Getting doctors to manage – large metropolitan academic health science centre

This large institution was committed to medical practitioners being at the table for decision making. It considered the establishment of clinical operational leadership roles essential for giving doctors an appropriate voice. This institution has a range of internal networks, and a consultation council. It has a focus on mental health and wellbeing for staff, and is willing to invest in retreats for its council and off site half-day meetings for program directors (and includes junior staff in processes). It is quite unique, though, in giving a considerable number of practising medical clinicians' accountability and power with line management, safety and quality and budget responsibilities. In the main, this is via a clinical directorate model where unit heads work with a senior nurse and business manager.

Investing in orientation and induction – regional private hospital

This institution felt their investment in orientation and induction for VMOs was extremely worthwhile. New appointments meet with the entire executive individually and have the processes for clinical governance, clinical review, and incident reporting and open disclosure discussed. They also meet with the director of mission, who goes over the mission, values and code of conduct. The overall aim is: 'to set ground rules and to invite them into a community, so they understand we are more than a factory and that we operate as partners trying to get good outcomes'. This also builds a foundation for any later difficult conversations by getting them from the beginning to 'feel part of an institution and a community where they are valued'. Getting the culture right this way resulted in good care.

Development of a medical staff executive compact – metropolitan specialist hospital

This process was led by the chief of surgery and influenced by the compact at Virginia Mason hospital. In February 2015 80 people (executive, board members, and 50 senior doctors) spent two days together. Discussions started with 'what's wrong?' and then moved toward finding the will to address it – an agreement that 'unless doctors and management work together toward a common goal we're all sunk'. There was found to be limited opportunities for casual conversations between doctors, and between doctors and management, and many heads of department did not know each other well. When they got to have conversations that were not about immediate concerns, these were novel and good. The RCH spent the next year developing the pledge, which involved multiple workshops and mass staff engagement. Significant external facilitation was employed. More than 150 medical staff formally signed the compact, and some are now 'calling out' behaviour they witness that is incompatible with the compact. Positive results attributed to the compact experience include a recent successful electronic medical record (EMR) implementation, and doctors now competing for senior leadership positions rather than being reluctantly persuaded. The development of an all-staff version is now underway. A steering committee now oversees the ongoing process and regular formal 'compact conversations'.

An anonymous survey respondent to this investigation corroborated the effectiveness of this process: 'A clinician compact with an emphasis on teamwork, good behaviour, communication, and improved culture is slowly transforming our hospital' (metro doctor).

Overall, the importance of health service organisational structures and clinical governance arrangements for clinician engagement cannot be overstated. Below, a clinical network member describes a successful experience:

> '…restructuring of governance within my organisation has had two major effects. Clinicians [now] feel they are being heard and also they are working more closely with executives within the hospital to establish strategic goals and find solutions together. It also gives clinicians the opportunity to understand the health system and appreciate some of the challenges that go with that.' (clinical network member).

Recommendation

Promote best practices in clinician engagement in the workplace – *Safer Care Victoria identifies best practices in engagement and promotes them across the sector, including through a statewide meeting in 2017 to celebrate best practices in clinician engagement.*

Private not-for-profit hospital CEOs

The chief executives of three private hospitals were interviewed together with the general manager, group DON and group DMS for a chain. All were from the not-for-profit sector. They agreed that overall VMOs can be a challenge to engage being: 'a bit of a law unto themselves'. Encouraging leadership from the VMOs can be difficult, because not only are they not employees, but the requirement may be to 'coax and cajole their small business competitors/colleagues'. Engagement for very part-time staff was seen as nearly impossible, but they all had a core group that spent more time in the institution and who were engaged (several nominated approximately 25 per cent of VMOs being in this group). Engagement, though, in this sector can also be seen as a business imperative, where there are other hospital options for VMOs to work at. However, one of the potential strengths or engagement in this sector is a flatter structure than the public system; hence 'a good thing about the private sector is that ideas become action sooner'.

Relationship with the Department of Health and Human Services

They felt that the relationship offered by regulation was limited – 'a bit tick-a-box' and they have felt peripheral. They appreciated the increased effort the department had made over the last year, but their appetite for more was substantial:

> '[There] should be no distinction between private and public with regard to how the DHHS uses performance indicators.'

> 'The funding stream should be irrelevant to the achievement of better safer health care for the community.'

There was a suggestion that the department take its regulatory role more seriously, including some standardisation of the issues of hospital-practitioner-procedure volume work. There was interest in working in partnership with the public system for better outcomes, including being part of statewide collaboratives. The point was made that it is important that the for-profit institutions not be allowed to veto plans for closer collaboration.

There was a request for the department to create more overarching statewide policies (for example, nutrition, end-of-life care) so the staff could concentrate instead on improvement. A tool for how to write a good policy, a standard was also suggested. Central advice on morbidity and mortality meetings (M&Ms) was desired, because it was felt that all M&Ms and audits should be done the same way across the state, because this is an example of a 'critical control point' for safety. M&Ms can be a problem in private hospitals, because there are not enough junior doctors.

They enjoyed the private CEO forum this year: 'first time ever we were in the same room' – and want to 'understand strategically where the health department is headed'. They were keen for some meetings that were shared with public CEOs. Topics suggested for these included: response to the Duckett Review, electronic medical records, data and benchmarking, innovations and technologies.

There was also interest in the department engaging in 1:1 strategic and performance discussions. There were thought to be opportunities for the private sector to be mobilised to fill gaps in provision of services for specific communities. Management exchanges between private and public sector were suggested to help both sectors understand each other better – much of the department 'has no idea of the nature of the private system' and 'needs a more dynamic view and more visibility in this system'; '[there is] not a lack of good will but pure ignorance' and 'they think they know what the private sector is like'. On the other hand, most people in the private sector have worked in the public sector. One CEO suggested she would like to be able to second people from the department, rather than use a consultancy firm – that way, intellectual property is developed rather than lost. It would be possible to give public staff exposure to service planning and infrastructure projects and so on. The development of a private hospital version of the statement of priorities (SoP) was also suggested.

Data

The private hospital CEOs were hungry for data. While length of stay and similar management data were available, they had limited benchmarked clinical outcome data. Some are involved with the Health Round Table, and some have been able to use Medibank Private indicators to have conversations with VMOs. A 'line of sight of clinical networks' and registry data (including information about outliers) was requested. It was noted that 'doctors love data'. They may question and disagree with it, but are 'hungry for data and information'. The data private hospitals now receive in relation to perinatal outcomes is much appreciated. Examples were given of investigation of variation spurred by receipt of this data: around blood loss (turned out to be odd documentation practices) and Apgar scores of babies post vacuum delivery (this led to changes in clinical practice). Other good data mentioned was in relation to blood use and from the Victorian Healthcare Associated Infection Surveillance System (VICNISS). Much more data of this quality, timeliness and detail was requested. Some noted they lacked the information systems that were present in the public sector.

One CEO listed their biggest desire as being for Victorian Admitted Episode Dataset (VAED) benchmarking at a state level, wanting the 'opportunity to put a blow torch over the service against a set of indicators' (while also noting that some regional areas wouldn't want their work exposed, because 'it's a bit dog eat dog re private and public in some of those areas'). Ideally, length of stay and complication information for a doctor across all hospitals where they work (public and private) in would also be available. She was committed to the idea that 'When you get data you get evidence-based critical thinking going'.

Conclusion

The disparity in capacity between organisations in the health sector is very great. For instance, it was suggested that small private hospitals need a bigger partner for capability in safety and quality, because 'at the moment the DON does all the work'. Some are large and insular – they may benchmark independently because they can afford to, but this does not energise multi-institution engagement for statewide improvement, nor allow the necessary Department of Health and Human Services oversight of safety and quality. There are always

issues or parts of an organisation that become a 'no-go zone' locally, and external scrutiny is necessary to force investigation and change. One private sector leading medical clinician suggested:

> '1. Increase the inclusion of private hospitals in department activities and meetings with the public sector. 2. Introduce common data points for public and private reporting. This allows for direct comparisons of activities across sectors.'

Shared scrutiny of important care outcomes, by big and small, public and private institutions across the state seems to be an ideal aspirational goal.

Recommendation

Engage with private providers and clinicians working in private organisations to explore development of a strategy for their sector.

What do we know about the middle managers – the nurse unit managers?

The majority of full-time, hospital employed clinicians are nurses; thus their engagement in the workplace and in safety and quality improvement is of major concern. Employees of the international survey company Press Ganey claim that their research shows fifteen of every 100 nurses are considered disengaged (thus lacking commitment and/or satisfaction with their work), and estimate each disengaged nurse costs an organisation $22,200 in lost revenue as a result of lack of productivity.[73] Continuing this financial focus, it is documented that poor engagement leads to increased nurse turnover (costly for the health system).[74, 75]

Nurse wellbeing is also of increasing concern, with research on compassion fatigue[76] – the 'cost of caring' – a combination of burnout and secondary post-traumatic stress disorder.[77] Readers may remember that in the job demands-resources model, burnout is the obverse of engagement. Systematic review of engagement in nursing practice has supported the applicability of the job demands-resources model to nursing practice.[78] Positive predictors of the work engagement of nurses included:

- leadership and structural empowerment which both directly impact and indirectly influence work engagement through operational resource factors
- social identification with the work unit, satisfaction with the interaction with the unit, collaboration with doctors
- positive relationship with nurse managers
- autonomy, including decisional involvement
- rewards, fairness and staffing resources
- professional development practices, such as critical reflective practice and self-evaluation.

Negative predictors of engagement included some aspects of job demands. Workload and work pressure were not statistically associated, but shift work was negatively associated. There is little research on patient-related outcomes and nurses' work engagement, but self-

reporting of perceived care quality and work effectiveness have been reported to increase with greater work engagement. However, empowerment is a key feature of 'magnet' hospitals – which have been shown to be associated with improved patient outcomes.[79-81]

Measurement at unit level is very important.[82] Press Ganey found that work unit attributions are typically more favourable than organisational attributions, and that the lowest scoring items for nurses are almost all related to their engagement to the organisation.[73]

It is said that:

> 'Each individual in a health care system typically makes a causal contribution (however small) to outcomes, at the same time as the system shapes and structures the possibilities open to individuals.'[23]

However, the individuals who have the most key roles in shaping the possibilities open to individuals in the hospital system are NUMs. They connect down to grassroots clinicians (nurses and junior doctors) and up to management and influence horizontally (senior medical and allied health).

As managers, they have a unique role in influencing the disposition of operational resources and providing support for quality improvement (for example, the implementation of guidelines[83]):

> 'Middle managers… have the power to accelerate or impede the implementation of innovations, mediating organisational messages for front-line staff, but also upwardly influencing their seniors to draw attention to the high-level support needed for specific QI programs. Acting as information brokers, translating organisational strategy into actionable tasks, and promoting innovative practice, middle managers can convince clinical staff to prioritise QI implementation among numerous competing demands.'[3]

Conversely, large-scale quality improvement initiatives have the potential to measurably improve nurse engagement; for instance, as reported in an Irish study of the implementation of the 'productive ward'[19] across seven hospital sites.[84]

Nurses are well represented in hospital management positions, and have usually worked as clinicians for many years prior to moving into management roles. Survey of directors of nursing (DONs), assistant DONs, nursing unit managers (NUMs), assistant NUMs and midwifery unit managers (MUMs) was therefore undertaken to investigate barriers to clinician engagement with quality improvement (QI). In total, 436 public nursing and midwifery leaders and 109 private leaders completed a survey with a special focus on quality improvement.

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[19] Productive Ward was designed by the NHS Institute for Innovation and Improvement with three main aims: to increase the proportion of time nurses spend in direct patient care, to improve experience for staff and for patients, and to make structural changes to the use of ward spaces to improve efficiency in terms of time, effort and money.

Figure 12 Backgrounds of nursing and midwifery survey respondents
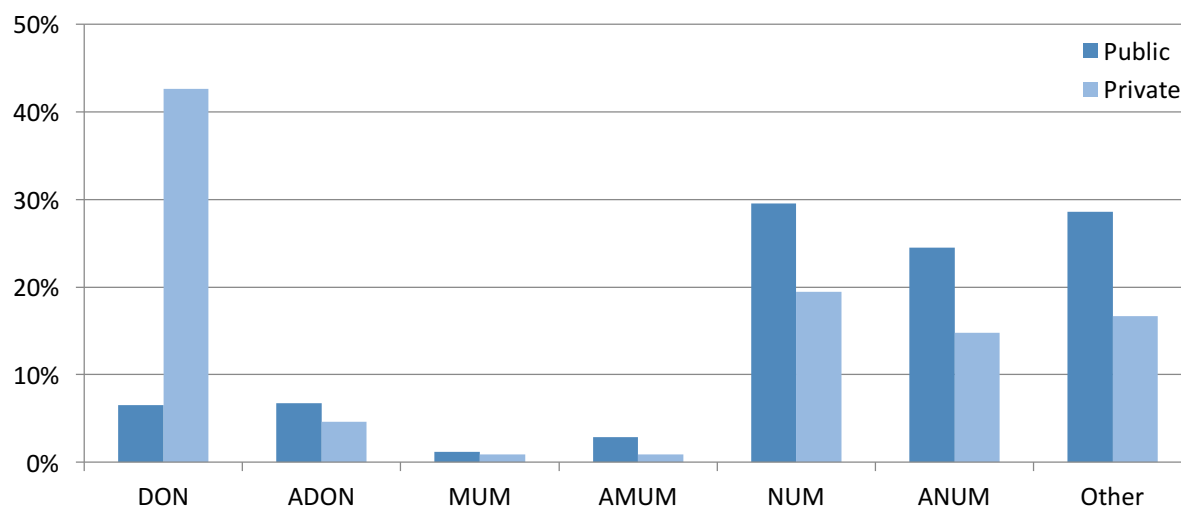
Source: survey of nursing and midwifery executives and managers in public and private health services.

Notes: Survey responses relied on directors of nursing circulating the survey, and so are unlikely to be perfectly representative and unbiased. N = 521 respondents (n = 413 from public and 108 from private), encompassing 73 DONs (n = 27 public and 46 private), 33 ADONs (n = 28 and 5, respectively), 143 NUMs (122 and 21), 117 ANUMs (101 and 16), six MUMs (5 and 1) and 13 AMUM (12 and 1).

Public DONs were much more likely to circulate the survey to their staff:

Figure 13 Distribution of survey responses by position and sector
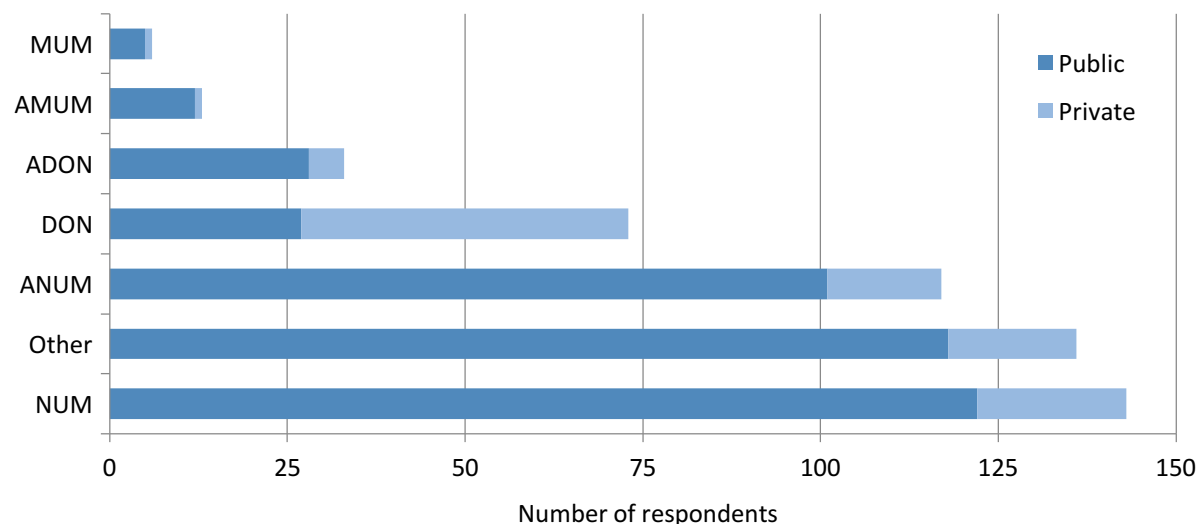
Source: survey of nursing and midwifery executives and managers in public and private health services.

Notes: Survey responses relied on directors of nursing circulating the survey.

Overall, nurses did not feel very supported to undertake quality improvement. Figure 14 assesses their views on the support they receive in terms of time, training, recognition, encouragement and support from non-nursing clinicians.

Figure 14 Lead nurses' and midwives' agreement with the question 'Do you receive enough of the following kinds of support for quality improvement from your organisation?'
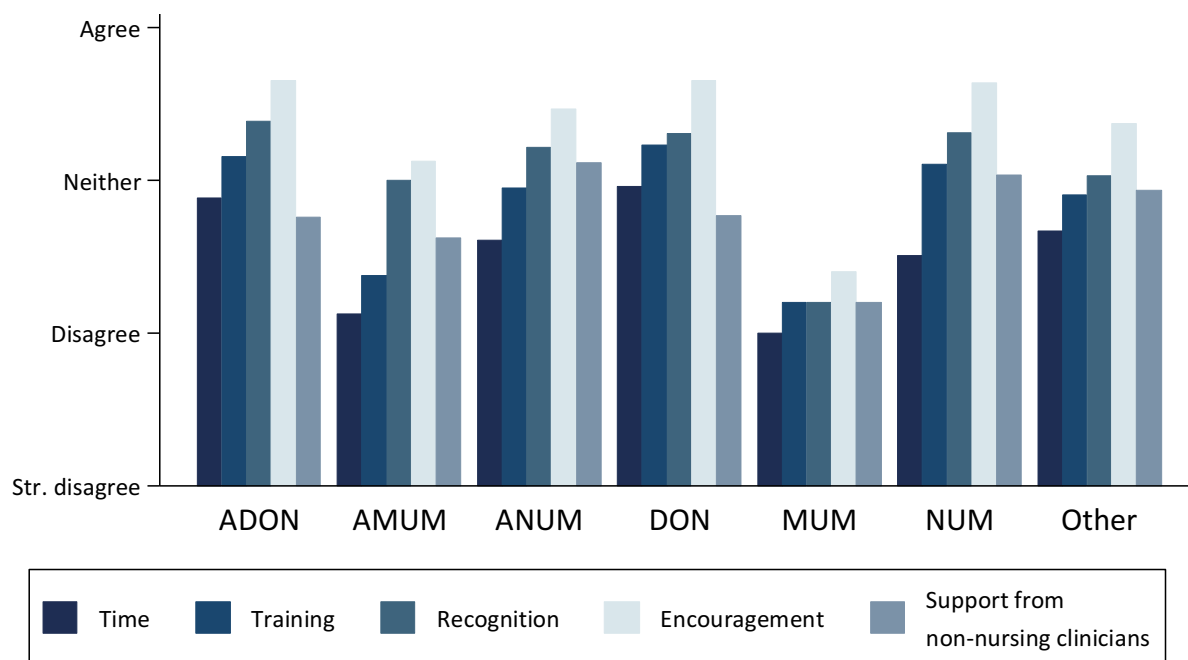
Some of the less senior respondents were harassed and frustrated at the lack of support and recognition they experienced:

> 'Recognition that an ANUM IS a leadership/management role, and not an additional set of clinical hands… I have an MBA and understand the business component to our role; however, am frustrated by the lack of infrastructure to do my role efficiently and effectively, such as suitable IT and consistency to systematise process and information.'

Time available for quality improvement

Nurses were asked about proportion of their time spent on quality work compared with operational work. Then they were asked about their ideal proportion. Their responses are shown in Figure 15 below.

Figure 15 Lead nurses' and midwives' views on their current and ideal share of time spent on safety and quality improvement work
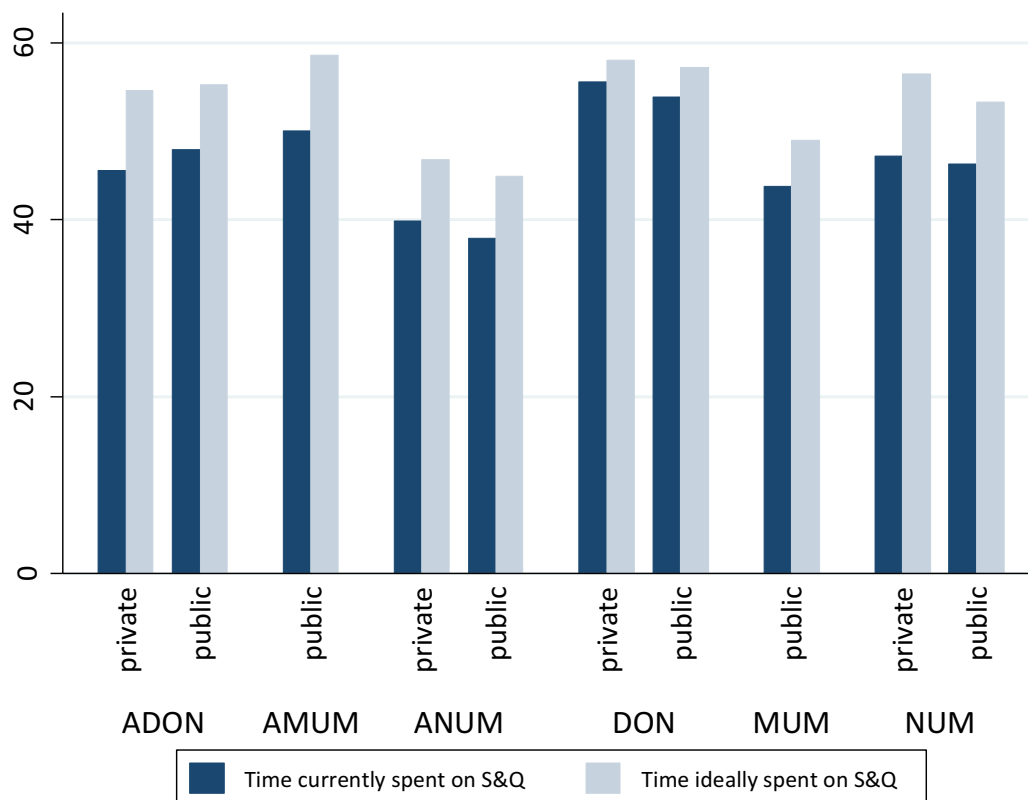
Source: survey of nursing and midwifery leaders in the public and private hospital sectors.

Notes: S&Q = safety and quality. Survey responses relied on directors of nursing circulating the survey, and so are unlikely to be representative and unbiased. DON & ADON = director and assistant director of nursing; MUM & AMUM = manager and assistant midwifery unit manager. NUM & ANUM = manager and assistant nurse unit manager. Private MUMs and AMUMs have not been displayed here due to their small sample sizes (n = 1 of each). N = 295 public and 90 private respondents, encompassing 73 DONs (27 in public and 46 in private), 33 ADONs (28 and five, respectively), 143 ANUMs (122 and 21), 117 ANUMs (101 and 16), six MUMs (five and one (not displayed), and 13 AMUMs (12 and one – not displayed).

When asked 'are there workplace reforms or supports that could help people in your position better exercise leadership?' nurses were enthusiastic about education programs. In fact, in response to this question showed that leadership education programs were valued even more highly than increased time away from clinical duties to exercise leadership. Interestingly, responses to this question varied between nurses working in public and private hospitals. In the public system, nurses were more likely to name leadership education as their answer, compared to increased time. Nurses who worked in private hospitals were much more likely to prioritise leadership education rather than more time. This may suggest a lack of opportunities in private hospitals.

> 'Many senior staff are either leaving our profession or not applying for leadership roles. These roles are becoming increasingly unattractive and the responsibilities not achievable within the paid hours. These positions are discriminatory by design for parents (especially single parents) a critical issue in a very female dominated profession.' (private NUM)

Executive support for quality improvement

Senior executives were considered by these middle managers to be out of touch with the priorities and challenges faced in clinical work. The free text responses demonstrated that a lack of visibility and personal contact with the executive was a source of frustration for many nurses:

> 'They should be required to visit these areas such as outpatient departments, emergency departments, theatres, ICUs and so on, to see what they are actually doing and what difficulties they actually face. I personally find it hard to understand why decisions that affect those working at the coalface, are made by people who we rarely see present in our department, who have little or no relevant medical/nursing background.'

> 'Leadership starts from the top – there needs to be a lot more support from exec to the clinicians on the floor, to initiate change and to have confidence that it will be supported and sustained. Exec let us down time and time again.'

There were complaints of poor communication between the executive and clinicians, particularly when new programs were being 'imposed' by executive. A common suggestion was that more NUMs and ANUMs be given more senior leadership roles.

> 'Clinical nurses need more help in leadership and management roles, but they often know what the patient needs more than other members of the leadership team.'

> 'Structure and flatten the organisation with less DONs who are not productive and have too much time to criticise each other, gossip, and pick holes in other departments. My view is that NUMs and ANUMs are highly engaged and are passionate about person-centred quality improvement and long-term health outcomes for the community – unfortunately, many of my NUM colleagues are exhausted and stressed as they are delegated much of the DON work.'

> 'More nurses in senior positions and less separation of medical lines of communication from everyone else.'

Other suggestions for improving clinician engagement with quality improvement

Disrespect towards nursing was seen to be a major barrier to increasing clinician engagement with QI. Nurses felt that not only was their involvement in QI disregarded, but there was a lack of respect and understanding of their nursing work:

> 'Doctors to realise that nurses are equal partners in the team and not still treated as handmaidens to do the doctors' bidding. Very obvious in private systems.'

Some described dysfunctional clinical relationships between nursing and medical staff. If these relationships are not sound, there is no foundation for shared improvement. For instance, one responded to the question of: 'What would make it easier for you to collaborate with allied health clinicians and doctors in your work?' with:

> 'If they didn't argue with you about assessing patients' needs and why it was unnecessary to see the patients. MET calls are used to get doctors to see patients and sometimes no doctor attends MET calls.' (regional public ANUM)

The nurses strongly felt that other professions did not take sufficient responsibility for QI:

> 'A requirement for the allied health and doctor cohort to contribute to quality and safety initiatives instead of leaving all of it to the nurses to complete and try to enforce!'

DONs in particular were likely to suggest that the culture of quality improvement needed to change so that: 'shared responsibility for quality and safety was agreed by all clinicians'.

Nurses felt that reduced turnover of doctors (that is, longer registrar rotations) and increased numbers of hospital employed specialists would make doctors more likely to engage with quality improvement. A noteworthy minority of respondents stated that they already worked well with allied health and doctors. These respondents tended to work in regional areas or private hospitals.

Recommendation

Set standards for clinician involvement in safety and quality. *Develop a statewide memorandum of understanding (or similar) setting out the expectations of clinicians who operate and consult in the public sector regarding their involvement in safety and quality improvement and consumer engagement.*

Conclusion

It is very difficult to respond to the overwhelming call for 'more time' from the NUMs, except to say that time does need to be found (that is, resourcing provided) for the redesign work and appropriateness work that will give them more time. Centrally produced guidelines and protocols were called for by many Victorian stakeholders and should be able to reduce the time-consuming 'reinvention of the wheel' that appears to happen in many units. It was notable and impressive that nursing retention was not reported to be a major issue. Multiple enquiries in interviews were made about this point. This suggests nurse executives in Victoria are undertaking effective work to support their teams and build a positive culture.

Recommendations

Increase the availability of training in quality improvement for clinicians.

Identify and address barriers to engagement caused by workplace and system inefficiencies, freeing up clinician time for engagement. *(Investigating the clinician time costs of departmental and local compliance requirements as part of Better Care Victoria redesign projects would be a good first step.)*

Engagement issues and solutions proposed by leading clinicians and clinical network members

A mailing list of 'leading clinicians' was devised, which included individuals nominated by their CEOs as such to the Duckett Review team, individuals nominated by the CEOs of private hospitals to complete this survey, directors of allied health, safety and quality managers and graduates of the LINK programs. The number of leading clinicians who completed the survey was 191. Of the whole cohort, 66 per cent were from metropolitan, 24

per cent outer metropolitan, five per cent regional and two per cent rural. Of the 40 private hospital respondents, 30 per cent were from for profit institutions, 43 per cent NFP, 20 per cent day procedure and seven per cent other. Their professional backgrounds were: 48 per cent allied health, 29 per cent nursing, 14 per cent medicine, two per cent finance/business and seven per cent 'other' (this group included pharmacists, oral surgeons, medical scientists, quality and risk managers, managers, administrators and teachers). They had a spread of views on the strength of clinician engagement.

The responses of this group to the question offering options to improve engagement was much the same as that of the nursing leaders, with time being most desired, followed by data, administrative support, training and statewide initiatives. However, the more than 600 free text comments made by leading clinicians had a slightly different flavour to surveys completed by staff in management roles or those involved with the clinical networks. They provided a range of novel suggestions. They certainly considered clinician engagement important:

> 'This is clearly the single biggest issue confronting hospital administrators globally. Communications practices (the way in which information is shared within and by an organisation) are an essential component, and this is an area in which Victorian hospitals invest very poorly.' (metro political scientist)

Clinicians had plenty of passion for new ways of working:

> 'Centralised pooling of expertise and resources (that is, The Melbourne Cardiac and Neurosciences centre for Healthcare Excellence)! Can you not envisage a state-of-the-art health care facility which incorporates research, primary prevention (remember that old chestnut?) and provision of evidence-based medicine? One which spans the continuum (emergency/acute to rehabilitation and community transition) as well as the lifecycle (neonates, paeds and young adults and the elderly). The perfect (adequately resourced) provider of hub-and-spoke style telemedicine services to regional and rural Victoria? A centre which would promote sustainable models of clinical practice (that is, nurse practitioners, neuro-interventionists) reduce duplication of research efforts, and take a bigger picture planning approach to strategic direction? One which would have more power to deal with commercial enterprise (making a more attractive target for providers of technology and pharmaceuticals). Saying 'too hard', only to work ten times harder is just senseless. Make it happen, people.'

Measurement and board level reporting with engagement being a KPI were suggested. One respondent mentioned the need for mental health support for clinicians (oral surgery metro). While there was some mention of burnout as part of description of the pace of work, interestingly, (considering the job-demands-resources model), this was the only time in this investigation where a solution to assist with staff wellbeing was suggested.

There was some negativity toward the Department of Health and Human Services, with one respondent suggesting the need to 'stop the we are smarter than you, carrot and stick, demand more and more information and share nothing attitude' (metro doctor). Some commented that engagement was good in their environment: 'Not everywhere has a problem' (CEO metropolitan NFP), 'I think clinician engagement at our organisation is

generally very good indeed – people are happy to go the extra mile to improve patient outcomes' (metro doctor); while others reported more desperate states.

Members of the clinical networks were also asked the question 'What mechanisms other than clinical networks do you think could enhance clinician engagement for quality improvement in Victoria?' This group will have contained more grassroots clinicians then the 'leading' group. Their most popular suggestion (in addition to provision of data, which had been explored in another question to this group and was a high priority) was for information – guidelines and other resources (for example, successful programs and quality projects) but especially 'A website with up to date clinical practice guidelines to standardise patient care'.

Some struggle to be able to do any improvement work

There were sobering comments made about constraints due to size, profit focus and lack of training for medical clinical management positions:

> 'Our organisation struggles financially. We do not have sufficient resources to provide adequate training of staff. We do not have a nurse educator. Our resources for OH&S are scant.' (rural nurse)

> 'I think clinicians in the public sector are expected to deliver too much and are often 'promoted to incompetence' by asking them to do administrative duties of the head of department without the appropriate resources to support them. They have brilliant ideas, but need the infrastructure to make this happen and to deliver QI projects in a systematised and logical way.' (medical scientist)

One respondent claimed that accreditation may be the sole impetus to quality improvement work in their day procedure centre:

> 'If it weren't for ACHS I doubt we would be allowed to do any of it.' (private day surgery centre DMS).

Part-time staff and/or doctors are a problem

Part-time staffing was nominated as a problem, with casual employment not allowing for quality or continuity of care:

> '[Engagement is] difficult when we have a large number of part-time staff who tell me that they are too busy to check emails (nursing outer metropolitan).

Doctors (and their employment arrangements) were nominated as a major problem with clear call to 'decrease the number of senior medical staff with small fractional appointments'! (metro nurse).

> 'Medical staff are the main issue at our regional health service and unfortunately it is worse amongst the most experienced doctors / medical leaders… Nursing staff are easy to engage, medical staff are holding up improvement across the board.' (regional nurse)

> 'Until the medical staff are all FT employees… (and not part-time in private practice), we will struggle to truly engage them as a group.' (metro nurse)

'The current employment/engagement system fractionates all the care and responsibilities, and doesn't invite commitment or engagement.' (doctor, private not-for-profit)

Data was desired

The leading clinicians wanted data that was 'Frequent, timely, clinician friendly, benchmarking' (metro nurse), some were forward thinking, 'data collected in real time through electronic workflows; e prescribing and so on' (doctor metro). There was one suggestion to:

'Use performance data to attract multidisciplinary clinician researchers to apply for funding to tackle performance issues / improve quality of care / reduce variation in care with $ grants for projects they would result in credible publications… doctors are motivated by being able to publish their work as it helps with career advancement.'(metro nurse).

Recommendation

Provide clinicians and provider organisations with better patient outcomes data to inform and motivate clinician engagement.

Allocated staff time is needed for improvement work

There was an overwhelming request for resources – essentially protected staff time/backfill, including in the private sector, 'Give them time to do it' (metro doctor private NFP), especially when there was perceived to be 'an ever increasing number of complex time consuming patients [to be seen] in shorter period of time'. There were no suggestions on where this paid time might come from. While medical practitioners are paid a significantly higher salary than other clinicians, there will always be tension about paying them for non-clinical work. One regional doctor claimed: 'health needs to stop employing poorly paid managers and put some real $ and effort into leadership and proper governance'. This is also an issue in other states with, for instance, doctors wanting to be redesign leads or quality managers, but also maintain their clinical salary.

'It's not easy to engage with staff who are already working 2+ hours of overtime per day. There has to be something extra in it for individuals (unless they are in management positions and feel it is part of their job) to make the time to contribute.' (metro nurse)

'Paid time for clinicians to be involved in quality improvement activities and attend clinical unit/departmental and health service-wide forums is essential particularly to engage visiting medical officers.' (metro doctor)

Allied health clinicians wanted structural reforms to staffing arrangements and more executive roles to be open to them:

'Funded scholarship opportunities… for allied health would make a huge difference and would facilitate a culture change (we would be seen as more valuable in the organisation and better contribute to quality improvement). Significant opportunities for nursing in particular with supernumerary and project roles. No similar structure exists for allied 'health.' (metro allied health practitioner)

'Funding and supporting allied health clinicians to take senior leadership and management roles.' (outer metro allied health practitioner)

The demand for training and education

Training was generally much desired. The clinicians in redesign program was strongly supported. There is obviously an overlap between (mandatory) training provided by an employer at one end and education primarily undertaken for career advancement at the other. Certainly the existence of scholarships for only some could seem quite unfair when the size of the health work force is considered. Outside health there are organisations that pay a certain percentage of any work-related higher degree any employee chooses to do. Alternatives include free baseline education available for all:

'Subsidised post-grad courses. The cost of post-grad courses has escalated, the availability of funded places has diminished and the expectations around post-grad training have increased.' (metro allied health practitioner)

'Consider a statewide quality framework with PG qualifications such as the framework introduced in Ireland.' (metro nurse)

'All senior staff be offered free leadership training; that is, a certificate course with online access as part of the program.' (metro allied health practitioner)

'Funding for IHI courses for as many staff as possible.' (metro nurse)

Inclusion of quality improvement in health professional education was also advocated: 'Lobbying with training colleges to incorporate QI in training programs' (metro nurse); 'Engagement with clinicians in QI should start with their training and be embedded… prior to commencing in any health service' (rural nurse). There was a suggestion for work with medical colleges to align QI with required clinical practice improvement (CPI):

'Engagement needs to start with the medical colleges and seen as a priority. More emphasis on QI activities in hospitals as CPI opportunities.' (metro allied health practitioner)

'Real' Department of Health and Human Services people need to visit and communicate directly to clinicians

There was a clear desire for the Department of Health and Human Services to visit with them, 'come out to the country' (allied health rural) and NOT to communicate only via the CEOs.

'Become more visible: 'real' DHHS people come to heads of unit meetings and have some real two way conversations with us. DHHS currently seen as too remote, out of touch and therefore easily dismissed by clinicians.' (metro doctor)

'Have DHHS… regularly send updates and so on, to ground staff/program managers and so on, rather than just corresponding with CEO.' (metro allied health practitioner)

'Effective and timely communication to clinicians. Often information goes directly to the CEO, but this does not always filter down to the clinicians who require [it].' (regional nurse)

Statewide quality improvement work

There was a request for more statewide work and less competitive funding processes, which were antithetical to collaboration. A leading Victorian redesign expert who was interviewed, also commenting: 'Interhospital competition means you can't get spread in Victoria', and another quality improvement expert remarked, 'in Victoria all the time we give permission for everyone to be special and different'. Competitive funding rounds are not the sole cause of this situation, but they are something the department can influence. Respondents had clear view of the need for change:

> 'Establishment of statewide, focused initiatives (that is, identified universal significant problem where collective improvement is required) – create multidisciplinary improvement team in each health service to lead the improvement; provide information / evidence base on solutions; training in methods to improve and backfill support. Use of data and specific milestone targets.' (metro nurse)

> 'All grants awarded through DHHS should come with T&C around sharing the information. There should be a data repository for all DHHS-funded projects, and there should be complete signing away of IP rights attached to any DHHS dollars. This way the learnings could be shared for all projects. It should be freely available for reference (including samples of successful grant applications, reports on progress, evaluation findings, any resources developed and final reports). It would also be great if there were resources within DHHS that clinicians could access for quality project mentoring and support.' (metro allied health practitioner)

> 'Improve the EOI process so it is not a convoluted and has clearer outcomes… Reduce the duplication of work being completed within DHHS and across networks. Create collaborations for innovation because the culture is competitive.' (metro allied health practitioner)

developed materials, including via the Better Care Victoria website, by responding to enquiries and hosting visits.

This should include department-funded improvement projects being contractually required to share all developed materials, including via the Better Care Victoria website, by responding to enquiries and hosting visits.

The two other very interesting themes in the leading clinicians' responses were the possibility of introducing greater accountability for QI (especially for senior doctors) and the need to disinvest/streamline work to make more time for QI. With regard to the former, while it was suggested that there need to be 'reward and recognition (many guises) for participation and performance [and] accountability for non-performance/participation of seniors/leaders' (metro nurse), again, senior doctors were singled out: 'accountability for senior doctors in participating in clinical governance' (regional nurse).

However, senior medical clinicians interviewed wanted to know 'What is the extent to which DHHS wants clinicians to contribute: to shape the agenda or are they vessels of the execution?' (metro doctor), and they very much wanted to see department staff listening to them in their service. There was a desire for both more power sharing and more action. It was agreed that doctors would come to meetings if there was an emphasis on quality and meaningful and unequivocal improvements in quality.

More sharing with the rural sector

Sharing of solutions and resources with the rural sector was both suggested and requested: 'Sharing of resources by the larger organisations would be a good step' (rural nurse), 'offer support for the struggling Health Services or rural services with less resources though partnerships, opportunities to collaborate' (metro doctor). Ideas included regular regional meetings/forums. Better video link access was requested:

> 'It's not feasible for me to join in at present as it's a 10-hour car trip, accommodation costs or flights to get there for meetings with no backfill. Making it nearly impossible.'

Rural case study perspective

This hospital had a charismatic CEO and staff at all levels clearly felt valued and supported. There had been highly effortful attempts to guarantee safety and quality locally by upskilling and supporting staff. Dedicated staff had implemented some excellent practices; for example, bedside ED review and handover by the receiving ward nurses. They run a very impressive leadership program for their staff – in house.

The absence of strong reliable referral links with a single metropolitan hospital was a major problem. They had cobbled together a surprising range of cross-hospital relationships which worked well in some disciplines but poorly in others. In general, they felt neglected by the department, but a visit by the chief medical officer had been very much appreciated. The ED NUM described the yearly state forum as very valuable.

Developing and maintaining suitable medical staffing (both junior and senior) had been a major focus. The relationships with GPs were delicate and the recent employment of two specialist physicians had

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been threatening for them. Important issues included providing ways to support improving medical clinical practice, including ongoing training for GP proceduralists (in anaesthesia and obstetrics). They would like a department directive mandating such training and setting out expectations of GP proceduralists. The concept of the department defining and then funding the workforce they need for clinical safety (currently restricted by the WES) was raised.

A senior doctor considered: 'Full time medical staff have a focused intent on practice that the system needs – VMOs can't give this (although GP's knowledge of their customers, continuity of care, trust and knowledge strengthens what they do)'. He told a story about a patient resisting a specialist intervention, the GP said, 'let me try she knows me' – and was successful.

Medical staff had access to Commonwealth money for skills improvement but there was a real lack of local relevant networks/relationships/meetings for all clinical staff. Senior nursing staff describing that they 'Want to get up close with what others are doing – how best to change and improve practices by learning from others [like them]'. A rare visit to a nearby institution was described, but there is no funding for learning visits.

Recommendation

Improve access to department staff, consultation and engagement for rural stakeholders with multisite videoconferencing facilities.

Build stronger subregional networks and referral relationships

Respondents asked for operational regional clinical networks 'that actually implement outcomes across regions'. It was stated that neonatal paediatrics 'is begging' for 'regional and subregional alliances'. Links into primary care were also requested.

> 'For my regional hospital, I would like it to be linked to a metropolitan hospital and have all patients sent to that hospital if requiring hospital admission. I believe executives from the two hospitals and senior clinicians need to meet regularly for these linkages to be successful.'

> 'Linking the hospitals' governance may be helpful for smaller organisations. Establishing mentorship opportunities and strengthening the relationship between hospitals and primary care will also be critical.'

Disinvest, simplify, reduce reporting requirements

Simplifying work by removing redundant low value tasks is an obvious solution to the lack of time for QI. This included 'reporting requirements that do not lead to health service improvement or development' (outer metro medicine) and the appealing notion of disinvesting – doing less evidence-based care. This latter issue also came up in a meeting with senior medical staff (metro) where the increasing work in radiology was bemoaned and then the group agreed that a percentage of radiology investigations were unnecessary and improvement work on this issue was a priority.

> 'So much time is spent filling out surveys and providing facts and figures from our client management systems to provide DHHS with something to talk about. We continually

have collaborative approaches, client-centred care, multifactorial, multidisciplinary, local solutions, accessible, sustainable and of course evidence-based rammed down our throats like we have never heard or done it in the past. I think they should trust that we do these things and look at ways for health across the wider spectrum to include clients, family and community all the time, rather than when someone is sick.' (rural nurse)

'Lead some work around disinvestment – we do too many things that are non-evidenced based. Divert time into QI and development of evidence-based models of care.' (outer metro allied health practitioner)

Other ideas included: moving from a VMO model to a staff specialist model, 'Paying clinicians to do quality work' and 'Having clinicians work within the department'.

There was a desire to simplify work and reduce change:

'…reduce the mounting overlay of bureaucracy, administration, forms and data collection which has no apparent benefit for the client. This alienates our clients and is not client centred in my opinion. It detracts significantly from providing quality client-centred work. Continuous changes of systems, forms and data collection coming from the department is causing disengagement and burnout in the clinicians from what I can see.'

Conclusion

There was no shortage of positive and interesting solutions to improve clinician engagement. While training and education was requested, importantly, many suggestions pertained to redesigning work. These included employment arrangements, accountabilities and time for quality and safety work, but also formalised referral networks. Interviewees also talked about the great difficulty of arranging patient transfers in Victoria, one CEO (metropolitan) describing it as the 'State's biggest issue'. If staff are spending large amounts of time doing unsatisfying ('hindrance') work such as arranging transfers, then their time and enthusiasm for improvement work will be diminished. Staff want to be part of a well-functioning system where they can concentrate on the satisfying parts of clinical care. A very large multimethod study of the NHS found 'Poor organisational and information systems sometimes left staff struggling to deliver care effectively and disempowered them from initiating improvement'.[72] Some Victorian clinicians had similar experiences.

CEOs had found a range of ways to improve clinician engagement in their institutions. However, the lack of statewide collaboration was a prominent theme among respondents' comments. Agreed statewide work was desired including more operational networks as well as opportunities for greater peer-to-peer sharing of ideas.

Perspectives – allied and community health, junior medical officers

Engagement and allied health practitioners

There are 27 different and quite diverse professions included under this label, and allied health practitioners represent 26 per cent of the health workforce (versus medicine 18per cent and nursing 66per cent). In Victoria, allied health includes over 42,500 practitioners (often divided into therapy and science disciplines). These professions have struggled to

develop appropriate organisational and governance structures.[85, 86] Despite making up a large proportion of the health workforce, they are underrepresented in leadership and management positions. This means there are not many allied health clinicians as CEOs or members of the management executive or board members. The career development structure available to nurses does not exist, and thus allied health clinicians are less likely to have leadership opportunities. Their disadvantage is significant, with a recent report finding: 3.4 per cent (36.5/1061) of Australian top management positions in health being a named allied health position versus 10.4 per cent for medicine and 9.3 per cent for nursing/midwifery.[87] The situation in Victoria in regard to this is a little worse than the overall national statistics. Nationally, only ten of the 129 (7.8per cent) CEOs had an allied health qualification (lack of access to top management positions is suggested as a major cause). Allied health practitioners are also underrepresented on health boards. The authors suggest that 'In the case of allied health clinician leaders… the issue is not so much [of] an engagement gap as it is an "access gap"'.[87]

The problem plays out at another level – there is a problem retaining allied health professionals in the institutional workforce. Where there are fewer opportunities for self-employment, individuals may also leave the profession; for example, dietetics. There is an industrial campaign underway in Victoria to:

- expand horizontally to broaden career pathways and improve health care outcomes through the creation of:
  – a suitable management stream (including properly integrating the chief structure)
  – an effective clinical educator stream
  – a research stream
  – an effective advanced or senior clinician stream

- expand vertically to assist with recruitment and retention and to properly remunerate experienced allied health professionals by increasing the number of wage tiers.

What was discovered?

This commentary is based on interviews (internally, including with the chief allied health advisor in the workforce branch and with clinicians) and survey results. The chief allied health advisor meets quarterly with the directors of allied health. They bring ideas and issues, and also from this peer network have started to collaborate (for example, two-to-three hospitals working on a project together). Some clinical networks have little allied health participation. Some allied health clinicians are very part time, creating a burden for others and a problem with organisational or professional engagement.

Their attempt to deliver flexible, client-centered delivery of care[85] is disadvantaged by hospital budgetary arrangements, with allied health therapists who informed this review, describing a substantial daily burden of documenting activity to justify their funding – work that is not done by nursing and medical staff. Allied health practitioners are very vulnerable to expanded activity (as patients get sicker or when beds and services are opened). There are opportunities for role expansion in allied health work: physiotherapists could be involved in clinical risk management for falls and occupational therapists for pressure assessment.

While allied health does not have an infrastructure to support much work beyond the patient in front of them, innovative work like recent Victorian work finding intensive physiotherapy can significantly reduce length of stay for patients after hip fractures[88] is unlikely to spread or be replicated in other areas. Allied health professionals are inter-professionalised early on and experts at patient-centred validated goal setting, but have few opportunities to become involved in redesign of patient care. This is essential, because more care needs to be delivered in the community and is associated with patient partnership in the management of chronic disease. The lack of organisational infrastructure means that allied health clinicians are not positioned to be able to provide upward critical voice, and can become silenced by the prevailing culture resulting in workplace presentism. Many consider the clinical networks too doctor-centred and do not seek involvement. It is all about a fair seat at the table for this group. Hence, the recommendation regarding appropriate representation within health service executive ranks made in the section pertaining to board oversight of clinician engagement.

Engagement and community practitioners

It was not possible in any way to do justice to this sector in this review. However, some notes providing a little of their perspective are provided below almost as a 'placeholder'. A recommendation is made for more investigation of this sector. This commentary is based on interviews (internally with the community health branch and with clinicians and managers and including one brief site visit) and survey results.

The strength of the sector is that it is client centred and value set driven. There are often multiple funding streams, so participants 'have to dance to make it all fit together'. The big limitation to engagement is that the sector is so diverse. There are 31 standalone facilities; the rest are integrated with health services. Due to the diversity, it is common not to get a consensus, so the Department of Health and Human Services may have to carry through with changes where everyone is not happy, but at least they try to ensure they are all invested. For small organisations, the opportunity cost of engagement is high. The department engages often with the willing and those who have capacity, 'but often without those critical to success – where engagement is needed to bring up the tail'.

Greater involvement in collaborative work with acute care is desired, as after all: 'What happens in a hospital could be influenced by people not in a hospital – who can tell you about the patients' experiences'. The community sector also forms part of the liaison the acute sector needs with general practice and the PHNs.

This sector is dominated by allied health and prefers the term 'community health clinicians'. Senior allied health staff working supported by a health service (metropolitan) noted:

> 'In the community, while we can get people around the table to solve problems, it's tricky to give permission, empower, enable. One of the best ways to empower staff is to get them to visit other health services to see what is happening – this does not happen. People are more likely to go interstate.'

They asked for greater visibility for others' work: 'there are department funded projects they are not willing to share'.

They considered that ideally, no one works fewer than three days a week, and a good job share handover is essential. A community CEO remarked on the problem of engaging part-time workers for who 'work is somewhere I can do my job with everything taken care of and then go home'. They lack the capacity (and sometimes the interest) to 'to look up or around'.

The independent community CEO interviewed found junior department representatives and a failure to visit the sector a problem. He felt 'The current department structure does not connect and flow through to good care', and there was a need for 'better policy closer to the difficulty of seeing clients in their home'. There was a need to provide retraining for integrated models of care that had not been met.

Community clinicians and CEO complained about the multiple accreditation processes they are required to participate in: multiple regulators lead to 'document disease'. It was felt that there needs to be a way to 'do governance one' – 6/12 accreditation by state and Commonwealth is expensive, exhausting and wasteful and the result is a 'tick-a-box' effort that disengages staff.

A senior Department of Health and Human Services staffer said:

> We talk a lot about trying to engage GPs but it continues to be a problem and there is a 'failure in both directions to communicate critical information. Primary care organisations are fragmented and it's not clear that GPs are engaging with PHNs – it's a priority to support leadership in this area.'

> **Recommendation**
>
> **Engage with community-based providers and clinicians working in community-based organisations to explore development of a strategy for their sector**. *This would include investigation of how the department can strengthen its understanding of clinical engagement in community settings and with community-based practitioners (including general practitioners) prior to development of a strategy designed to strengthen engagement in this sector.*

Junior medical clinicians

There were multiple calls for greater involvement of younger clinicians in engagement structures such as networks and advisory committees, and for them to be given a greater role in institutional redesign. Junior clinicians were not among those surveyed by email. When small groups were interviewed, they were quite absorbed by the challenges of gaining clinical competence and in study for the next stages of their career. It was suggested that advanced trainees and junior consultants be target for leadership and development activities. It was noted that 'NUMs are key influencers for shaping JMOs and can get them engaged' (presumably in units where there is time for more than transactional interactions).

Interview with directors of medical services (DMS) confirmed the problems associated with the pace of work:

> 'Every ward/hospital works differently – simple admissions, referrals outpatient appointments and discharges are different on every ward.'

'JMOs get caught into the workarounds; hospital is full of workarounds.'

'Patients change every few days/move across units as result of KPIs. Clinical work that is busy with high throughput, grinds clinical staff down resulting in limited engagement.'

JMOs were considered so busy on transactions ('everything has become transactionalised') that they have no time to reflect on the work or build relationships. For example, consultant coffee breaks are reportedly almost nonexistent now in one health service. The DMS' were distressed by the high levels of psychological distress in the junior doctors, and suggested options for longer employment contracts and also:

'Personalised mentoring for JMOs can facilitate engagement – that is, working for the same team for six months.'

JMOs said confirmed these notions with limitations to engagement being not due to 'a lack of ideas, but transience of JMOs, lack of time, and real and perceived hierarchy'. There was interest by some in integrating safety and quality into your clinical processes to change culture but others pointed out: 'If there is a problem in the rotation – why bother fixing it within the three months'. JMOs had mixed views on the desirability of longer rotations, with the assumption that this was equivalent to 'more experience' and beneficial.

Workload was a large barrier – it gets in the way of meaningful engagement:

'Need space and time allocated to clinicians to ask them how can we improve this unit? How can we improve the care?'

Many had to study at the end of their work days. (In other Victorian research, junior medical practitioners have described management responsibilities as 'more work'.[54])

However, there were significant barriers related to the hierarchical nature of hospital work: people do not want to hear ideas if you are not in a senior. The JMOs told stories about attempting to suggest improvements, but this had not gone well for them and they had been discouraged from future action. They thought the 'system needs to encourage it as a prized attribute for JMOs to speak up'. The JMOs were positive about the committee structures their hospital did offer for them to have a voice and about the fact that junior doctors could do project work in quality and safety in a designated term (opportunities do exist throughout the state, but there is not a statewide approach, as occurs in WA[89]).

The JMOs considered medical students to have poor system understanding, but more time to contribute to quality improvement. They said that no clinical improvement type research is encouraged at medical school. The suggestion was made to pitch some clinical improvement priorities to the universities and allow students to pick.

Recommendation

Investigate a systematic approach to engaging health professional students in improvement. *Approach health professional schools to see if a systematic approach to engaging students in improvement is possible. Medical schools and students have the most discretionary time in their curriculum, but involvement of all health professional students would be ideal.*

Section E - Clinical communities of practice and clinical networks

Introduction

While there is a current Department of Health and Human Services focus on the statewide clinical networks, it is important to recognise that there are many other informal and formal clinical networks extant and active in the Victorian health care system. Informal networks often help department staff do their work, because more than half have worked in the system and have friends and colleagues they continue to call on. Examples of other formal networks are the Child and Family Network and the Oral Health Network. This formal network was described by one community sector attendee as 'brilliant, really good forums, lots of good ideas, the department attends giving us a good voice up and now there is a process that helps ensure CEO commitment for action'. By virtue of their nature, though, all networks will be variable in their quality and value and influenced by the particular individuals involved at any point in time.

This section of the paper provides recommendations on a certain kind of clinical networks only, but the theoretical discussion that follows is relevant to all such structures.

Theoretical basis and literature

In health, operational proximity and value sharing (for example, within a craft or professional group) maximise knowledge sharing between staff.[90] It is suggested that:

> 'The networks in which people participate shape the norms and values that guide their decisions and actions, the opportunities available to them, the constraints on what they do, and the activities they undertake.'[91]

For the dissemination of innovations,[92] informal networks are very important.[90] In fact, the 'nobody in charge'[93] model may be a surprisingly effective way of achieving change in health care settings. Doctors, for instance, have been shown to look closely at the behaviour of peers[91] and will take safe opportunities to experiment and imitate before adopting a new clinical practice.[94] The controls within such informal clinical communities are primarily social in character (for example, successful change requires that peers see new behaviours as positive and accept the development of new shared norms).

Communities of practice[95] are groups who engage more explicitly in collective learning in a shared domain. They have a passion or common interest in something they do (this gives them an identity), and they interact regularly in order to learn to do it better (this makes them cohesive). Initially the concept referred to informal self-organising groups/networks and described how members helped one another learn and apply knowledge in practice,; thus becoming socialised in a particular way of doing and knowing.

Communities of practice (CoPs) are important for those concerned with diffusion of knowledge and uptake of new practices and there began to be an interest in developing and fostering CoPs,[96] especially because 'rapid disintegration can occur within structures that rely primarily on voluntary social connections'.[91] Additionally, established professional and organisational structures were seen to have failed to respond to the need for multidisciplinary collaboration[97] and collaboration across organisational boundaries. Networks provide:

> '…a structure for clinicians to work more closely across institutional and professional boundaries, and allow for continuous working relationships and flow of knowledge about best practice between individuals and organisations, thereby improving the quality of and access to care for patients, including those who require coordination of care across a range of settings.'[98]

Creation of formal clinical networks represents an attempt to create, strengthen and stabilise communities of practice. However:

> 'Because of their dependence on shared knowledge and identity, CoPs cannot be artificially created but need to build instead on existing commonalities and practice-driven relationships that need to be identified, foregrounded and legitimated.'[97, p. 266]

If there are limited existing commonalities, community formation is unlikely unless pre-work is undertaken to increase a sense of commonalities (for example, provision of data and patient stories that illustrate a shared problem) and build relationships.

Usually, champions make a start and are supported by recognition (legitimation), institutional support, governance (specific roles allocated and leadership identified), resources (including facilitators) and infrastructure (communication technologies).[97, p. 266] Things that help sustain the CoPs include:[97]

- adequate leadership and governance (to ensure that participation continues and that newcomers are welcomed – cliques can be a problem)

- allowing them to develop place and rhythm (for example, by regular communications, an annual convention, reporting as part of an annual report)

- giving them goals and deliverables.

Learning collaboratives ideally result in development of a CoP. However, when learning collaboratives have a top-down approach, with resources being provided and mentoring by a small number of experts, the changes in social networks among participants which promote the transmission of new ideas and social support (and sustain this improvement and others) is limited.[99] The real story of the US Michigan Keystone study (the extremely successful collaborative that reduced central line associated infections across a state) was not about checklists, but about the creation of social networks with a shared sense of mission, whose members were able to reinforce the efforts of each other.[100] [101] Implementing the program was time consuming and expensive, it included hotel stays, meals and hospitality to bond interdisciplinary in-hospital teams and give them links with other teams. Rather than a 'rollout' this was a cultural and organisational change process, because instituting the

invitation/responsibility for all staff to 'call out' breaches of infection control into a stressed and hierarchical environment was a major change.

CoPs in health can become very insular,[97] and circulation of knowledge between communities is limited. This can be improved by creation of boundary objects, boundary spanners and the promotion of boundary crossing interactions.[97] Multidisciplinarity is considered important. Not only are such groups able to come up with novel solutions to health care problems, but they challenge medical dominance over priorities. It has been described as the 'most insidious form of power'[23] to let 'people whose business it is define what that business includes, which versions of it are serious and important, and which don't matter much'.[102]

Systematic literature review has defined the following barriers and facilitators for successful clinical networks[98] (adapted).

Facilitators of network success	Barriers to network success
Sufficient resources – funding, administration and human (staffing)	Lack of funding and resources
Availability of information and communication technologies	Poor communication and unwillingness to collaboration
A bottom-up, locally-initiated and driven approach to network implementation, with subsequent formalisation	A top-down approach of network implementation, or where decision-making powers and responsibilities are maintained by external parties thereby limiting the powers of network members
A positive, trusting culture, where networks are seen as desirable and perceived to be necessary to sharing knowledge, and where there is open and inclusive communication and widespread genuine stakeholder participation	Tension, distrust and competition (particularly over resources) between network members
The norms and values of the network are compatible with those involved	Lack of confidence in the ability of network leaders and managers
Strong personal leadership, by widely respected clinical leaders and network managers using a facilitative approach	An imbalance of power between network members resulting in competition for resources (or disengagement of the poorly resourced)
Inclusive membership in the network, including representation of patients and other stakeholders	Lack of representation of key stakeholders in certain contexts (for example, rural and indigenous interests)
Evidence-based work plans and projects that address issues identified by network members, particularly gaps in current practice, with goals that are feasible and can be objectively measured	Poor record keeping and documentation, which made it difficult to measure the impact of network initiatives and track progress

Questions that can be asked when evaluating a CoP for improvement are:[103]

- Are structural elements (community, practice, shared domain of knowledge) appropriate?
- Are implementation tools (for example, access to data, access to evidence, project management and communication support) available and sufficient?
- Is there evidence of intermediate CoP outcomes (innovation, knowledge transfer, social capital, and organisational memory)?
- Have patient outcomes improved?

The possibility of and importance of measuring intermediate outcomes is often overlooked. The diagram below, modified from[103] illustrates this assessment approach.

CoP inputs
Evidence gaps - quantitative
Practice gaps - qualitative
Process gaps - improvement science

CoP tools
Access to data
Access to evidence
Project management
Communication

CoP Outcomes
Social capital
Knowledge transfer
Innovation
Organisational memory

Improved quality of care and patient outcomes
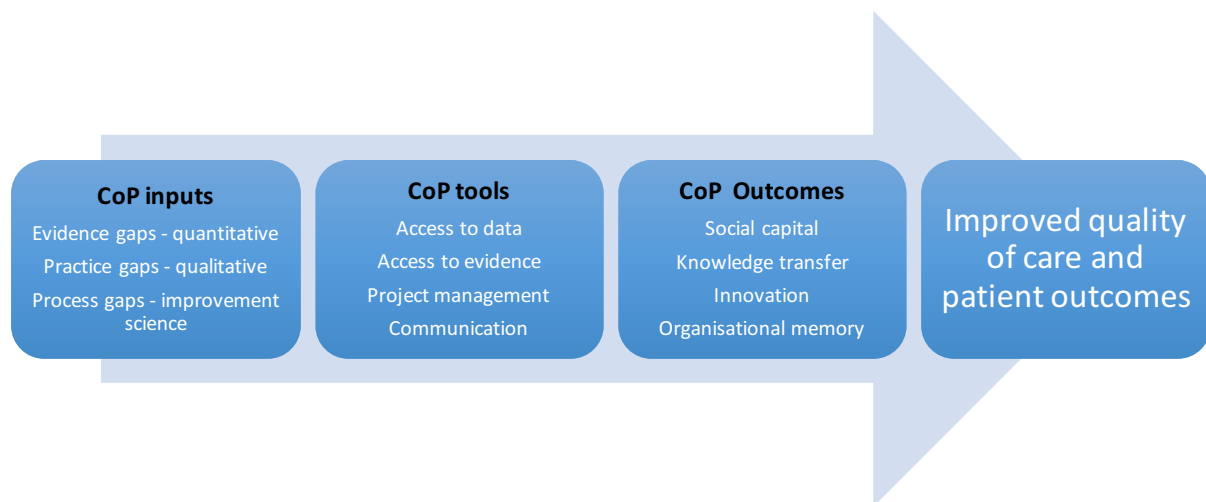
Demonstrating the value added and justifying the resource investments in this area is difficult.[97] Overall, there is little international data on the effectiveness of clinical networks for improving the quality of care.[98] While clinical networks are agreed to be a useful vehicle for quality improvement,[98] it is not clear when a clinical network is the only or best way to achieve these outcomes.

Managed clinical networks – international and interstate experience

These networks are defined as:

> 'Voluntary clinician groupings that aim to improve clinical care and service delivery using a collegial approach to identify and implement a range of quality improvement strategies.'[98]

This definition excludes information networks and fully integrated service delivery networks (although both structures may share some features with managed clinical networks). This model has been employed internationally.

NHS Scotland has an extensive range of networks which are given five years of funding to achieve agreed objectives. Networks are not expected to be permanent. The networks deal with quite niche areas[20] (for example, children and young people's allergy network) and manage their own external websites, with the NHS not being responsible for the content of these external sites. While it is considered that they add value, managing their structures, leadership succession and making accountabilities clear have been identified as challenges.[21]

NHS UK is enthusiastic about networks:

> 'Clinical networks are an NHS success story. Combining the experience of clinicians, the input of patients and the organisational vision of NHS staff, they have supported and improved the way we deliver care to patients in distinct areas, delivering true integration across primary secondary and often tertiary care.'[104]

In 2013, the NHS UK established four initial strategic clinical network groupings, which operate throughout the country (in 12 geographic areas): cancer; cardiovascular; maternity and children; mental health, dementia and neurological conditions. This means each geographic area has its own set of four networks, managed by an office that also manages the clinical senate for that area. They are closely linked with the clinical senate and also work alongside the academic health science centres. Strategic clinical networks are charged with advising commissioners, supporting strategic change projects, improving outcomes and serving as the engine for change and improvement across complex care systems.

The NHS also has operational delivery networks which focus on coordinating patient pathways between providers to ensure access to specialist resources. They cover areas such as adult critical care, neonatal critical care[105], trauma and burns.

Most Australian states have at least six clinical networks: WA (18), Qld (14) and NSW has 39. The NT has none, and the ACT one, and plans to add more. Around Australia, networks have been primarily hospital focused:[106] only one state has a primary care clinical network, but a further three have chronic disease networks. While there is overlap between the roles and responsibilities of clinicians in federal and state-funded health care services, networking between these clinicians tends to be localised and person dependent.

There is little inter-state commonality between the clinical *foci* of networks. The table below contains a list of Australian clinical networks. Across Australia, clinical networks cover about 50 different areas, but only one clinical network (aged care) is common to all six states with established clinical networks. The majority (27) of clinical network foci are only covered in a single network, nationally. Some networks are highly condition specific (for example, diabetes, stroke), while others are specialty specific (for example, cardiology). Some Australian networks will be involved in operational work, but the general focus is on improvement.

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[20] list of Scottish networks at http://www.nsd.scot.nhs.uk/services/nmcn/index.html)

[21] http://www.nsd.scot.nhs.uk/Documents/NmcnNpfReview.pdf

Current formal clinical networks in Australia

State	NSW	Vic	Qld	WA	SA	Tas	NT	ACT	Total
Acute	Y								1
Aged / older people	Y	Y	Y	Y	Y	Y			6
Anaesthesia & Perioperative	Y		Y						2
Blood/marrow transplant	Y								1
Brain injury	Y								1
Burns	Y								1
Cancer		Y	Y	Y		Y			4
Cardiac / cardiovascular / cardiology	Y	Y	Y	Y	Y				5
Child & youth		Y	Y	Y					3
Chronic	Y					Y		Y	3
Dementia			Y						1
Diabetes			Y	Y					2
Disability				Y					1
Drug & alcohol	Y								1
Emergency	Y	Y	Y			Y			4
Infections & immunology				Y					1
Falls				Y					1
Gastroenterology	Y								1
General			Y						1
Genomics				Y					1
Gynaecological oncology	Y								1
Intensive care	Y	Y	Y						3
Intellectual disability	Y								1
Maternity & neonatal / women and children		Y	Y	Y		Y			4
Mental health	Y			Y					2
Musculoskeletal	Y			Y					2
Nuclear	Y								1
Neurosciences & the senses				Y					1
Nutrition	Y								1
Ophthalmology	Y								1
Orthopaedic					Y				1
Pain	Y								1
Palliative	Y	Y		Y	Y	Y			5
Primary care				Y					1
Radiology	Y								1
Rehab	Y				Y				2
Renal	Y	Y		Y	Y				4
Respiratory	Y		Y	Y					3
Rural health	Y		Y						2
Spinal	Y								1
Stroke	Y	Y	Y		Y				4
Surgical	Y								1
Transition	Y								1
Trauma	Y			Y					2
Urology	Y								1
Variation	Y								1
Total	33	10	14	18	7	6	0	1	

The New South Wales experience

The Agency for Clinical Innovation in NSW employs approximately 130 staff to support 39 clinical networks (each with volunteer clinical leads and an ACI-funded manager), as well as three networks that function as institutes with more formal budgetary and managerial arrangements (including paid clinician directors): the Emergency Care Institute (ECI), the Institute of Trauma and Injury Management (ITIM) and the Intensive Care Coordination and Monitoring Unit (ICCMU). In addition, there are four taskforces: the Critical Care Taskforce, the Surgical Services Taskforce, the Acute Care Taskforce and the Unwarranted Clinical Variation Taskforce, each charged by government with specific reform objectives. Most of the institutes and taskforces are representative groups. Networks work together on some improvement projects. The ACI has a support portfolio: Clinical Design and Implementation, which includes teams with expertise in project implementation, patient experience and consumer engagement, health economics and evaluation and redesign.

About 2200 clinicians are actively involved in committees and working groups and about 6000 are on the mailing list. The ACI also funds redesign leads that are based in the health services. Health services choose (or not) to be involved in working with ACI on improvement projects. The ACI considers its partners to be the 15 local health districts and 10 PHNs, and some specialty networks (St Vincent's, Justice and Forensics, Children's and Ambulance). The overall work of ACI is based on the IHI triple aim (improving health care performance, controlling cost and improving the experience of care).

The NSW networks have been extensively evaluated.[107, 108 109] Findings included the following:

- Some disconnections between network recommendations and implementation, as authority for implementation resides with the local health districts.[107]

- Projects undertaken that had not addressed a significant health need, were not aligned with Ministry of Health strategic goals, or were not evidence-based were thought to have minimal impact.[108] If the networks set their own priorities, there is always the likelihood that some will not address a significant health need, and many may not line up with statewide strategic goals. This is a necessary consequence of allowing communities to work on matters that concern them.

- Leadership issues:
  - Resources were regarded by most members of successful networks as less important than leadership.[108]
  - Charismatic visionary network chairs were necessary to 'kickstart' a network, but successful longer term work could not depend on the chair to be the driving force.[108]
  - Ability to engage clinicians who were initially skeptical was crucial for success.[108]
  - Links to academic, professional, policy and clinical organisations (for example, medical colleges) external to the network were important for long-term success.[108]

Results from a recently published survey of the NSW clinical networks gives insight into the nebulous nature of clinical networks.[109] First, there was a low response rate (18per cent)

from the 3000 'members', despite multiple reminders and personal invitations from the chief executive of the agency. Engaged individuals answer surveys. Second, while there was strong reported commitment to the network and belief in the work that the network undertakes, there was less agreement that respondents' views and ideas had contributed to network activities (55per cent) or that they had been able to help drive the network agenda (30per cent). This leads to the question of how many people can be effectively involved in leadership or decision making. Finally, in NSW, just over half the respondents agreed that network agendas were aligned with state government strategic plans. They also reported a reluctance to implement network recommended changes by hospital management, clinicians and local area health service managers. This result goes to the status of clinical networks – outside the normal accountability structures.

Meeting with senior ACI staff revealed that their work was a mix of bottom-up work driven by the volunteer enthusiasts on the networks and top-down improvement work driven by representational taskforces. They thought maintaining this balance was important and quite sensitive. They considered the most productive situation was when policy prioritised, supported and created a demand for their improvement work (which hopefully they had already developed and piloted).

Victorian clinical networks – what do we know?

Victoria established its first set of clinical networks in 2008 to: 'provide a mechanism to increase front line clinician engagement in continuous quality improvement in order to reduce variation in practice and build stronger collaboration across health services'.

The cancer clinical network was established in 2005. The next group of networks was established in 2008: cardiac, emergency care, stroke, renal and maternal and newborn. In 2009, paediatrics and palliative care were added. The care of the older person commenced in 2014 and critical care in 2015.

The Victorian policy document, *Clinical networks: A framework for Victoria* (2008, updated in 2011 but not endorsed[110]) states that the focus of networks should be on system change and measurable outcomes, and that they would receive resourcing for change management through local facilitators. A diagram was provided to illustrate the roles and relationships of the networks. It was made clear that the Department of Health and Human Services was to set priorities:

> 'Networks need a strong cooperative relationship with the department to facilitate alignment between network activities and departmental priorities. They have a mandate to operate within an agreed scope that aligns the two, and builds on or links with work undertaken by policy, planning and program areas within the department.'[110]

This sits at odds with the clinician-driven basis of networks where, even when managed, are fundamentally designed to be bottom-up organisations.

The networks are located in a fuzzy space. However, a vast range of work was listed as being within the network remit, and some of this is very expensive (for example, guideline development). The Duckett Review[111] was critical of the department's management of

clinical networks, which have been restructured a number of times, had limited funding and appeared to lack a clear strategic purpose. Despite their unclear direction and some limited support, the networks have worked hard to improve care in their respective areas.

Accountability; governance; policy and program directions; funding; reporting

Department of Health
Responsible for:
- strategic directions in health
- policy development and service planning
- program management and funding
- measurement of service quality and performance
- workforce initiatives

Policy directions

Clinical advice into program, service and system planning and policy development

Clinical networks
Responsible for:
- clinical leadership
- clinical advice and influence
- identifying best practice
- clinical standards and protocols
- facilitating changing models of care
- recommending quality indicators
- building and supporting collaboration between clinicians and health services
- workforce support

Clinician input

Education

Clinical influence and advice

Health services
Responsible for:
- health service delivery
- service quality
- agency service planning
- reporting – activity and financial performance
- workforce

Contribute   Benefit

Patients and consumers
Non-government organisations
Professional associations

Exemplar of network achievements – The Victorian Stroke Clinical Network (VSCN)

Key achievements of the VSCN over last five years have been achieved through a clear vision and prioritisation of key elements to improve patient care. These have included:

1. Rapid translation of evidence into practice through the implementation of the ECR protocol. Within 12 months of the release of pivotal trial data, the VSCN led the development of a comprehensive strategy to ensure that all patients could access this powerful new intervention. This involved selecting two dedicated ECR providers, creating protocols for ambulance transfer, determining relevant collection of variables to monitor performance, and coordinating a clinical governance structure to oversee the implementation.

2. Increasing statewide data collection through the Australian Stroke Clinical Registry (AuSCR) to monitor quality of care and outcomes. This has occurred via funding the registry for a statewide implementation program ensuring the 22 hospitals who manage more than 100 stroke patients per annum are contributing data to the registry. To reduce the burden of data collection the VSCN has led a technology project to extract information from existing sources within hospital IT systems, streamlining data collection methods and embedding this into routine clinical practice.

3. Reducing variation in care by implementation of the statewide Victorian Stroke Telemedicine service. This novel telehealth platform provides regional hospitals with 24/7 access to specialist

91

neurology support for hyper acute care. This has ensured that regional patients receive the same rates of IV thrombolysis and referral for ECR as metropolitan patients.

4. Increasing the knowledge base of the stroke workforce by providing regular evidence-based education through the monthly STROKE webinar program. This program enables regional staff to easily access the latest updates in clinical practice for stroke.

5. Enhancing the uptake of innovative models of care through the subacute stroke initiative projects. Through the cardiac and stroke initiative, the VSCN has funded a range of metropolitan and regional hospitals to develop new models of care in the rehabilitation setting, outcomes of which will be shared on completion.

What did system and Department of Health and Human Services stakeholders think about the networks?

Views on the networks were explored as part of interviews on the larger topic of clinician engagement. There is discontent among hospital CEOs with the networks: two-thirds did not agree the networks significantly improved safety and quality or served local priorities.

Figure 16 Public health service chief executive officers' views on the clinical networks
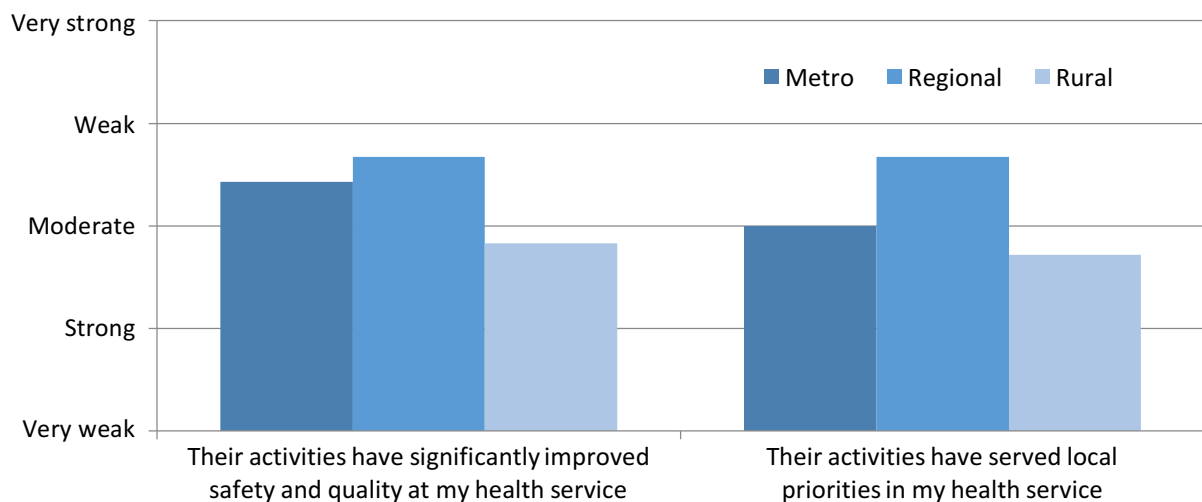
Source: survey of public health service chief executive officers.
Notes: n = 28 CEOs, including seven metropolitan, three regional and 18 rural.

It is highly likely that network activity would not always be favourably viewed by CEOs – the work of communities advocating for improved care in their clinical area of interest will not necessarily be aligned with the CEO's priorities or their forward budget plans. This could be the case for network work of high clinical significance and of high quality.

> **Two metropolitan public health service CEO views on Victoria's clinical networks**
>
> 'It's not the case that the networks are universally unhelpful – for example the paediatrics charter was a huge success. But all the networks are doing their own thing. It's not clear what those things are. And not clear that they're engaging with the right people, including with leaders. I assume that what they do is time and resource intensive – there are real questions about whether their design and configuration is right, and whether they're adding value.'
>
> 'There are many groups with limited overarching governance or integration. For example, there is no overarching governance or integration of the maternity and newborn or paediatrics groups – even though the former in particular is a very crowded space (with a clinical network, a Department of Health and Human Services program, an advisory committee and a consultative council). In maternity we're particularly sensitive to what happened at Bacchus Marsh, where we have all these groups in play and not one that sees the full picture.'

Internal informants commented:

- Good clinical engagement for cancer was in part due to the close engagement of the lead with the minister and at senior levels in the department. It was also suggested that the cancer network was a success because it was an extension of the program areas of the department and tightly associated with it.

- 'Clinical networks are largely "decorative". Without a clear basis in evidence of what are the problems in the Victorian health system, their priorities are idiosyncratic and driven by the interests of the random individuals appointed.'

- Networks have seen themselves as advising the department, rather than leading and championing among their colleagues. There are also tensions regarding role delineation: 'they are all for involvement in policy until it affects their service'.

- There is very little knowledge 'out there' on what clinical networks are working on.

- Networks need some non-doctor leaders.

- There is a need to encourage a system view in network members ('take their hat off'), and to increase their capability in improvement methodology and leadership.

Other key system informants outside networks commented:

- 'Most clinicians are not interested in the networks', and that a big body of medical clinicians only engaged with the medical colleges: 'we need to find a way to join this but it's hard at state level'.

- Guidelines should be major work for clinical networks (rural CEO).

- There is often inadequate long-term data for monitoring and the work of the networks can lead to project fatigue. It was noted that the emergency network has little high-level data, and was considered to be 'all quality improvement, small projects'. (The contra view was provided by a rural NUM who thought the clinical network was 'just great', and her nurses have picked up and led a project a year for the last five years. The network had also allowed for sharing of new evidence-based practice and had helped them develop their own clinical pathways.)

- The networks should invest in collection of special VAED codes which would allow for routine and ongoing data collection.

- There was a feeling that the networks 'have rich insights and data on outcomes but sitting at the DHHS and not filtering back to [health services]' – this may refer to registry data and there was general confusion in the health sector around who 'owned' registry data.

- One informant proposed the Advanced Health Science centres should run the networks, because:

  – they have the expertise to establish the work as implementation research projects

  – they have access to primary care data

  – they have the CEOs on their board and thus able to influence participation and implementation.

- Another made a convincing case that the paediatric network should fund and organise health services research. It was suggested that there were plenty of others in the educational space. The network should ask 'What difference do we want to make to children's health?' and 'What is missing?'. It should develop outcome measures and high quality evaluation is and should be considered 'research'. Topics could include the mental health of children, moving chronic care from clinics back into the community and the general topic of new models of appropriate care that are more timely and cheaper. A clinical network also offers the opportunity to collect data about current unknowns in online forms; for example, PROMS and QUALYS related to outpatient care. Certainly, work like this aligned with the mission of the 2016 Victorian Health and Medical Research Strategy: 'To embed health and medical research into the Victorian health system and accelerate the translation of research findings into clinical practice'.

- Some networks are not considered well focused (for example, paediatrics), and because it's hard to find common threads, priorities may not be well set. With tiny budgets, not always the right people on the steering groups and work that is not necessarily aligned with strategic priorities of institutions or Department of Health and Human Services' performance focus, it can be hard for them to be effective.

Network chairs' views

They welcomed the new opportunities planned: 'first time in years the department has wanted to engage, previously it has been "we'll tell you what to do"'. Several described major departmental policy, for example, around funding models, where the network 'had not been listened to', with unfortunate consequences. All were enthusiastic about their role: 'to serve on a network is really enjoyable; you get involved in an area you love and see it improve across the State'.

Comments were made on the inadequacy of their current communications due to lack of department support: 'just not good enough', 'only to the heads of units' and 'frontline staff have no idea what we do'. There was a desire to be able to share the results of network

work more formally and more comprehensively. Even if there was no money for implementation, there was a plea to 'put it on a website and people might implement it'.

A pattern was described where 'a project goes into the department and nothing comes back', and an example was given of nine months waiting for project reports to be made public. The lack of feedback and acknowledgement can frustrate and demoralise network members, and there was felt to be the 'need to achieve something to get more staff involved'.

The objectives they had for their networks were disparate, from 'helping grass roots clinicians improve practice' (ED) to concerns with reducing care disparities across the state. A member of the cancer network described the ICS for their region 'as a body with expertise to organise, analyse data, get grants and support clinical people to come up with ideas'. Representatives of the ED network talked about engaging staff by doing; that is, CPI projects nominated by staff and owned by staff. They described stronger nursing uptake of their work. They run project management workshops to support this project work and would like additional resources for mentoring and site visits for units involved in their collaboratives. Renal network aspirations included more secure funding for their registry, computerisation of registry data entry. They were keen for proper examination of data – and for transparency. The lack of participation of private dialysis units in the collection of the six agreed KPIs was not considered acceptable. There were consistent complaints from network chairs (and members) about the absence of high quality, timely data.

One chair noted 'networks don't have any clout, they are reliant on clinicians to engage fellow professionals'. While this is an entirely valid mode for a CoP, a more structural influence was desired by some. It was noted by one chair that the current Department of Health and Human Services director was their fifth, and appreciated for being the 'most engaged and politically savvy' they have had. The level and nature of department engagement was considered very important. Involvement of the private sector in the clinical networks was minimal, and some but not all, were concerned about this.

Care of the elderly – case study of network development

The chair of the Care of the Elderly network described the journey of the network. It was unsure how it should operate for the first couple of years, but after a period of 'talking as a group', they developed an agenda of practical implementable things that would interest the Department of Health and Human Services. Their group is very interdisciplinary and the chair considers that a great strength. Once there were real and important things to do (for example, projects relevant to application of the national standards to older people, such as discharge medication safety and nutrition), meetings became well attended. Their annual forum covered topics such as harm in older people and older people and cancer. They are aware that one size does not fit all and of the importance of engaging local groups. Funding from the Continuing Care program has now 'dried up', and there is too much volunteer work being asked of members. They would very much like to receive regular metrics so that the network could provide a system assessment around caring for older people. He emphasised that 'effective network activity resulted in visible change which increased the level of commitment of network members'.

One network outsider corroborated the view of the chair, volunteering that the work of the network 'was just not visible now', but it was so good when there were project officers for environmental and care auditing.

There is considerable variation in network structure and function

Network managers contributed to construction of a spreadsheet with details of their steering committees/leadership groups, activities and their communication strategies. The leadership groups ranged from 15–28 members. Most have carefully designed representative structures:

Maternity and neonatal leadership group: neonatal advisor and medical director, regional, midwife consultant, midwifery academic, consumer, midwife private sector, midwifery representative, clinical director anaesthetic, medical director NETS/PETS/PERS, medical director PIPER perinatal, executive director nursing and midwifery, obstetrician and president of RANZCOG, regional director/consultant midwife, head of neonatology, course coordinator University of Melbourne, aboriginal liaison officer, executive director rural, GP/GP obstetrician.

The processes of nomination and selection to the network steering committees (involving expressions of interest and CEO nomination) did not seem to be transparent to network members, nor to offer opportunities for challenging voices to join the committees. Some have had chairs in place for a long time; others have limited their terms. Planning for refreshment of the steering groups is unclear. Most have consumer representatives, but not the ED network. There are managers or executive members on all steering groups, and for some groups there is a very high representation of such members compared with 'grassroots' clinicians. There is a range of subcommittees, and interestingly, the renal network has both an environmental sustainability special interest group and auspices the Victorian and Tasmania Renal Transplant Committee.

In terms of reach, the cardiac network has defined some of its important constituencies with meetings of unit heads twice a year; the paediatrics network also does this. The renal network is associated with a hub-and-spoke model of care and all satellite services are involved in activities. The cancer network is very different, with significantly more funding and thus a strong reach into its sector, including the 'tumour summits' and development of optimal care pathways for cancer.

There is a large variation in how much the activities of the network focus around the work of steering committee itself (for example, stroke, where there are monthly meetings and the steering group has developed an ambitious statewide improvement vision), or 'reaching out', whether by visits (for example, critical care, paediatrics, maternity and newborn), webinars (for example, critical care, paediatrics) or educational meetings (for example, critical care, paediatrics, emergency and cardiac).

Newsletter production by most seems to be relatively infrequent. The neonatal e-handbook – a product of the maternity and newborn clinical network – is highly accessed. The renal network has just established an extra-net portal to help improve communications. As Figure 17 shows, the email lists provided by the networks were highly variable in size.

The emergency care network manager pointed out that 60 per cent of the medical workforce in emergency departments moves every 6–12 weeks. This points both to the work involved in keeping communication networks up to date and for the need for networks to develop stronger web presences as places that members can go to – to keep up to date with the network and to find out more about best practice.

Figure 17 Size of clinical network's mailing lists
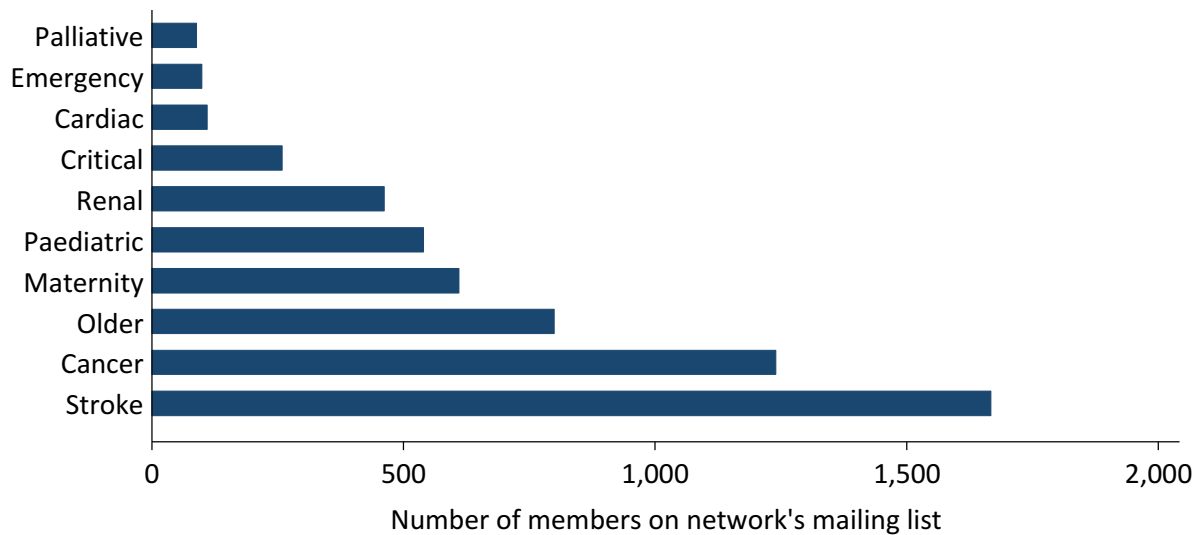
Source: Department of Health and Human Services.

Results from survey of network members

A survey of network members returned 770 responses, with over 450 ranking kinds of clinical network activities in order of importance, and appraising and ranking hypothetical changes in their network. Around 150 provided free text responses across four questions about potential changes in network structure, data they would like their networks to have, ways to make their networks more effective, and mechanisms other than clinical networks that could enhance clinician engagement for quality improvement in Victoria.

The network email lists are described above; however, unexpectedly, many clinicians on the overall mailing list were unsure of their connection with a specific network. Figure 18 shows the large number who did not identify a network, where 'other' was assigned.

Figure 18 Number of survey responses per clinical network
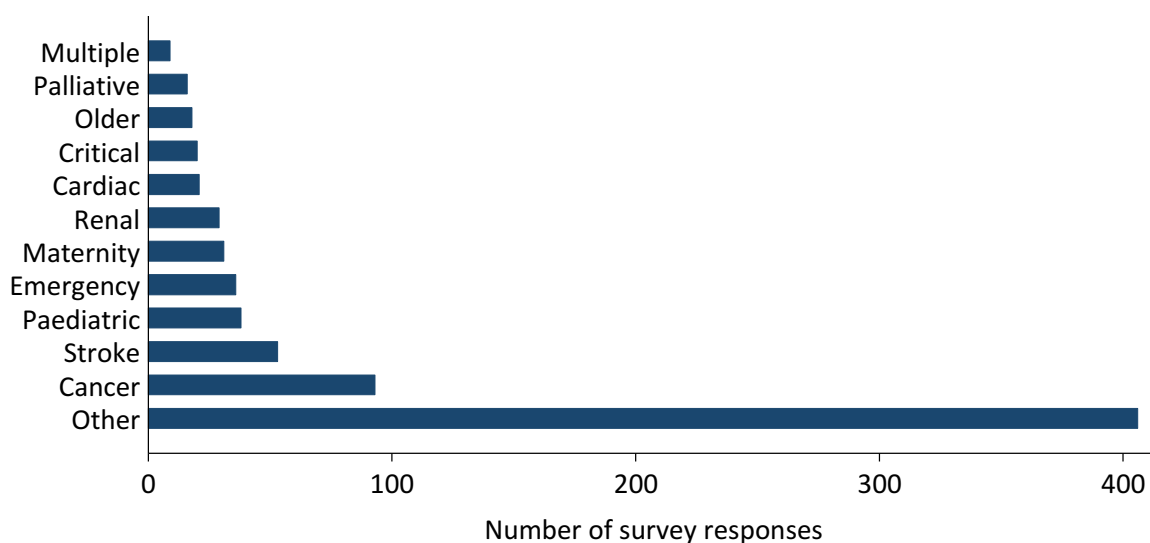
Number of survey responses

Source: survey of clinical network members and mailing lists.

Notes: n = 770 respondents. Respondents were able to specify their network in a free text field. Some listed more than one network ('multiple') while many others did not specify a name that corresponded clearly to a network ('other').

This is indicative of the networks' lack of a brand and identity that is recognised by their constituents. One respondent remarked: 'I really am not clear about the role of the clinical networks at all.' The cancer clinicians who have an elaborate and well-established structure do not refer to it as a network, and the term is not used much by the Care of the Older Person group either. When the response rate was looked at by clinical network, it was much higher for some than others:

Figure 19 Survey response rate, by clinical network
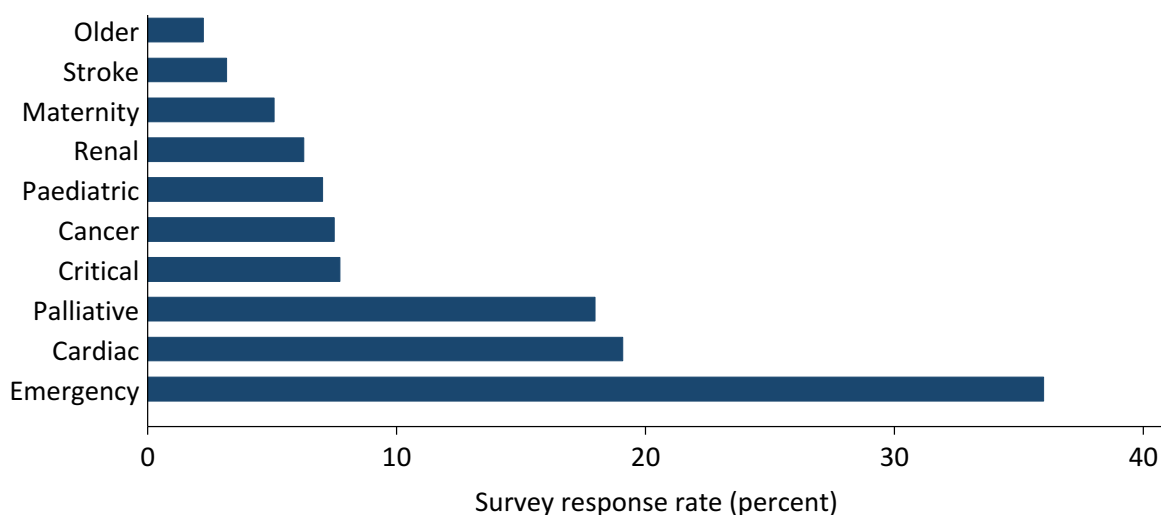
Survey response rate (percent)

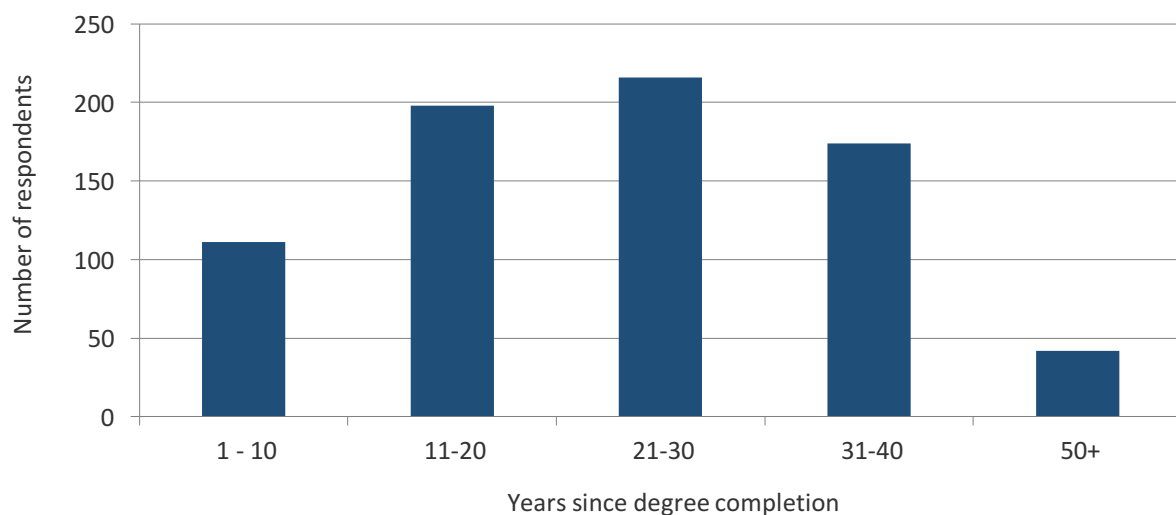Source: survey of clinical network members and mailing lists.

Notes: n = 770 respondents. Respondents who listed more than one network or did not specify a name that corresponded clearly to a network (n = 496) are excluded from these results.

In fact, there was a relationship between response rate and the size of the network's mailing list. Those with smaller lists had, in general, more engaged members.

The graduation year of respondents was collected to get an estimate of network member age. This is illustrated in Figure 20. Network members were an average of 23 years post-graduation.

With regard to the profession of respondents, 48 per cent were nurses, 26 per cent doctors, 25 per cent allied health and one per cent consumers. Just under half (49per cent) worked in metropolitan, with 29 per cent being from regional areas, 13 per cent outer metropolitan and 13 per cent rural. Only nine per cent worked primarily in private practice. With regards to the statewide network governance/steering/leadership group, 15 per cent of respondents identified as members, with the number increasing to 25 per cent, when reference group and tumour summit groups were added. Interestingly, 41 per cent said they would like to be part of the statewide network steering/leadership group. However, there was overall little knowledge about the steering group, with 15 per cent considering the right mix of people were on this group, seven per cent suggesting they were not right, but 78 per cent simply didn't know.

Figure 20 Time since clinical network respondent completed their primary health professional degree

Sources: survey of statewide clinical networks mailing lists.
Notes: n = 751. Response rates varied and may not be representative.

Priorities suggested by clinical network members

Somewhat lengthy lists of options were derived from information received about the kinds of work the networks have been doing and ideas suggested for change by key Department of Health and Human Services informants. First, network members were asked which kinds of work they thought were most important. Promoting evidence-based practice via implementation of statewide clinical strategies and developing clinical guidelines were the top choices. This was followed by building capability for quality improvement work.

Figure 21 Clinical network survey respondents' views on the most important work for networks

Percent of respondents agreeing
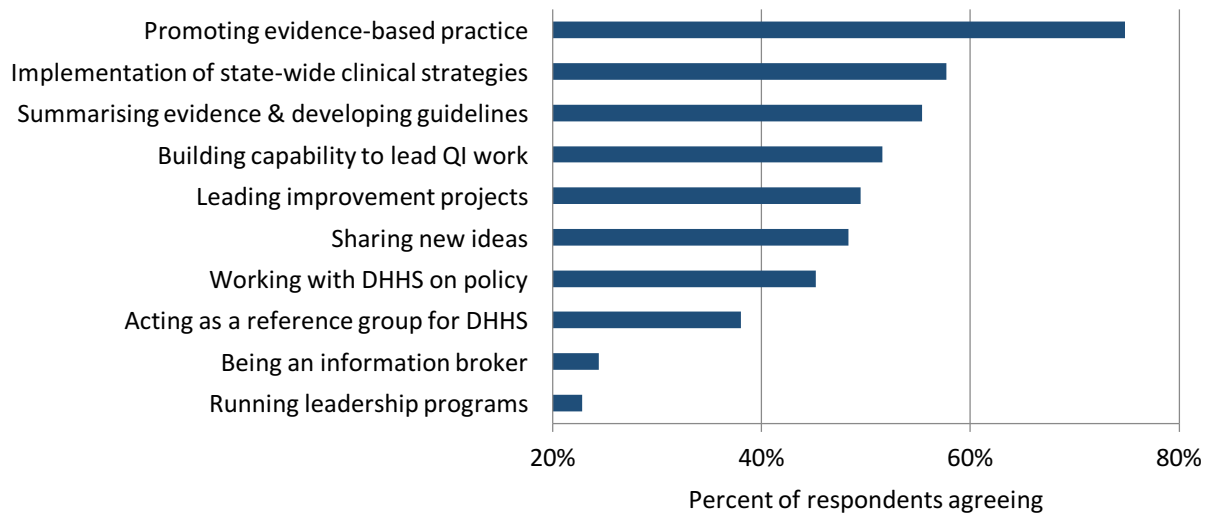
Sources: survey of statewide clinical networks mailing lists.

Notes: n = 671. Respondents were able to select as many possible answers as they liked. Five per cent of respondents selected an 'other' category and entered free text suggestions (not depicted here). Response rates varied and may not be representative.

As Figure 22 below shows, when respondents were asked to rank some hypothetical changes to network function they were most enthusiastic about more financial support for statewide projects, prioritising unwanted clinical variation. Greater focus on supporting clinicians who are leading local projects was the fourth choice.

Figure 22 Network respondents' support for hypothetical changes to the clinical networks
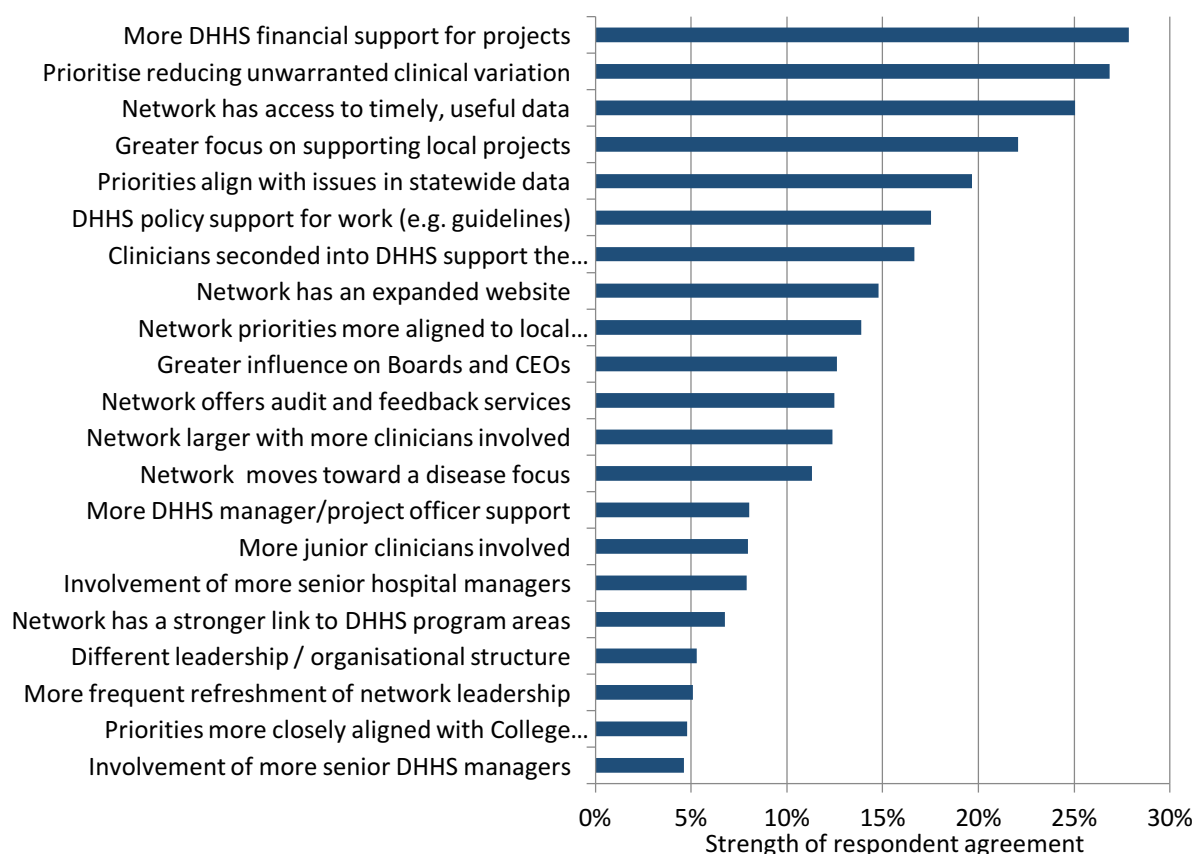
Source: survey of clinical network mailing lists.

Notes: Respondents were able to select up to five priorities for change and ranked them in order of priority. Each priority listed in the chart is ranked by respondents' support, with support calculated by the number of respondents who selected the change as a priority, weighted by the average relative priority it was assigned. A higher agreement corresponds to more and stronger support among respondents. Each change was ranked by support, with support calculated by the number of respondents who selected the change as a priority, weighted by the average relative priority it was assigned. A higher agreement on the x axis correspondents to more and stronger support among respondents.

Free text comments on priorities reflected the quantitative results. Exploring variation was of interest, including:

'Benchmarking between like units and monitoring clinical registry data.'

'Having a statewide perspective on cardiac issues and providing vision and direction of areas for improvement.'

There was strong focus on the need for statewide policies and guidelines:

'…encouraging statewide policies, not health network-wide policies, based on EBP, such as TED stocking management – surely this is a terrific time/cost saver.

'…developing statewide guidelines that are pertinent, particularly to smaller providers of paediatric care.'

'We need consistency across the all hospitals. Because some hospitals lack resources to develop a high quality clinical practice guidelines, then open sharing across the state in a government sponsored site (such as ICCMU – NSW) is vital.'

Priorities mentioned that were not included on the list given were: involvement in workforce development strategies and suggestions concerning service delivery (especially in cancer but also 'Linking regional non tertiary services to subregional services' or even quite specifically 'Barwon South West Region aligning with local Primary Health Network boundaries'.

In response to the question 'If you think a different network organisational structure would be useful, what do you think that could look like?', some respondents specifically suggested no change. This is an important comment from satisfied members, one even stating; 'Just glad that it exists'. Suggestions for improving the structure of the statewide clinical networks focused on more grassroots input – this was a strongly represented theme:

> 'Ask clinicians, not hospital managers (even if they are doctors) if they would like to be involved and what they think is important to do.'

> 'Grassroots-level input from nurses, doctors and allied health workers, patient input.'

> 'More representatives who work closely with patients/clients and their needs.'

Some suggested a more devolved and inclusive structure with local branches or subcommittees and more regular meetings: 'local feeding to regional feeding to state'. Adding professional or inter-professional diversity, GPs, VMOs, more regional, community (including services like the ambulance service) and private sector representation and younger clinicians was also advocated:

> 'Some junior clinicians (medical, nursing, allied health) to hear their opinions, engage them in network projects and help to identify future clinical leaders (longer-term succession planning and sustainability for the networks).'

> 'What about the nursing unit managers? We are on the ground running the services day to day, we manage flow, finance, staffing, clinical governance etc. etc., yet are not invited.'

Others saw the network playing an operational role with the Department of Health and Human Services in the coordination of care across the state.

> 'DHHS to have greater influence over managing system and greater central governance.'

> 'Coordination of care in tertiary centres and support of the larger regional centres.'

> 'For emergency, it would incorporate the clinical and public policy areas; for example, Network + EARC under one governance structure.'

> 'Networks to inform, monitor and direct the clinical council.'

Cancer network members had stronger views, with one respondent even suggesting the network become a controlling and coordinating structure itself:

> 'For the ICS – in my view they have lost the plot… They have no power, mainly as they have no control of how the money is spent within a hospital. A new structure requires that the ICS control the hospital's spending on cancer care – not the hospital.'

When network members were asked 'What data you would like your network to have access to?', the bulk of the 185 responses asked for benchmarking data. Long responses reflected respondents' enthusiasm for having access to this for improvement, for instance:

> 'Areas within the specialty that need improvement, but with ability to see where the institution sits on the benchmark. Regular feedback about these QI markers so that you can see if a project / change in direction is working. Ability to identify processes that the 'best' hospital is doing, without necessarily knowing who it is. Also, what is known about poorly performing hospitals so that processes that result in poor performance can be eliminated at the same time that we look at what can we adopt from best practice hospitals.'

Quite a few also asked for service use data such as:

> 'Bed availability and average flows of beds.'

> 'Nursing hours per patient, with a disease (DRG) focus. Activity in raw numbers. Costing data. Data to be presented as benchmarking, against peers.'

Some variation in health information literacy was evident in the answers. A set of members asked for best practice guidelines and another set simply asked for 'all the data'! A couple of respondents were happy with the status quo, one making an interesting point regarding national data collections:

> 'Not sure the DHHS has ready access to data useful to the network given clinical / resourcing data already captured in specialty specific data monitoring at national (+NZ) level.'

There was generally felt to be a need for more timely data and data that was easier to access. Ideally, it would include the private sector. Better access to community data including education data and population health data were also mentioned by individuals. Longer term follow-up of patients was of interest, as was pathology and prescribing. Some had very thoughtful specific data requests.

Examples of appetite for detailed data to improve outcomes

'ANZNN data is comprehensive and good benchmarking for NICUs but a similar structure for Levels 1–5 of neonatal care is needed and should be compulsory for all units.'

'The VAED and VEMD needs to be made more accessible to health services and clinicians and further augmented with good patient outcome data – morbidity and mortality Data registries should also be explored.'

'In stroke we need to know about severity of stroke, and outcomes at 30–90 days. Ultimately I want to know what influence management is having on patients and is it the best it can be and if there is a problem (variance from standard practice), what is it and what needs to be changed. The data need to help direct and focus change. So specifically I need demographics, pathological diagnosis and all the prognostic that go with that stage of disease, patient co morbidities, ECOG, where the treatment occurred and by whom, what treatment was delivered, when and where. Was the treatment completed? Complications of treatment with severity and type. Relapse rates and survival. I want this information from my region and also know what happens when they go to Melbourne or other regional

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areas. Often the data is based on where the patient lives, but doesn't reflect where their treatment has been so it's less helpful.'

When members were asked for other suggestions to make the work of your clinical network more influential and effective, the two top priorities were increased visibility and increased structural influence. Other issues raised that have not already been discussed (such as data and guidelines) included the provision of teleconferencing facilities and multiple comments on the problems and waste associated with the lack of statewide IT systems. A couple of respondents suggested the need for the networks to support research, one suggesting the need to involve clinicians with epidemiology training:

> 'This will help to lift the quality of the endeavour. Well-meaning clinicians, especially if they are senior and have strong egos, can lead others astray if they make statements outside their areas of expertise.'

A few respondents felt excluded by the network, for instance suggesting:

> 'Less people with strong ties and undeclared conflict of interests.'

> 'Being inclusive and engaging is always better than secretive and separate.'

The processes of nomination and selection to the network steering committees did not seem to be transparent to members, or to offer opportunities for challenging voices.

In regard to the need for increased visibility, many considered this a significant problem:

> 'I'm not sure what's going on in the network – the newsletter is crap and it's difficult to keep abreast of progress/projects/opportunities.'

> 'More communication with local services. I would have no idea what the network is doing.'

> 'Until I joined a reference group the clinical network seemed an abstract ideal, and I know that junior staff in my area have poor awareness of it.'

> 'Clinicians receive limited communication from network, and hence implementation of recommendations is patchy.'

The reintroduction of network conferences (which had been valued in the past) received significant support. NSW's Intensive Care Coordination and Monitoring Unit site was praised. Quite modest suggestions were made (reflecting the current poor state of communication) such as: 'Maybe the minutes are circulated to a wider group' or for a three-monthly newsletter or even annual reports:

> 'Clinical network annual reports with summaries of achievements across network and access to online site where this information is available.'

Bolder suggestions related to increasing the size of the network and the creation of a situation where belonging to a network is an important identity for clinicians:

> 'Needs to be bigger to be effective, many clinical staff would be unaware of their existence and work.'

'More visibility, I only know of the clinical network through emails I receive. I don't hear or see the clinical network anywhere else; for example, representatives at hospital committees, visibility at conferences.'

'Increased size to enable improvements to be implemented more quickly, for example, statewide guidelines to reduce variation, and free up time in clinical departments.'

Suggestions for increased structural influence varied in approach from liaison to the development of serious surveillance capacity:

'Greater, transparent liaison between clinical network and health service managers and executives.'

'Must link into the new regional clinical councils. Must provide interpretative analytics to hospital boards to assist in their data becoming clinically relevant information.'

'Agreed clinical indicator sets that are relevant to HS activity, reported at board level and monitored by DHHS / clinical networks to focus attention and resources.'

Some respondents referred to Department of Health and Human Services work in areas related to the network and suggested a more combined approach. This included: 'closer links with program / policy / funding area', the department leading more dissemination strategies but also more 'more governance of the state wide organisation of care'.

There is always going to be tension in where the power for decision making sits and network members asked for more influence:

'DHHS membership should… seize the opportunity to use the work of the network to change their thinking when appropriate… sometimes the politics is that the network is guided to match the DHHS view of the world intentionally or unintentionally.'

'If there is a clearly defined relationship between the network and the DHHS (policy) such that a network's recommendations are acted upon by the DHHS, the network will be highly influential and effective. This would be a massive change to the way the DHHS currently works.'

Conclusion

The reality of the arrangements is that despite many successes, network activity has not been reliably influential at either health service or department levels. Carefully crafted reports and guidelines have 'disappeared' into the Department of Health and Human Services, or there has been a failure to match development work with implementation efforts. These latter cannot merely consist of packages for discretionary quality improvement. The aim of statewide clinical networks is to improve care across the statewide system. Yet, to date, this has to date only marginally included the private sector and rarely (if at all) has there been demonstrated statewide uptake of improvement work. This was not a review of the value of the work that has and is being undertaken by the clinical networks, but of their effectiveness as engagement structures. It was evident that many of their achievements were not recognised by the sector. A Victorian network manager ruefully pointed out the results of their own evaluation undertaken at a conference that showed that the attendees were very positive about the meeting, but not about the network (the provider

and organiser). Senior ACI staff reported much the same thing, where system- changing work was not at all attributed to the organisations that had driven and created it.

Resolving a future role for the clinical networks is urgent. One member listed their top priority as 'Just better role clarity. Not so much what the network is doing but clarity about its role in the system so it has the authority to change and influence'. Different networks may well have different roles, but thought about the role and nature of each network are needed.

The following categories, devised from the literature and this research are not exclusive, but are a list of categories of networks that 'work':

- **Networks as advisory groups** – this works better if networks are relatively small and members are selected and have competence in management and working with policy makers. Some current Victorian networks are really of this nature – large advisory groups (who do contribute to important program and policy work). The mailing lists for some are notably small.

- **Networks as ideas generators** – that is, networks of enthusiasts. These can be of varying sizes, but importantly, are very open and include a high percentage of junior and grassroots clinicians and people with more diverse backgrounds (for example, social services, education, ambulance and so on as appropriate).

- **Networks as practice influencers** – that is, influencing clinicians' practice directly. In this case, the networks need to be large – every relevant professional should know at least someone on 'their' network. With this model, education activities are an important (but should be designed around measurable variation to be reduced). Networks like this could feed up to an advisory group and it would be desirable to have work proximity-based groups within in (based on regions or referral patterns) so members have face-to-face opportunities to discuss shared concerns and share good ideas with peers.

- **Networks as organisational delivery structures** or responsible for the organisation of care (such as the UK operational networks). The Cancer Network has done some work of this kind (among other activities).

What doesn't work is:

- **Networks as system influencers** – members struggled to influence CEOs and wanted Department of Health and Human Services support for this work. Networks are not situated with accountability in the system for delivery of care – so they cannot be effective at this.

- **Networks where members do not represent a community of practice** – if the networks are designated to cover large areas of clinical concern (such as paediatrics), then finding and supporting important CoP within those networks becomes a priority.

- **Networks where priorities are set by an external body** – for example, the Department of Health and Human Services. It can be an influencer, but if it wants to be a full manager, it needs to be managing either an advisory body or a structure responsible for the delivery or organisation of care.

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Victorian clinical networks – suggestions

1. Refocus the networks as practice influencers

There is no demonstrably superior model for network function that can be simply recommended for implementation in Victoria. The existing networks have undertaken good work, and practical improvement to the status quo is therefore the obvious solution. Role clarity is essential, and members reported great frustration (and suggested a range of diverse solutions) as they sought to determine the best ways to influence care. The support of energised groups working relatively autonomously on matters of shared clinical concern is a logical approach to supporting improvement in a complex adaptive system.

The overriding interest of network members was to work on reducing variation, doing this aided by usable data and then working on guidelines and quality improvement activities. This is the model of a network as a practice influencer. To do this well, their reach and representativeness need to be enhanced, and ways to do this are discussed below. (Some networks could be given operational roles if the Department of Health and Human Services desired, this has happened for emergency and critical care in NSW, but the influencing network still needs to work independently alongside other responsibilities.)

Some networks engaged in effortful data collection. There were complaints by network members and key informants about local data extraction projects and software development (for example, stroke, ICS). There was a desire to have such work done more centrally and to have much better access to registry data. It is important that data is turned into information that meets clinicians' needs or the perceived deficit will remain. Appendix C contains advice from the literature about the general features of data that meets clinicians' needs.

Some members' expectations that they can set their own priorities and then have work on these priorities be generously funded by the Department of Health and Human Services are unrealistic. However, they should be able to be a strong voice into how priorities are set by the department, and this is not always the case. In the case of cancer, the network and program are closely entwined, but in some other areas the policy areas may ignore or compete with the networks. Placing the chairs of the steering groups on the Clinical Council will help with this. However, it would be good to think of other mechanisms, perhaps at one network-organised conference a year; there could be a listening-focused session with attendance by staff from the department.

The monitoring of KPIs for performance assurance would seem to be the work of the department (accepting that some KPIs may be closely related to the data provided to networks in the future and thus the work of the networks). Where the department chooses to monitor an area, hospital boards and CEOs will be focused and more likely to invest. This is also something network members want.

The network steering committees could play a second advisory role in helping the department interpret data, but their primary responsibility should be to drive the practice-influencing work of the network.

2. Take a community of practice approach to decisions on network number and focus

It will not be possible to 'cover' the whole health system and all its concerns with networks. Clinical networks are also not the only vehicle for improvement work. Of the current networks, stroke was the most convincing example of a multidisciplinary statewide CoP, with relevant stakeholders being aware of their work. Some of the current networks are assigned to cover domains where clinical interests are too specialised to allow them to work together to form a meaningful CoP, and the steering groups need to thus formalise structures under their guidance to become functional CoPs. Some of these may come from the current 'subcommittees'. These do not need to be long term, and may be temporary networks associated with particular improvement activities or current clinical foci of interest (for example, a year-long focus on anaphylaxis and so on). Shorter-term groups working on collaborative improvement work are valid and strong temporary networks. It may be, for instance that the Department of Health and Human Services chooses to support 15–20 networks at any one time, with half of these being for limited terms.

Members of the community should be given the opportunity to be involved in steering the networks activities (this both builds individual's commitment to the network and their capacity to work with data, on improvement issues and so on). This can also be improved by the use of more modern communication techniques (for example, involvement in priority setting using Delphi processes or similar).

3. Enhance reach and influence

Overall, the reach and influence of the existing networks needs to be significantly expanded. They need more members – everyone in a relevant area should know someone involved in the network. Practically, what could this look like? It means scoping out the size of the relevant community and setting a target. For instance, there are currently 100 individuals on the emergency network mailing list. There are approximately 5000 clinicians working in 40 emergency departments in Victoria. A sensible target for network size might be 1000. That is, 1000 individuals receiving information and being invited to attend and participate. Diversity of all kinds is important to ensure that clinical networks are not at risk of focusing on a medical specialty's self-defined concerns.

As well as a more conscious approach to patient and consumer involvement and reach into the community (including groups like the police where appropriate), the involvement of more younger clinicians needs to be sought. This means making it easier for them to be involved; they are more likely to have childcare responsibilities and limited ability to take time away from clinical work without backfill.

Seven actions are recommended to enhance network reach and influence:

1. The development of local chapters or regional subgroups

Such groups can be incentivised (by the organisation of meetings with speakers of interest) to come together to discuss their work. This allows for crucial horizontal learning and sharing. An inclusive approach to membership should be developed, including allowing 'ordinary' members to vote for at least some members of the steering committee. The desire for more grassroots influence in the networks was strong. The advantages of creating regional subgroups become obvious when the potential expanded size is considered. This also makes it much more likely that younger and more junior clinicians will be able to be involved in the networks.

2. Link systematically with the community and primary sectors

It has been suggested that in the future 'Hospitals will need to be governed as part of a network of outpatient and inpatient care providers that are concerned with patient responsiveness and better attention to the role of professionals'.[112] While funding models are a barrier in Australia, there has been a failure, to date, for the networks to link systematically with the community and primary sectors. This should include outcomes data. Networks need to do this so that they can be patient centred, having influence over the continuum of care.

3. A more agile and professional approach to communications and public relations

This includes freeing up network managers and chairs to manage their own communications, on a site hosted externally to the Department of Health and Human Services if necessary. There needs to be the opportunity for debate and for divergent viewpoints to be aired by the communities. This is an immediate priority, and will be costly, but the good current work of the networks is not adequately visible. Thus, the return on investment, of department and system money, and most importantly, of clinician energy and volunteer labour, is far more limited than it should be. Additionally, the ability to create a brand identity has been restricted, to date, but is simply necessary for their work. This is one way that communities define themselves and create a sense of belonging in members and recognition of the entity in non-members.

4. The development of a navigable portal accessible to all clinicians (or publically accessible) containing agreed statewide guidelines and protocols

A second site needs to be provided for simply sharing material that guides local practices. The current attempt to do this – Prompt – is considerable unnavigable and to contain mainly out of date material. Access to Prompt is also bizarrely restricted (for example, just to quality managers in some institutions). It would be ideal to incentivise uploading of material to the new site; network managers could play a role in soliciting and supporting this. This is key for encouraging peer learning and peer support. Currently, too many Victorian health services look to overseas and interstate models when there is excellent practice within the State.

5. Provide stable senior Department of Health and Human Services support

Provision of regular senior department staff participation in network activities, so that queries and concerns raised by the network are then answered responsively by a designated person. This is about enhancing voice up, is useful for the department but will also meet the needs of network members – who want to work autonomously but also to be heard when necessary.

6.Consider how best to involve consumers

The consumer involvement in the work of the current networks is not sufficient. This is not surprising as CoPs did not traditionally involve consumers – just practitioners. The benefits of, and moral imperatives for, consumer engagement are now well known. The networks could consider work such as that of the UK James Lind Alliance[113] for consumer involvement in priority setting. Involvement of large groups of consumers will often be appropriate during guideline development (co-design of care).

7. Reduce the number of little projects and seek strategic alignment where possible including by monitoring

Finally, and this may seem a contradictory recommendation, some oversight of overall system improvement activity is needed. System stakeholders complained of 'death by a thousand projects'. Change and project fatigue were evident in the health system, perhaps most especially in clinical areas where the cognitive load is intrinsically high; for example, ED. The folks involved in 'doing' projects (whether teams, ED registrars undertaking formal projects or nurses leading QI projects supported by a clinical network) may have a good experience, while also exhausting the goodwill of their colleagues. There will always be local priorities and problems and local projects, but what is added needs to be carefully considered. It has recently been suggested that regulatory bodies do need to play a role in giving institutions time and space to so that they properly implement a limited number of QI interventions.[3]

Department of Health and Human Services staff considered a negative kind of clinician engagement was:

> 'Paying health services to deliver short term clinical improvement projects. These are rarely sustainable and become another revenue source rather than building the safety and quality culture.'

In the UK, 'QI work is often pursued through time-limited, small-scale projects, led by professionals who may lack the expertise, power or resources to instigate the changes required'.[114] This will also often be the case in Victoria. It is also recognised that 'staff-driven initiatives that do not align well with strategic priorities have only limited impact or longevity'.[3] Frontline staff and senior managers often also have different perceptions of both the goals and results of quality improvement efforts, and without shared commitment and understanding by hospital leadership and staff, effectiveness improvement initiatives may be limited.[40, 115, 3] Thus, in addition to control of the excess of little projects, monitoring of

performance in a limited number of areas (rolling) where the networks are working by the department (and thus boards and CEOs) will help with the alignment of health service strategy with the pre-occupations and activities of clinicians and managers.

Summary of proposed clinical network model

All clinical networks will be given the mission of practice influence. This means that their role is to work among their clinical community to change practice. They will report against this mission annually, using a community of practice-based assessment template. Their utility will be reviewed regularly, with the expectation that some will need to be wound down or 'renovated' every five years. Some networks may be established from the beginning as being fixed term.

To influence practice successfully, they need to become much larger (say, 1000 members) and develop regional chapters (with 20–100 members) that meet regularly face to face. It is suggested that the network steering committees be increased in size – to approximately 30 members; however, half need to be grassroots clinicians, patients or carers, and there needs to be greater participation from the private and community sectors and by allied health. These committees will then need a small executive group (4–6) to manage day-to-day issues (for example, data liaison, working with the new data advisors). The chair of the network will be a member of the Clinical Council.

Networks will set their own priorities informed by variation data. In some other circumstances, little is funded other than a network manager. This is not recommended for Victoria. Networks need money so they can do 'real work' and energise their members; this also increases the value of members' largely volunteer energies. They will have a discretionary budget. However, any proposed network expenditure on data collection will require separate Department of Health and Human Services approval (information agency).

Network activities to reduce variation will take many forms, but there will be an emphasis on development of guidelines and sharing of protocols.

Network members may be asked by the Department of Health and Human Services to serve on advisory committees or taskforces, but this will be seen as separate from the practice influencing work of the network.

Duckett Review recommendations on clinical networks[111]

This direction and these recommendations are aligned with the Duckett recommendations. The development of the statewide quality and safety analytics report will take time, but the direction suggested can commence immediately with reinvigoration of the networks, with members discussing shared concerns and sharing practice ahead of the new data sources. Points of note regarding the Duckett recommendations are listed in bold below

- The department should revitalise the clinical networks. Each should be focused on a single objective: to improve outcomes of hospital care. **There is a strong desire by network**

members to become more involved with community care and long-term follow-up of patients. This seems desirable, and is implied in the consumer-focused recommendation (below).

- The OSQI[22] should develop a strategic plan for coordinating interdisciplinary improvement work to be published before 1 July 2017, with the strategic plan incorporating infection and infectious disease, mental health, surgery and general medicine. Work in these areas should begin as soon as possible. **The primary objects of their work which need to be agreed by network members and new priority setting should be based on new analytics when available**.

- Each network should be charged with improving the overall performance across all hospitals (public and private) on relevant indicators from the statewide safety and quality analytics report by reducing variation on quality indicators and lowering incidence on safety indicators. **Support will be needed from the Department of Health and Human Services to obtain participation of the private sector. Accountability for performance cannot sit with networks but will continue to rest with the Department of Health and Human Services and boards.**

- Every network should have at least two consumer representatives with personal experience relevant to the network's focus, who meet the requirements for being able to reflect the perspective of health system users set out in Recommendation 2.2.[23] **This target is too low, and implies a formulaic approach to consumer engagement (consumers on the steering committee). The Department of Health and Human Services consumer strategy needs to be refreshed overall, but is out of scope for this framework.**

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[22] Safer Care Victoria

[23] Namely, that "In addition to having the necessary board-level skill and knowledge requirements, any person recommended for appointment to a board under section 65T(3)(a) of the Health Services Act – 'able to reflect the perspectives of users of health services' – must have evidence of: personal experience as a patient or family/carer of a patient of the health service and ongoing involvement, preferably via both formal and informal structures, with health consumers in order to gain and maintain a broad community perspective. Either prior to appointment, or as part of their development plan to be completed in the first year of their role, those appointed under section 65T(3)(a) must also be able to demonstrate skills and experience (or appropriate training) in community advocacy on health as well as knowledge of what issues are broadly most important to patients and families.

Recommendations

Clarify the role of statewide clinical networks – to reduce unwarranted practice variation at the statewide level (that is, not just among organisations represented by members).

Structure statewide clinical networks to maximise reach and involvement.

The role of clinical networks is to focus on reducing unwarranted practice variation at the statewide level (that is, not just among organisations represented by members).

They will enhance their abilities to influence practice by:

- *defining their constituencies and then setting ambitious, measurable targets for engagement with those constituencies (which they will monitor and report on together with measures of influence)*

- *developing regional subgroups within the statewide networks, and also smaller communities of practice and time limited collaboratives to work on discrete areas of concern*

- *ensuring half of the members of their steering groups are 'grassroots' clinicians, patients or carers, with adequate representation from the private, primary and community sectors and of nursing and allied health*

- *developing agile and modern communication practices that inform and increase interest in their work.*

Empower clinical networks with tools, resources and policy influence. Statewide clinical networks are supported in their work by:

- *a consumer engagement strategy and toolkit appropriate to the networks' focus as clinician practice influencers*

- *being allowed to develop brand identities and to communicate freely and publicly about their work*

- *provision of usable data and by development of standards for data supply in response to system requests (for example, timeliness and ease of access)*

- *being able to propose regulatory or performance accountability measures when necessary to ensure that guidelines and improvements reach the whole sector (for example, through data collection requirements or statement of priorities conditions) and receive formal responses from the relevant part of the department or other agency*

- *development of an accessible and navigable portal for sharing agreed state guidelines and local protocols.*

Safer Care Victoria leading coordination and oversight of clinical network work plans to ensure that there is time and capacity to implement improvement activities sustainably (reduce the number of small projects).

Section F - Engagement for policy development and implementation

Theoretical perspectives

Many Department of Health and Human Services staff are highly experienced policy makers; however, many current advisory group processes do not deliver the value they could. There is an opportunity to help these processes reach their full potential and to consider department engagement more broadly – beyond establishment of formal advisory groups. Rather than synthesise a Masters unit of study, (which many staff have of course done), four ideas for fresh thinking are provided below prior to presentation of the results.

1. The intent of clinician engagement needs to be specified for each project and task.

For instance, three categories of benefit are suggested for public involvement in priority setting:[116]

- Instrumental: new information is gained and better decisions are made.

- Political: democratic accountability is enhanced. For this to occur, there must be active deliberation and shared decision making.

- Educative: complex ideas and concepts are better understood by all stakeholders.

2. Design advisory groups based on their purpose

The following table, modified from[117] and based on work with boards, gives some idea of the diversity of models. The role chosen for each group should determine its membership and function. Conversely, a group with a certain membership may start to function in the role appropriate to that membership.

Model	Role	Members
Compliance	Check compliance	Organisational representatives
Partnership	Improve performance: add value to decisions, support management	Experts
Democratic	Political: represent constituents, reconcile conflicts, make policy, control executive	Lay representatives
Stakeholder	Balancing stakeholder needs: make policy/strategy, control management	Stakeholder representatives
Rubber stamp	Largely symbolic: ratify decisions, give legitimacy, managers have real power	Representatives

3. Use co-creation methodologies when possible

'Co-creation' has rapidly gained currency as a way of addressing the widespread failure of health services research to meaningfully impact on health policy, practice and outcomes.[118] Co-creation brings academics, consumers, clinicians, and service organisations (across public, private and not-for-profit sectors) together to work from the outset to frame relevant research questions, create research designs that apply to real-world contexts and commit to

implementing the research and its findings more broadly.[118] When such a collaborative approach is taken to policy making, engagement is more satisfactory for clinicians and participation more active and enthusiastic.[119] It is also a good fit for a complexity view of the health system. There are some specific techniques that can help with co-creation, such as the use of deliberative dialogues. These are a type of group process that can help to integrate and interpret scientific and contextual evidence (including local data, published evidence or the best available opinion) for the purpose of informing policy. This approach addresses the accord between research evidence and the beliefs, values, interests or political goals and strategies of decision makers.[120, 121] Design features rated positively by participants in deliberative dialogues include focusing on alternative ways of addressing a policy issue, use of pre-circulated evidence summaries, involving all stakeholders, moderation by skilled facilitators, allowing frank, off-the-record deliberations and not aiming for consensus.[121]

4. Try to avoid 'policy alienation'

It is useful to consider the concept of policy alienation[122] when designing policy. There are two major issues: powerlessness (lack of control) and meaninglessness (being unable to see the purpose of a policy), which are considered to influence the willingness of professionals to implement a new policy. These dimensions can be measured,[123] and use of the validated questionnaire at regular intervals when policy has been introduced could be a good idea as a check on the effectiveness of the engagement that occurred during policy development.

Dimension	Definition and example	How to avoid a high score (that is, alienated clinicians)
Strategic powerlessness	The perceived influence of the professions on decisions concerning the content of the policy	Draft with implementing professionals AND professional associations (avoid working just with 'professional elites')
Tactical powerlessness	The professionals' perceived influence on decisions concerning the way the policy is implemented in their own organisation	Organisational managers consult with local clinicians regarding implementation (and have the discretion to customise implementation)
Operational powerlessness	The perceived degree of freedom concerning making choices about the sanctions and rewards associated with the policy (this is the obverse of discretion)	Allow some discretion in frontline actions
Societal meaningless	The perception of professionals concerning the added value of the policy	Establish shared/agreed goals before developing policy ('buy-in' to the importance or the problem and the suitability of the policy solution)
Client meaningless	The professional's perceptions of the added value of their implementing a policy for their own clients	Clarify the value of a policy for clients. Avoid cost control only policies as these never advantage individual clients and clinician-patient interactions

Table adapted from [122].

Testing this model among Dutch health care professionals revealed that operational powerlessness (autonomy) was important, but surprisingly, strategic and tactical powerlessness were not significant. The authors suggest that 'everyday professionals are different and disconnected from the professional elites, who represent them in their associations'.[122] Thus, additional efforts will usually be required to translate policy to the bedside.

The second finding was that both meaninglessness dimensions were significant: professionals resisted implementing policies that they did not see as meaningful for society or for their own clients. This included opinions that the policy was badly designed and would not meet its stated goals.[122] The lesson for policy makers is to make more meaningful policies and to make the intent of policies more apparent. Otherwise, when clinicians have to make sense of top-down directives, they can be deflected from providing optimal care and become distracted by resistance.[17]

In summary, there is room to apply design thinking to advice for policy, and the opportunity to use co-creation methodologies so that policy is richer and engagement more enthusiastic. Measuring stakeholder perceptions offers the opportunity to learn how to do both of these activities better.

Department of Health and Human Services perspectives on clinician engagement

Department of Health and Human Services experience of clinician engagement was investigated by survey and key informant interviews (with informants both within and outside the department). Comments from these interviews have been included in the commentary here, and also elsewhere in this paper. Three department areas have quite unique clinician engagement profiles and will be discussed in detail. These relate to their legislation or their role in licensing and/or accreditation. Mental Health Branch has comprehensive engagement with the public sector and a serious commitment to involving carers and consumers. The Aged Care Branch offers comprehensive safety and quality support for a portion of the sector, but has also created forward thinking work of wide relevance. The private hospital unit is tiny, but with more staff and greater use of its regulatory levers could exert a substantial influence, driving engagement for influence over a sector that represents 38 per cent of all patient separations.

Aged Care Branch

This branch is responsible for 5800 beds (12per cent) of the Victorian aged care sector. It is involved in accreditation, using the Victorian Clinical Governance framework, but there are also national regulations. They have focused on the most challenged services, and worked as consultants to assist, using persuasion and maintaining good relationships so that 'they ring us'. They aim to support services through issues using 'questioning conversations' and providing evidence and reference to the Act and to mitigate early.

Reduction in their funding means that they are no longer able to visit services or hold the seminars they once did (these were two-day events four times a year and attended by 200–250 people). They

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have an 18-member public sector residential aged care leadership group that is especially involved in workforce issues and models. They self-determine needs/projects.

The secretariat for this group is now supported by the Victorian Healthcare Association, which also provides funding for specific work. The team is passionate about clinician engagement and keen to have them 'drive' and control funds. Their successful clinical indicators program was picked up by the Australian government.

They work closely with the La Trobe centre for evidence-based aged care and funded a program that allowed 1500 nurses to train in comprehensive assessment of the older person (the program is still running on a fee-for-service basis). They fund a residential aged care communique, which has 35,000 subscribers. They currently have no direct engagement with the PHNs.

They funded a study involving 13 million bed days with the Monash Centre for Medicine use and Safety to understand the increasing number of the elderly taking nine or more medications (and to investigate the use of antipsychotics and proton pump inhibitors in this population). This group is keen to engage more with the rest of the Department of Health and Human Services and to be seen as a resource. They drew attention to the substantial gaps in health system readiness for dementia, their leadership role in death audit (with Joseph Ibrahim) and the hope for their approach to risk management of elderly to become a routine part of institutional risk management.

Mental Health Branch

The branch has multiple layers of involvement and engagement. Legislation gives the chief psychiatrist responsibility for clinical quality and safety and a leadership role. The chief psychiatrist has inspection powers to follow up on concerns, and may make formal enquiries and interrogate staff. The branch has no statutory jurisdiction for the private sector, although some are involved in branch activities (the branch also has no role in youth justice).

They would very much like to receive incidents and reporting from the private sector and conduct workforce development in this sector. The have an ECT review committee and a morbidity and mortality committee that includes consumers and carers and reviews all deaths. Cases are examined in depth.

The Mental Health Branch has lots of very direct involvement with clinicians. They work with clinicians on actual cases; for example, around access to care or facilitation of complex case conferences. Sometimes, if there are numbers of a certain kind of case, they develop a more thematic response. Many of their own staff are on time-limited secondments from the sector.

The branch runs forums that enable peers to connect, share concerns and discuss big issues and what is happening the department. These include monthly forums for the senior mental health nurses, and meetings for senior staff and NUMs working in adult acute, aged, community and child and adolescent mental health. They have developed a senior leadership program, which is undertaken by quartets of doctor, nurse, allied health professional and consumer/carer. By this method they have developed an inter-professional leadership network, which will form the bones of the statewide mental health network.

They work with a wide range of organisations; for example, Principals Australia and the police. They have been conducting work with emergency departments on restraint practices, and have piloted a program – Safe Wards – that is going to be rolled out across the state, including developing a CoP

who will lead the rollout. They have a significant involvement in workforce recruitment, retention and development, because there are major gaps and even more concerns with regard to future staffing.

Their work is characterised by working with patients and carers wherever possible – they consider this the best way to improve safety and quality. When they undertake co-production or co-design, and half the people involved are carers or clients. This work takes time.

Private hospital unit

In 2014–15 the private hospital sector accounted for approximately 38 per cent of patient separations, (62 per cent of patient separations occur in the public sector). There are 171 registered private health service establishments, comprising 81 private hospitals and 90 day procedure centres.

Six major hospital providers operate approximately 90 per cent of private hospital beds in Victoria. These include Epworth Foundation (with eight hospitals), Healthscope Limited (with 17 hospitals), Ramsay Health Care (with 16 hospitals), St John of God Health Care (seven hospitals), Cabrini Health (five hospitals) and Healthe Care (three hospitals). Five of the larger private hospitals in metropolitan Melbourne offer 24/7 emergency medicine. Sixteen provide intensive care services (ICUs) and of these, fourteen also provide coronary care services (CCUs).

The Department of Health and Human Services registers and regulates private hospitals under Part 4 of the Health Services Act 1988 (the Act) and the Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013 (the Regulations). The objectives of the Regulations are to provide for the safety and quality of care of patients receiving health services in private hospitals.

The branch has regulation-based engagement with these 171 organisations, whose registrations are renewed every two years. Staff did visit them all every year, but the branch now has a risk-based approach – some are only visited every four years, others more often. They examine the National Safety and Quality Health Service Standards Accreditation Report, and look at complaints, safety and quality reports and governance. They get VAED data, but are not yet routinely using it for benchmarking. They investigate complaints and are allowed to conduct onsite investigations if a matter presents a serious and immediate health risk to patients.

The private hospitals do not report sentinel events to the Department of Health and Human Services; there is only voluntary reporting. Some report infection data to VICNISS, but not all. Where issues of compliance are identified, the Department of Health and Human Services can provide recommendations and require an action plan, increase the frequency of inspections, place conditions on registration, revoke or refuse to renew a registration or prosecute for a breach of the Act or Regulations.

As the minister signs off on safety and quality in both the public and private sectors, in an ideal world there would be more management of emerging issues across the system as a whole, and all policies would be across the sector. The branch is responsible for engagement with the private sector in the development of departmental statewide policies and processes and identification of opportunities for statewide service design and system improvement, including linking public and private providers where appropriate. It was noted that the chief nurse is creating new opportunities for the directors of nursing in the public and private sectors to work together. These have been much appreciated, and the branch feels there is an appetite in the private sector for more shared work (this was confirmed by the interviews and surveys of this sector).

Department of Health and Human Services staff survey

Certain department staff were requested to participate in a survey, which was sent to a total of 530 people.[24] The focus was their views on advisory groups, but their connections to the health system and their other regular processes for engagement were also investigated. They identified the weakest and strongest areas of department engagement and made suggestions for improvement. The number of staff members who responded was 105.

As Figure 23 below shows, while many department staff are ex-health system employees, some had not worked in the health system for long before joining the department, and almost half of respondents had never worked in the health system at all. These proportions vary across departments. Nearly two-thirds of health service performance and programs respondents and over half of regulation, health protection and emergency management had worked in the health system, but only a quarter of portfolio strategy and reform respondents had had such experience. Of those who had worked in the health system, 26 per cent had been nurses, 19 per cent allied health, 11 per cent medical and 26 per cent chose manager or administrator (with 18per cent other).

Figure 23 Cumulative distribution of department respondents' prior work experience in the health system
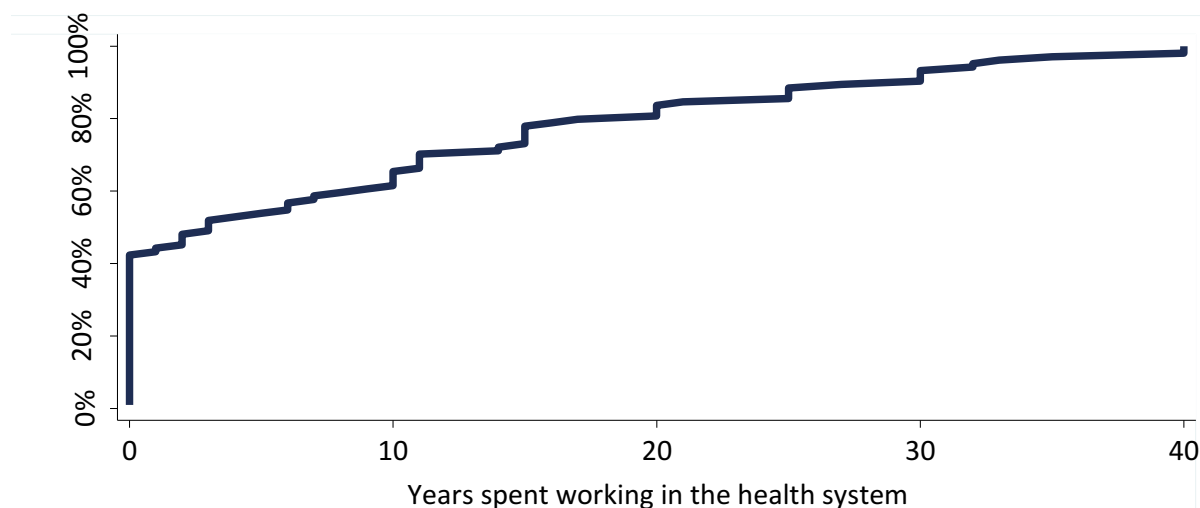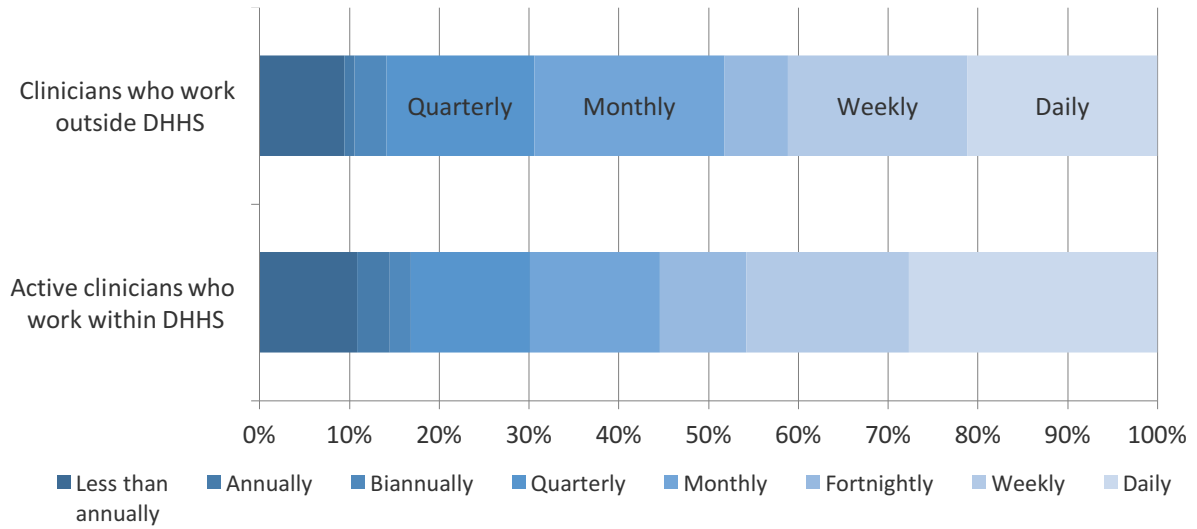

Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: total n = 102, encompassing staff in selected branches within Health Service Performance & Programs (n = 64), Regulation, Health Protection and Emergency Management (n = 23), Portfolio Strategy & Reform (n = 13) and Community Participation, Sport & Recreation, Health & Wellbeing (n = 1). Response rates varied and may not be representative.

As Figure 24 shows, in their work, staff collaborated both with clinicians working for the department and outside it, with over 20 per cent speaking to outside clinicians daily.

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[24] The following email groups were used: DHHS-M-CN&C&SP   DHHS-M-PSR-SIA   Health-M-RHPEM-CHOHP-AllStaff   DHHS-M-HSPP-Mental Health   Health-M-HSPP-Performance and System Design-AMB   Health-M-HSPP-Quality and Safety   Amit Dias/HeadOffice/DHS@DHS   Health-M-HSPP-HealthServicePrograms   DHHS-M-PSR-Better Care Victoria   DHHS-M-HSPP-HIR
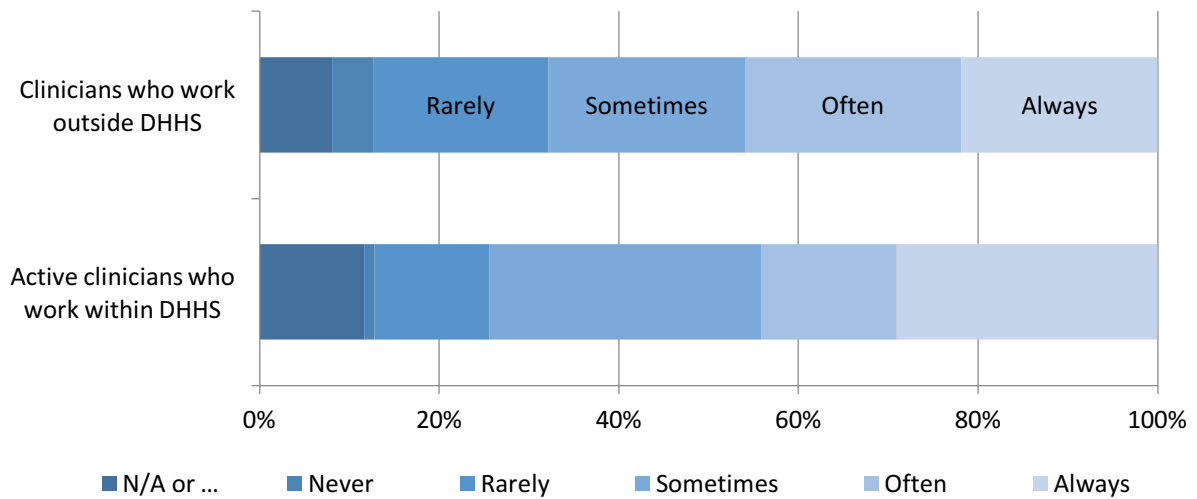
Figure 24 Frequency with which department survey respondents speak to or work with clinicians

Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 86. Response rates varied and may not be representative of all department staff or the branches surveyed.

As Figure 25 shows, many respondents felt they did not always have enough access to advice from active clinicians, either internally or externally.

Figure 25 Frequency with which department survey respondents feel they have sufficient access to advice from clinicians

Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 87. Response rates varied and may not be representative of all department staff or the branches surveyed.

As Figure 26 shows, while many respondents had been health service employees, once working in the Department, many reported they did not get back out often:

Figure 26 Frequency with which department survey respondents undertake substantive site visits to health services
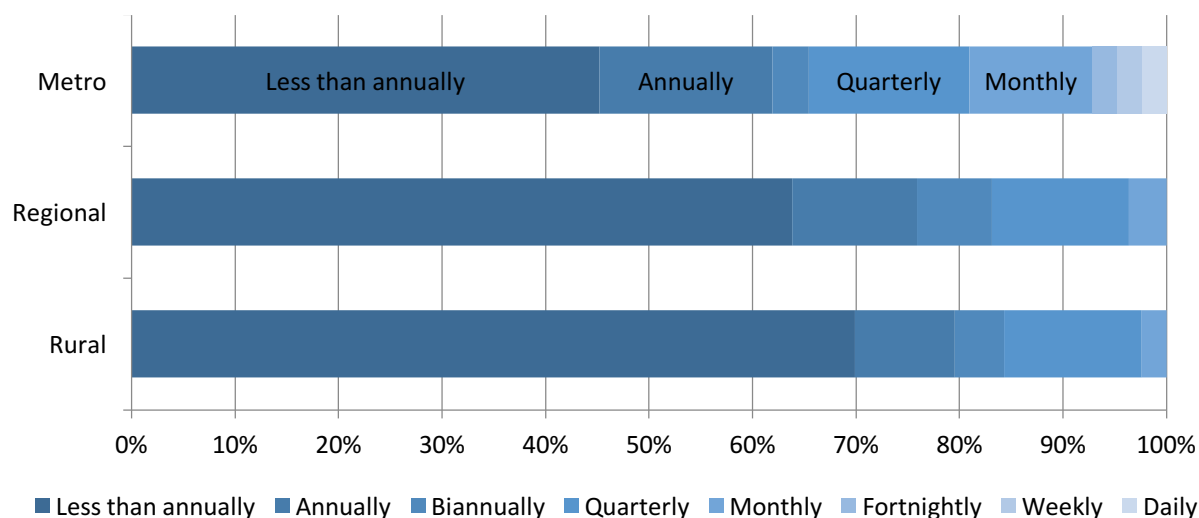
Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 84. Response rates varied and may not be representative of all department staff or the branches surveyed.

They were much less likely to visit regional areas, and unlikely to visit rural areas; however, the survey was not sent to the Rural Health Branch (this was an oversight).

Many respondents went to a great deal of trouble to answer this survey, and their lengthy answers reflected their concerns about the current state of Department of Health and Human Services clinician engagement. The strongest elements of clinician engagement by the department were considered to be involvement of clinicians in the department workforce, especially those employed part time who still continued with clinical work and access to experienced and committed clinicians in the system. The clinical networks were mentioned by many and the former Chief Cancer Advisor Professor Robert Thomas' work got special mention by one respondent. Main themes included staff frustration at the current limitations, the fact that the department is regarded by system stakeholders as a 'black box', including the fact that advisory processes lacked transparency for clinicians. Opportunities for improvement included provision of more clarity about processes, department staff visiting services and engaging more directly, improved department staff capability and discussion of new technology enhanced ways of engaging.

Frustrations about having to work with inadequate clinician engagement

Some respondents wanted more opportunity for breadth of views ('I am always left wondering if the information I receive is representative or comprehensive'). It was considered by some that clinical views were not balanced with service users' and consumers' views, that there was overreliance on medical advice, and that there was a relative exclusion of allied health advice.

> 'Membership invitations are often driven by academic qualification and departmental familiarity… results in association-bias-based decisions.'

There was a clear call from several respondents for less token engagement, but rather, for 'direct clinician engagement from the planning stages of projects'.

> 'In my experience there is either no clinician engagement or where clinicians are engaged, their involvement is tokenistic, often after the fact and with limited context or information.'

Some respondents chafed under Department of Health and Human Services organisational processes, wanting:

> 'To reduce the petty over-management… We can get very busy formatting briefs in department style, but this is not where real change, effective leadership and strong relationships will come from.'

Some respondents described formal restrictions being placed on their engagement activities:

> '…being directed to perform minimum standard core work only. Accessing experts for guidance and advice outside of an official committee meeting is considered wasteful, in conflict to core duties, and overstepping role.'

> 'It being undervalued by executive. It is dependent on the individual project officer. For me, developing strong, respectful, unbiased relationships with all levels of the health workforce is integral to my job, but it also involves a lot of time… At times we have been told to reduce our engagement with the sector and have needed to use 'under the radar' tactics to continue doing this, as without this relationship we are sitting in an uninformed position to make policy decisions and influence positive implementation.'

Weak elements identified by respondents included under-resourcing and undervaluing clinician engagement, and a lack of respect for health service providers in parts of the department, including:

> '…failure to link clinicians into areas of the department that don't, on the face of it, look like clinical issues, but in fact contribute to how clinical practice is undertaken and services run. For example, funding changes and approaches and data collection requirements.'

Poor processes for cross-department/division communication were mentioned by several together with tension in department between process-focused public servants and content-focused public servants (with clinical expertise). Staff wanted to:

> '…reduce the [internal] silos we work in, knowing about the great work of our colleagues, within and outside of the division and to be working more collaboratively.'

Poor provision of material to support advice was sometimes mentioned, including underutilisation of academic evidence.

> 'We sometimes provide clinician groups with data; we usually don't provide them with information that creates issues that they have to address. For example, information that can be used for variation reduction.'

Two very interesting themes are outlined below: the Department of Health and Human Services being viewed as a 'black box' and the lack of transparency of advisory process.

The former was also a strong message from health system informants and the latter from clinical network members.

The department is perceived as a black box by some

'We are a black box to many clinicians – they don't understand why we are doing what we do or what drives us to reach out to them; they often don't understand how that aligns with their own experience and clinical/research priorities. Although we talk about 'transparency', we rarely make the effort to make it easy for clinicians to understand our processes, responsibilities and culture. The focus on 'performance' in sector relationships may partly be responsible for this – we prioritise relationships with CEOs/boards/execs over communication with clinicians, and there are perverse incentives in the 'performance' process around openness and clinical engagement.'

'I've encountered plenty of anecdotal evidence that CEOs also like to give their senior clinicians the impression that the Department of Health and Human Services directly manages a lot of things it doesn't (most notably how funding is distributed between specialties within a health service) as that takes some of the pressure off the CEO/exec. For example, as a consumer at a hospital, I have often been told things like 'Oh, the department doesn't pay for that service on Wednesdays, we're hoping they'll give us more money next year' about services the department doesn't *directly* fund at all; senior clinicians in my personal acquaintance are likewise often unaware of where health service vs departmental roles sit, even when they are relevant to their work.'

Advisory processes are not transparent for clinicians

Some clinicians participating in departmental and ministerial advisory groups had expectations that they would be making decisions as well as providing advice and 'become frustrated and withdrawn when they realise that is not the case, that is, when decisions are made by the minister'. Interviews re-enforced the need to handle outcomes more sensitively and carefully, with the provision of clear explanations to advisory groups of who had considered advice and why it was not taken.

> 'Lack of transparency in function of advisory groups, lack of accountability for implementing the advice (or explaining why it was not), poor secretariat; the impression of many clinicians… is that there is a lot of talk and many meetings but what actually results bears little relation to their specific input, and there is little evidence of implementation of advice or recommendations… dealing with the department can be a 'talkfest' and a waste of precious time.'

Department of Health and Human Services staff were keen to get a greater mandate for clinician engagement, and looked for the engagement framework to help in 'determining in what circumstance consultation should occur, with whom' and to 'ensure it's timely, inclusive and effective'. Opportunities identified for improvement included: better understanding by clinicians of processes and decisions of government (this was probably the top priority); secondments (both ways); opportunities for clinicians working in the department to undertake clinical professional development and maintain their sector currency; and better access to and more meaningful reporting of data, which is crucial to understanding in conversations and sector visits.

Staff considered that:

> 'Being clear about our role and the factors that are relevant to a particular issue will support more appropriate advice and more effective engagement (and overall relationship development/management).'

In the box below, a policy maker thoughtfully describes the need to understand the clinician perspective; this is a big part of developing shared understandings and engagement that is satisfying to all parties.

Being clear about 'what's in it for clinicians'

'We also need to think more and be more explicit about 'what's in it for them' when we engage with clinicians, and make sure that the engagement can have positive potential for all parties, rather than being a burden on clinicians' time. Rather than assume that all good people will want what we want, we need to think about how clinical culture works, and what is meaningful to clinicians at different points in their careers. This can mean being clear about how we expect big policy initiatives to affect patient/clinician interactions, and clinician/clinician relationships rather than just throwing jargon about 'patient-centred care' and 'integration' around. It can also mean being aware of extrinsic motivations, like opportunities for research publications, career advancement, etc. and how working with us might impact that.'

However, some staff may struggle with considering the clinician perspective as an issue was raised about Department of Health and Human Services staff capability to work with clinicians:

> '…it strikes me that many managers are thrown in the deep end, being sent off to present something to a network or college or something with no training in how to approach these stakeholders or an understanding of their perspective.'

This is obviously stressful for the staff involved, but also limits their ability to find ways to get clinicians to willingly engage.

Staff need to be able to leave Lonsdale St

System informants were keen to meet with Department of Health and Human Services staff and discuss their concerns directly and department staff saw the value in this too, wanting a 'return to the 'good old days':

> '…when DHHS personnel (especially Health Dept. personnel) attended external meetings in person, rather than engaged only via email with, health services… there's nothing like putting a face to an email address to break down barriers to information flow, and to pick up information as an 'incidental' by-product of a meeting/gathering.'

It is of relevance here that both leading clinicians and CEOs were extremely positive about the relatively new department investment in 'chiefs': no questions were specifically asked about this role, but comments were volunteered. It was felt by doctors that having a CMO has made a big difference to engagement, because they ask clinicians what they want, rather than directing them, and importantly, communicate with doctors the way the like to be communicated with (which is verbal, via face-to-face meetings and phone calls – not via

email). Allied health respondents were also very enthusiastic about the Department of Health and Human Services workforce allied health advisor.

> '…we generally feel a bit neglected by the department but it was really good when Andrew Wilson bothered to come out.' (rural CEO)

Broaden the pool of clinicians who give advice

There was considered to be a need to include: more coalface clinicians (and fewer executives), more junior clinicians and more consumers. It was suggested that both consumers and clinicians should have a greater role in priority setting:

> '…engaging junior clinicians (for example, HMOs, junior allied health clinicians) early in their careers, because their training is current and are often able to identify the gaps and inefficiencies in the system, before they become indoctrinated as part of the system.'

> '…greater consumer/carer engagement to lead policy making – this is completely consistent with the department's strategic plan focus on person-centred services and care, and local solutions.'

New ways of engaging are possible

These include improved department connections between strategy and delivery arms, shorter engagements, 'We don't always need a committee', technology mediated ('Create virtual groups rather than making people travel to the department') and consumer led approaches:

> 'Collect patient outcomes (combination with experience) directly from patients. Articulate this with the care they received and use this as the starting point for clinician engagement.'

Some staff had creative and very future-focused ideas:

> 'Using technology to our advantage… to create new areas of improved policy making through engagement (for example, crowd-sourcing policy development, having greater access to regional/rural/remote viewpoints, making translated material available to CALD professionals and communities, accessing greater data about service delivery and experience).'

> '…consider moving to a 'crowd-sourcing' model of policy development – for example, as being developed by mindhive.com.au – enable other forms of online consultation and involvement by advisory groups – currently the department does not have a standard online platform to support advisory groups… this could potentially greatly increase the efficiency of operations and increase opportunities for out-of-session contact with advisory group members.'

There are commercial digital 'engagement' services, such as Bang the Table,[159] which are not irrelevant when considering the possible mechanisms that a contemporary Department of Health and Human Services could employ.

Working with advisory groups

As Figure 27 shows, some staff had frequent dealings with advisory groups with clinician members.

Figure 27 Frequency with which department survey respondents speak to or work with advisory groups with clinician members
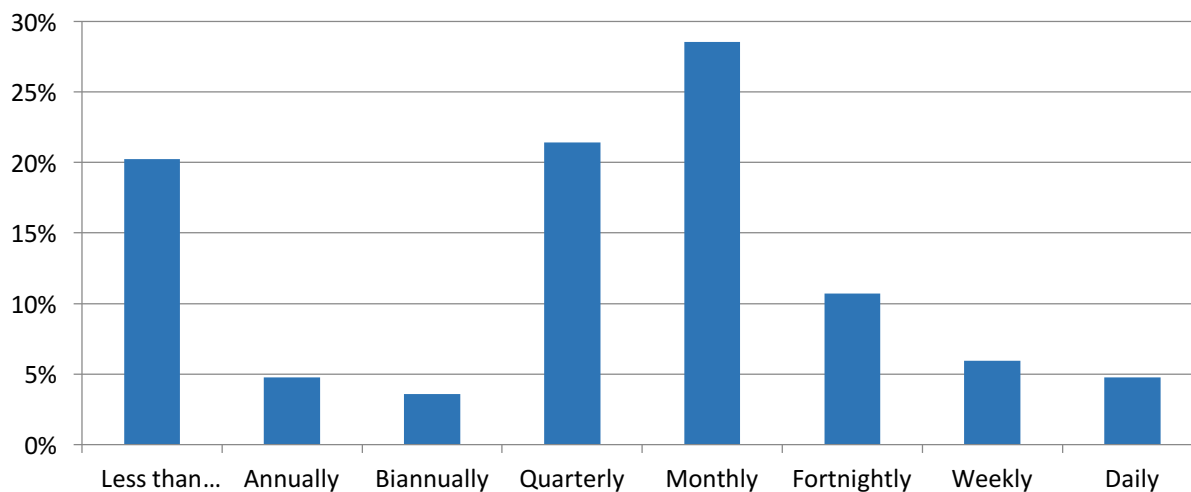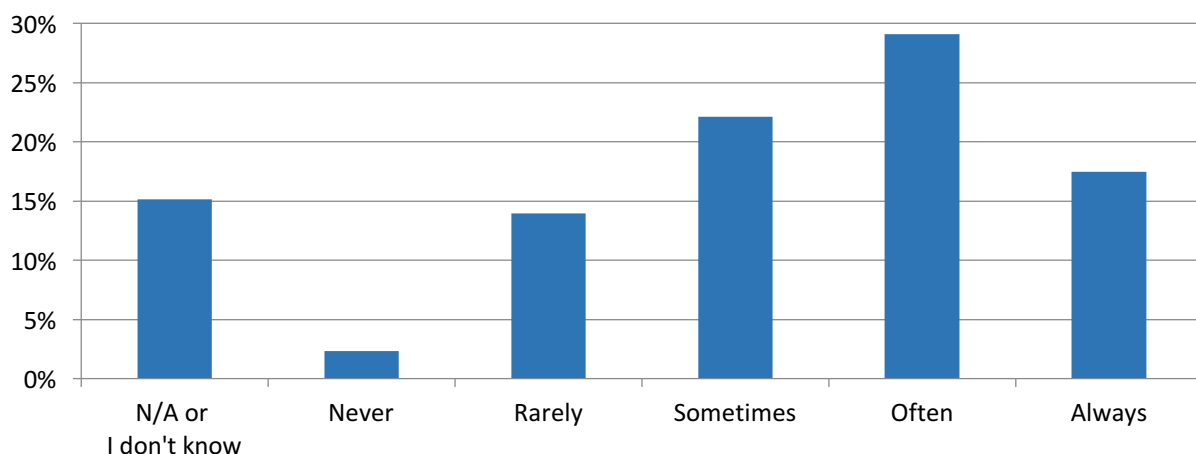

Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 84. Response rates varied and may not be representative of all department staff or the branches surveyed.

However, as Figure 28 shows, many respondents consider they have inadequate access to advice from clinician advisory groups. Only 17 per cent of respondents stated they 'always' have enough access; 16 per cent said they 'never' or 'rarely' have enough access.

Figure 28 Frequency with which department respondents considered they had enough access to advice from advisory groups with clinician members
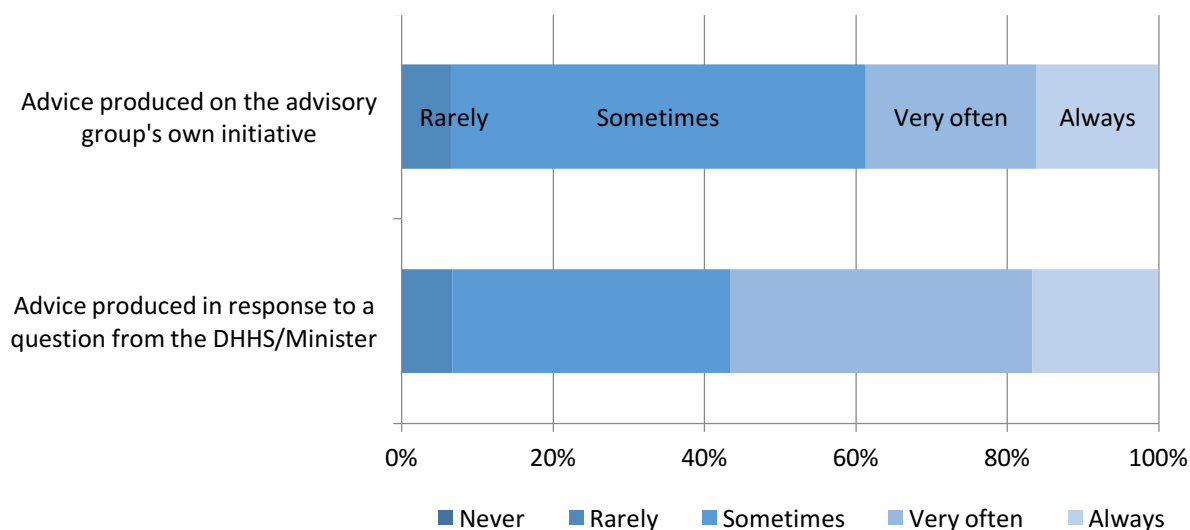

Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 86. Response rates varied and may not be representative of all department staff or the branches surveyed.

As Figure 29 shows, many respondents were also disappointed by the department's advisory groups. Almost half were 'rarely' or only 'sometimes' satisfied with their advice, and fewer were satisfied when the advice was produced on the advisory groups' own initiative.

Figure 29 Department survey respondents' satisfaction with the advice produced by the clinician advisory groups they work with
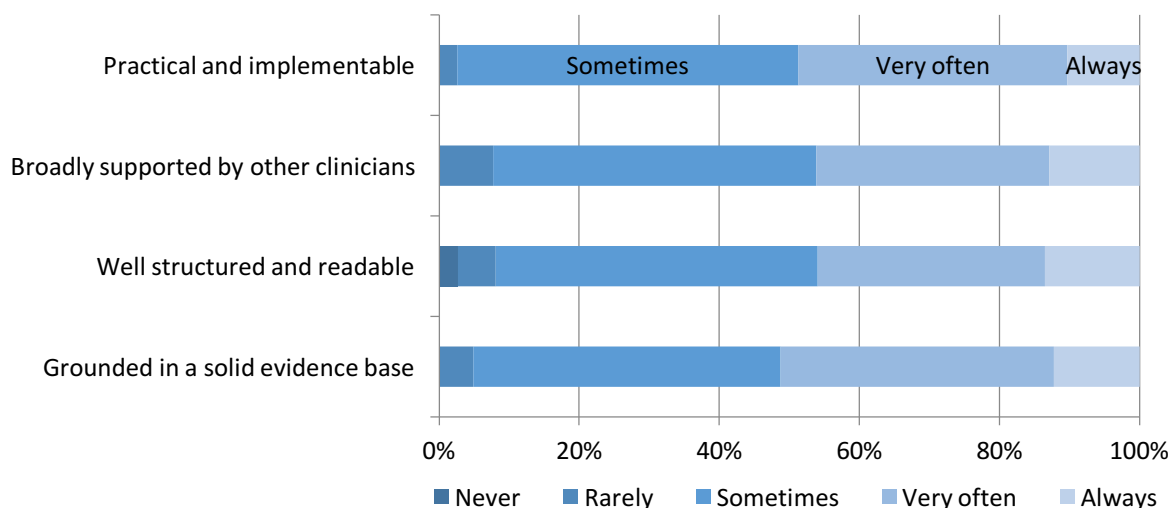

Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 40, of which 8 and 10 (respondents who answered 'N/A' to either question) were excluded from the responses reported. Survey respondents automatically skipped this question (and all subsequent questions on advisory groups) if they answered 'no' to the filter question 'Has your role involved consulting with or reviewing the advice of any of the department's clinical advisory groups*? *Including ministerial advisory committees, consultative councils, reference groups, clinical networks, or other groups providing clinical advice to the department on strategic issues.' No respondents answered 'never'. Responses may not be representative.

Survey respondents were not generally confident about the quality of advice provided by the advisory groups with clinician members. As Figure 30 shows, about half of respondents were 'never', 'rarely' or only 'sometimes' confident that the groups they worked with were provided advice that was practical and implementable, broadly supported by other clinicians, well-structured and readable, and grounded in a solid evidence base. The latter issue is possibly the most alarming.

Figure 30 Frequency with which department respondents are confident about the quality of advisory groups' advice
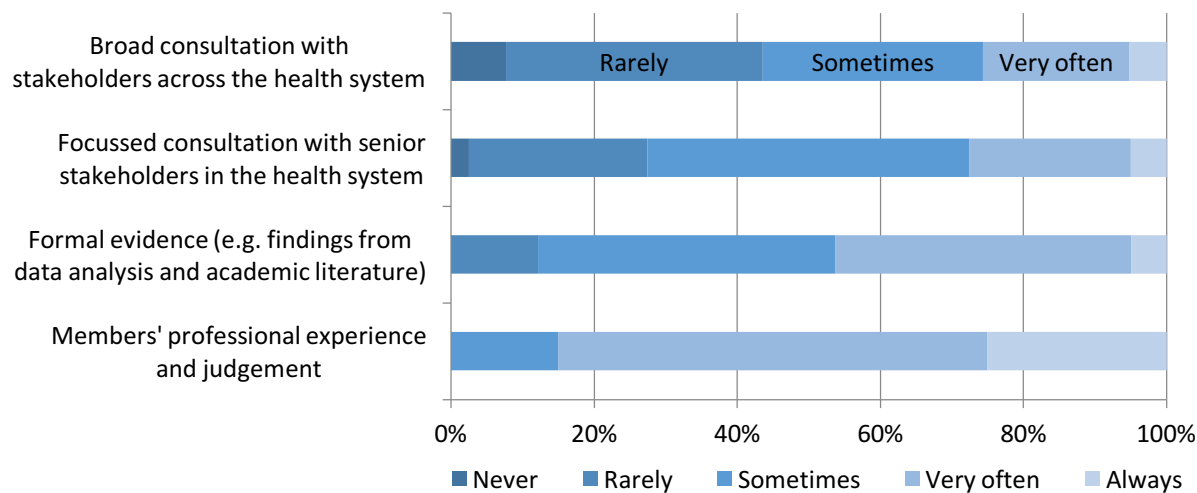

Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 42, of which up to four (respondents who answered 'N/A' to questions) were excluded. Survey respondents automatically skipped question on advisory groups if they answered 'no' to the filter question 'Has your role involved consulting with or reviewing the advice of any of the department's clinical advisory groups?'. Responses may not be representative.

As Figure 31 shows, about three-quarters of respondents believed that the advisory groups 'very often' or 'always' formulated their advice on the basis of their members' professional experience and judgment, and drew on formal evidence or consultation less frequently.

Figure 31 Frequency with which department respondents see advisory groups formulate advice on various bases
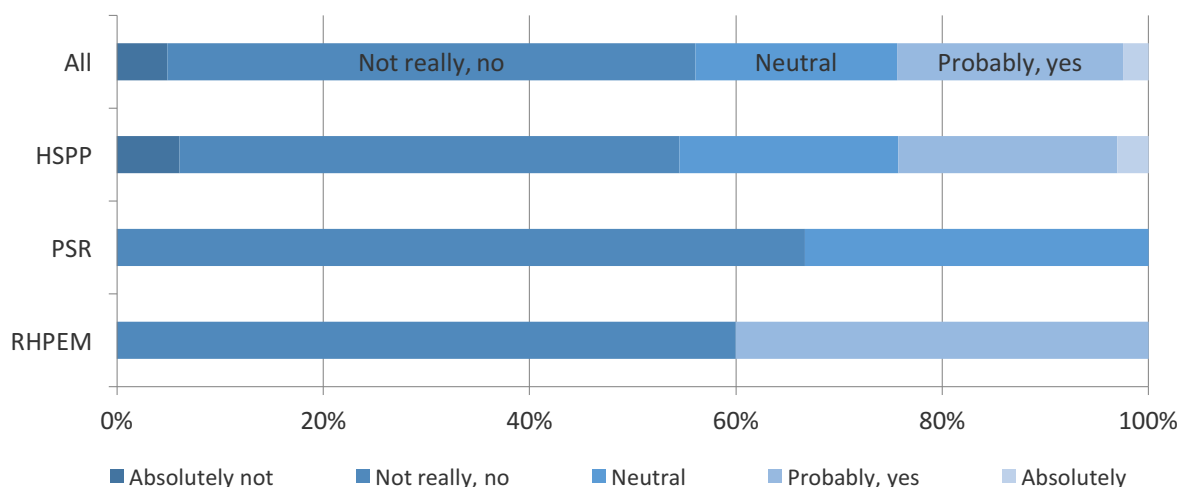

Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 41, of which 1 respondent (who answered 'N/A' to a given question) was excluded from the survey responses reported here. See full notes on Figure 29.

The majority of department respondents were 'never', 'rarely' or only 'sometimes' confident that the groups were providing advice formulated on the basis of consultation with stakeholders, or from formal evidence. As Figure 32 shows, only a minority of department respondents thought the advisory groups they worked with were 'probably' or 'absolutely' achieving their potential.

Figure 32 Department respondents' agreement with the question 'Are the advisory groups you work with achieving their potential?'
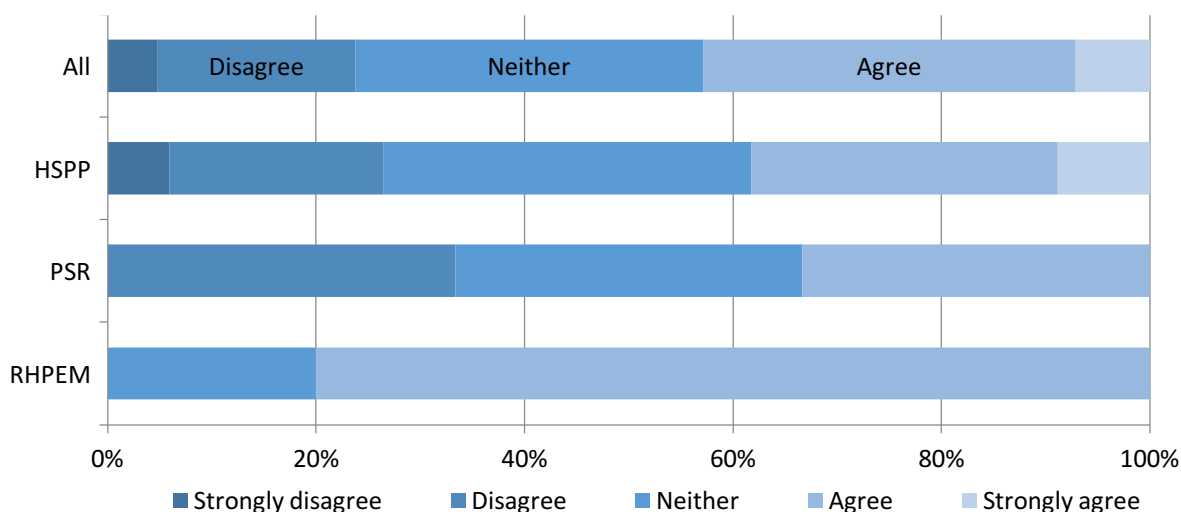

Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 40. HSPP = Health Service Performance and Programs (n = 33), PSR = portfolio strategy and reform (n = 3), and RHPEM = Regulation, Health Protection and Emergency Management (n = 5). Survey respondents automatically skipped questions on advisory groups if they answered 'no' to the filter question 'Has your role involved consulting with or reviewing the advice of any of the department's clinical advisory groups?'. Responses may not be representative.

The survey canvassed a number of possible reasons for this result. One issue was a lack of diversity of experience and opinion on the advisory groups, as Figure 33 shows.

Figure 33 Department respondents responses to the question 'Do you agree that the diversity of experience and opinion on advisory groups is sufficient to generate robust debate and advice?'

Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 41. HSPP = Health Service Performance and Programs (n = 34), PSR = portfolio strategy and reform (n = 3), and RHPEM = Regulation, Health Protection and Emergency Management (n = 5). Responses may not be representative.

Another issue was the 'busy-ness' of advisory group members. As Figure 34 shows, when asked 'In your view, how many of the people selected to be on advisory groups are able to spend enough time preparing for meetings?', 20 per cent said most, 22 per cent 'about half', 43 per cent 'some' and five per cent 'none'.

Figure 34 Department respondents' views on the question 'How many of the people selected to be on advisory groups are able to spend enough time preparing for meetings?'
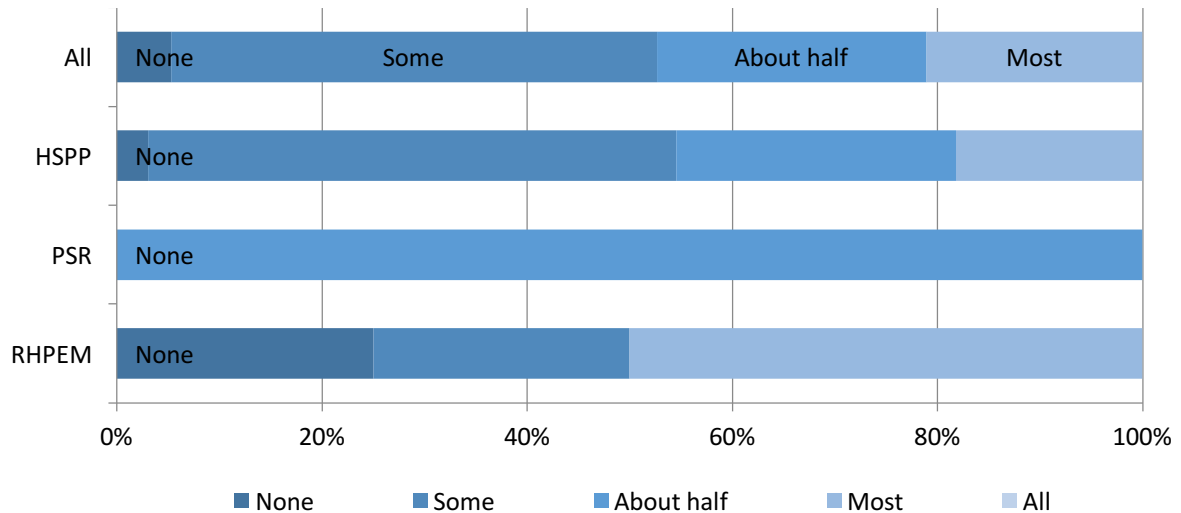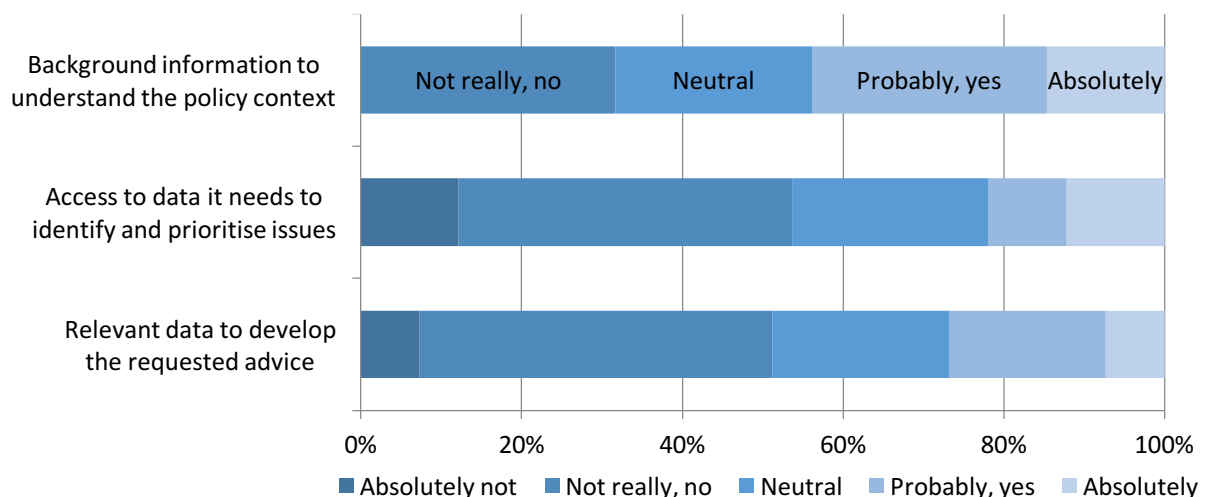

Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 41. HSPP = Health Service Performance and Programs (n = 34), PSR = portfolio strategy and reform (n = 3), and RHPEM = Regulation, Health Protection and Emergency Management (n = 5). Responses may not be representative.

However, Department of Health and Human Services respondents also felt that advisory groups were undersupplied with relevant data and background information (see Figure 35).

Figure 35 Department respondents' views on the question: 'Does the department provide advisory groups with sufficient background information and data?'

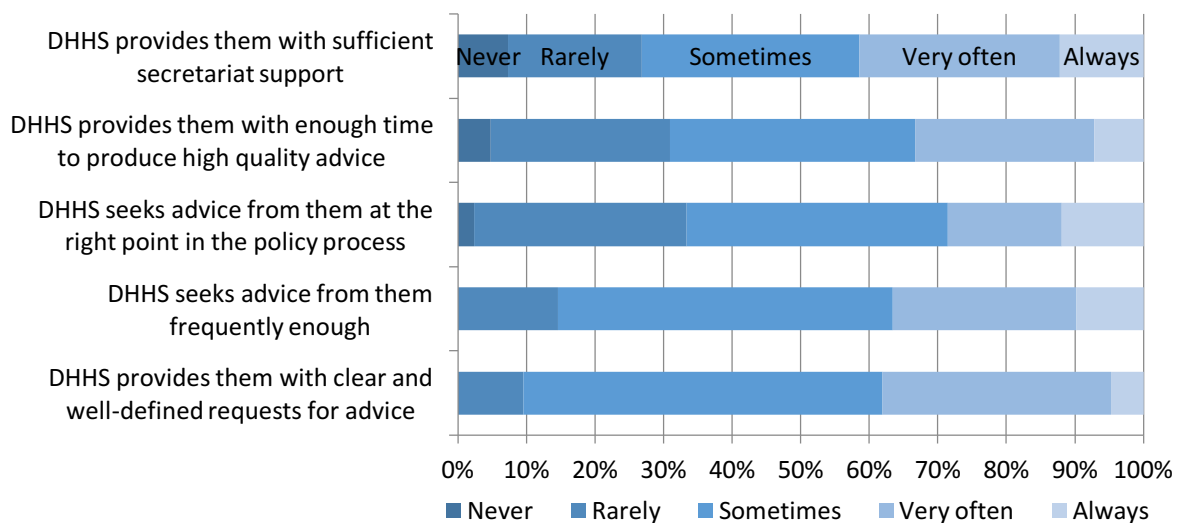Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 41. Survey respondents automatically skipped this question (and all subsequent questions on advisory groups) if they answered 'no' to the filter question 'Has your role involved consulting with or reviewing the advice of any of the department's clinical advisory groups?'. Responses may not be representative.

In answer to the question of how well the Department of Health and Human Services enables advisory groups to do good work, significant deficiencies were identified. As Figure 36 shows, over half of respondents believed that the department 'never', 'rarely' or only 'sometimes' provided the advisory groups with sufficient secretariat support, provided them with clear and well-defined requests for advice, and sought advice from them frequently enough (59per cent, 62per cent and 63per cent, respectively). Over two-thirds of respondents believed that the department 'never', 'rarely' or only 'sometimes' provided the groups with enough time to produce high quality advice or sought advice from them at the right point in the policy-making process (67per cent and 71per cent, respectively).

Figure 36 Department respondents' views on the extent to which the department enables advisory groups to do good work

Source: survey of selected department staff in relevant health policy and regulation roles.

Notes: n = 43. Respondents who selected 'N/A' as their response to a question were excluded from the final result (n = 2). Survey respondents automatically skipped this question (and all subsequent questions on advisory groups) if they answered 'no' to the filter question 'Has your role involved consulting with or reviewing the advice of any of the department's clinical advisory groups?'. Response rates varied and may not be representative of all department staff or the branches surveyed.

What changes could improve the use of advisory groups to inform health policy making?

The main changes suggested were improved clarity of function, correct selection of members and better preparation and the provision of data. One potential cause of the limited effectiveness of these groups was the 'busy-ness' of advisory group members. When asked 'In your view, how many of the people selected to be on advisory groups are able to spend enough time preparing for meetings?', 20 per cent said most, 22 per cent 'about half', 43 per cent 'some' and five per cent 'none'. This is severely suboptimal, and organising and supporting advisory groups is expensive work. This suggests that clinicians with more capacity to contribute professionally to the work of advisory groups needs to be sought (rather than 'the usual suspects'). Provision of better data, together with better data analytic capacity to allow a focus on variation was a major theme. It was noted that there may need to be upskilling of clinicians so that they can use it effectively. Other themes were the need

for clarity of advisory group function and process and correct selection and better preparation of members.

Clarity of advisory group function and process

It was felt that groups should be time limited and given clear objectives and dates for outputs, with members then clearly informed of the impact of their advice on policy decisions, that clear management of conflicts of interest/self-interest occur. Earlier engagement was desired, and it was not considered reasonable to use groups as a rubber stamp when things are non-negotiable. More time and less ministerial advisor pressure were also requested.

> **'More clarity and regulation around the function of an advisory group, the function of a taskforce, the function of a council.** The terms are used interchangeably and labels/titles are created that are inconsistent with what government and/or the department wants that forum to do/produce. One taskforce in particular has been created and it is not a taskforce at all – it is, at most, an advisory group or an advisory council in practice.'

> **'Functional secretariat** – Adequacy and impartiality of chairing. Ensuring all opinions are recorded and reflected in minutes and advice, whether implemented in policy or not, is recorded. Give reasons why some actions are taken and others are not. Ensure a formal conflict of interest process is tabled at each meeting and followed. Ensure the terms of reference are continually reviewed to guide discussions. Not to hold another meeting until all actions from previous meeting are taken or reasons why not are provided. If advisory groups are gathered without actually being used, probably this will lead to more clinician disengagement.'

Correct selection

This included more clinicians who can give fresh and relevant advice, avoiding those with the 'loudest voice or the longest serving'. Improved support of consumers and 'significant representation of consumers/people with lived experience related to the policy question' were suggested.

> 'Get the right people on the advisory group in the first place. One thing the department doesn't often appreciate is the variability in the skills, bias and experiences of clinicians. If clinician members were better targeted relative to the groups' purpose, then there is an increased likelihood of better advice. Inclusion of service users as well as clinicians is an imperative and is underutilised.'

Better preparation

It was felt that often clinicians were not well prepared on how to work with the department and that department staff needed training in conducting work with advisory groups, including for secretariat staff.

> 'In my experience… interaction with the advisory group was quite heavily led by the department; that is, this is the problem (as we see it), these are our proposed solutions, what do you think? With little/no information previously provided, group members walked into the meeting blind and without time to think about the issues more broadly. The result is a group that adds good value where it can but is doing this from a point of disadvantage in terms of knowledge and preparation. This is particularly so for community/patient representatives who… are on the back foot already in terms of familiarity of the terms / health vocabulary often used. These flaws weaken the quality of our policy making processes.'

The advisory group perspective

Members of a range of advisory groups were invited to participate in a survey that contained many of the same questions as the Department of Health and Human Services staff one. The groups were:

- Musculoskeletal clinical leadership group
- Victorian Consultative Council for Anaesthetic Morbidity and Mortality
- Victorian Surgical Consultative Council
- Consultative Council for Obstetric and Perinatal Morbidity and Mortality
- Board of Better Care Victoria
- Emergency Access Reference Committee
- Ministerial Advisory Council for Surgical Services
- Perinatal Services Advisory Committee
- Statutory and Forensic Services Design and Secure Services Governance Group

- Ministerial Advisory Council on Nursing and Midwifery
- Chief Psychiatrist Morbidity and Mortality Committee
- Chief Psychiatrist Electroconvulsive Treatment Committee
- Chief Psychiatrist Reducing Restrictive Interventions Committee
- Public Sector Aged Care Residential Leadership Group
- Patient Safety Advisory Committee
- Clinical Governance Expert Sub-Committee
- Participation Advisory Committee
- Clinical Incident Review Panel
- Mortality Expert Review Panel
- Healthcare Associated Infection Advisory Committee.

Because the questions were quite sensitive and these advisory groups are small, respondents were not asked which advisory group they belonged to. However, only 66 responses were received. This may reflect the fact that intermediaries (such as advisory group chairs) did not send the survey on. The pace of this research did not allow for follow-up. The response rate may also suggest that committee members are relatively disengaged or too busy to answer a survey. With only 66 responses the following graphs need to be interpreted cautiously.

As Figure 37 shows, there was a low representation of allied health practitioners and nurses among respondents, who made up nine and six per cent of respondents, respectively. Representation was particularly low compared to doctors (who made up 31 per cent of respondents). Many of the managers may have had a nursing background.

Figure 37 Advisory group respondents' backgrounds in the health system
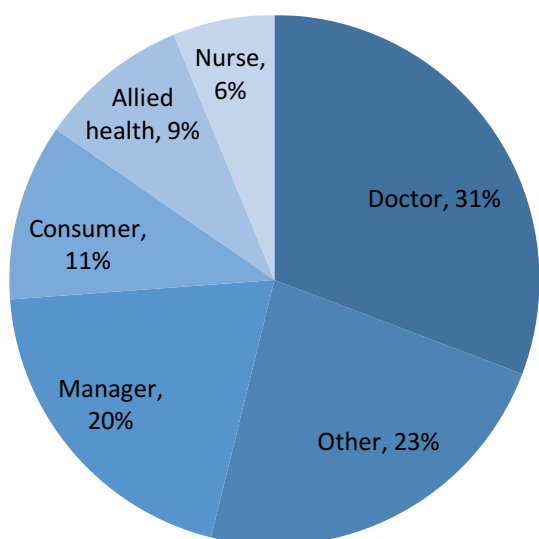
Advisory group respondents were quite senior, as Figure 38 shows, with no respondents aged under 30 years. The majority (70per cent) was aged over 50 years.

Figure 38 Age distribution of advisory group respondents
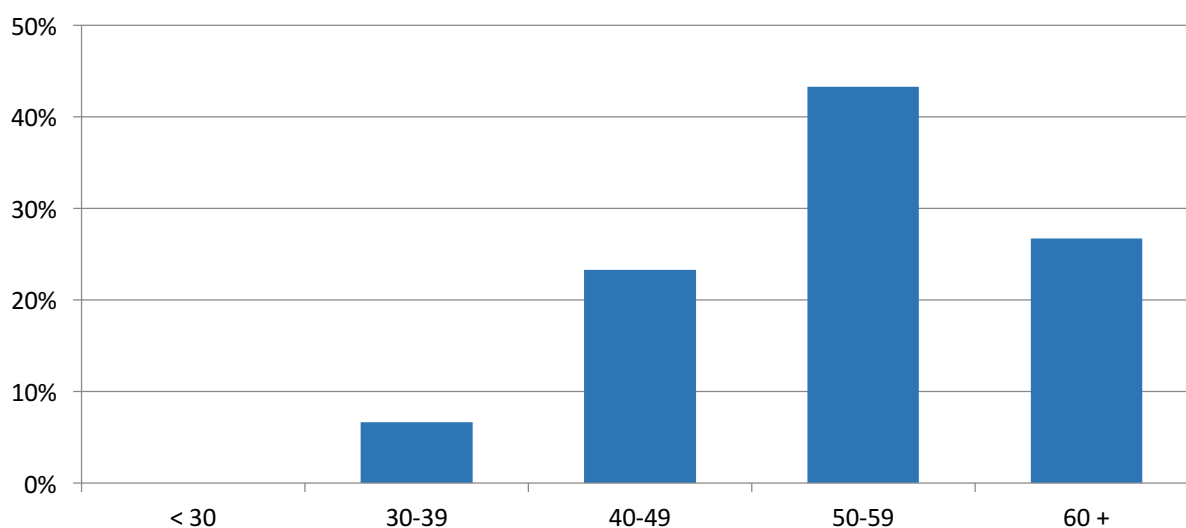
Notes: n = 60. Response rates varied and may not be representative of all advisory groups and their members.

As Figure 39 shows, half of the advisory group respondents are currently serving on more than one advisory group. Almost a third (28per cent) of them serve on two groups, with 13 per cent serving on three and a further nine per cent are serving on 4–12 groups.

Figure 39 Number of different advisory groups that respondent members are currently serving on

Number of advisory groups respondents currently serve on

As Figure 40 shows, the majority of respondents (80per cent) had been serving on advisory groups for one term (three years) or less, with almost half (43per cent) having been on their group for less than a year. Some had been on advisory groups for a very long period of time, with eight per cent (n = 5) reporting they had been on their group for a decade or longer.

Figure 40 Number of years that respondents have been serving on advisory groups

As Figure 41 shows, in general, advisory group respondents tended to be slightly more confident than department respondents about the quality of advice that the groups provided (and the readability of advice in particular).

Figure 41 Survey respondents' views on the quality of advisory groups' advice
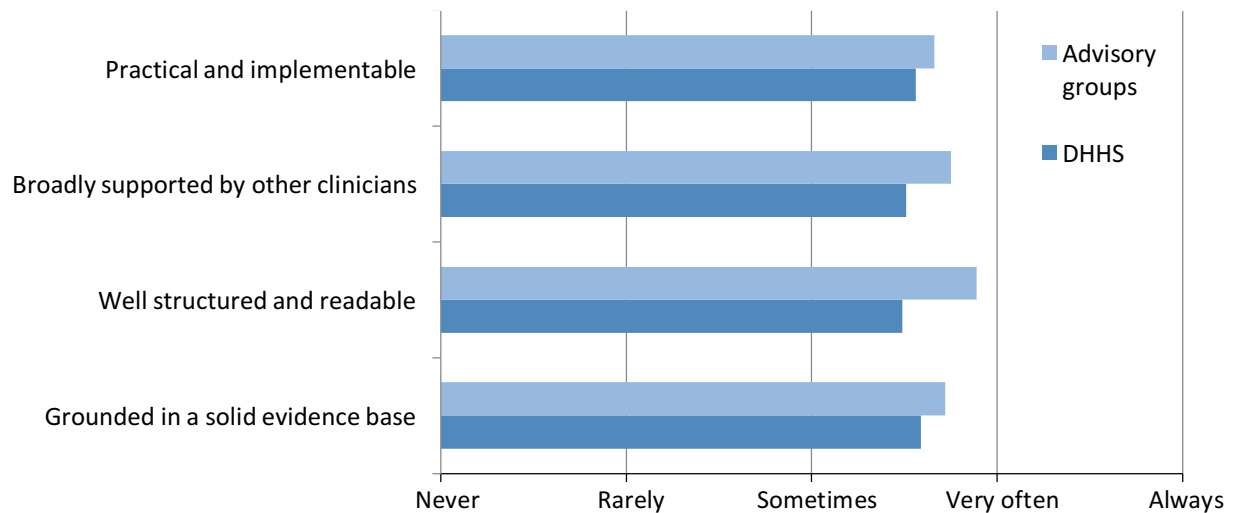
As Figure 42 shows, respondents had moderate confidence that they knew the role/purpose of their group, and were least sure that this was clear to the department.

Figure 42 Advisory group respondents' views on the degree to which the group's role is clear to various parties

However, Figure 43 shows that members were not so sure that their advisory group advice was reflected in departmental decision making. Such a finding leads to questions of the purpose of the group (and the members' understanding of this purpose) or about the quality of advice they provide. There may also be failure to communicate outcomes back to the group by the Department of Health and Human Services.

Figure 43 Advisory group respondents' views on the frequency with which they see their advice considered or implemented by the department

Source: survey of department and ministerial clinical advisory councils and committees, leadership groups, consultative councils and reference groups.

Notes: Advisory group n = 61. Respondents who answered 'don't know' to a question (n = 2–6) were excluded from the results presented here. Group responses are produced through a weighted average of all individual responses.

As Figure 44 shows, limitations on the value of the advice might be due to suboptimal process, which was recognised by members (as well as by the department staff).

Figure 44 Advisory group and department views on the process by which the department seeks advice from the groups

Source: survey of department and ministerial clinical advisory councils and committees, leadership councils, and reference groups.

Notes: Advisory group n = 61, DHHS n = 43. Respondents who answered 'I don't know' . (Advisory group n = 2–7 people per question, DHHS n = 1–2) were excluded. Group responses are produced through a weighted average of individual responses.

Neither the members (nor the department) thought advisory groups were achieving their potential, although the members were not quite as negative as the department (Figure 45 compares these views).

Figure 45 Department and advisory group views on whether the groups are achieving their potential
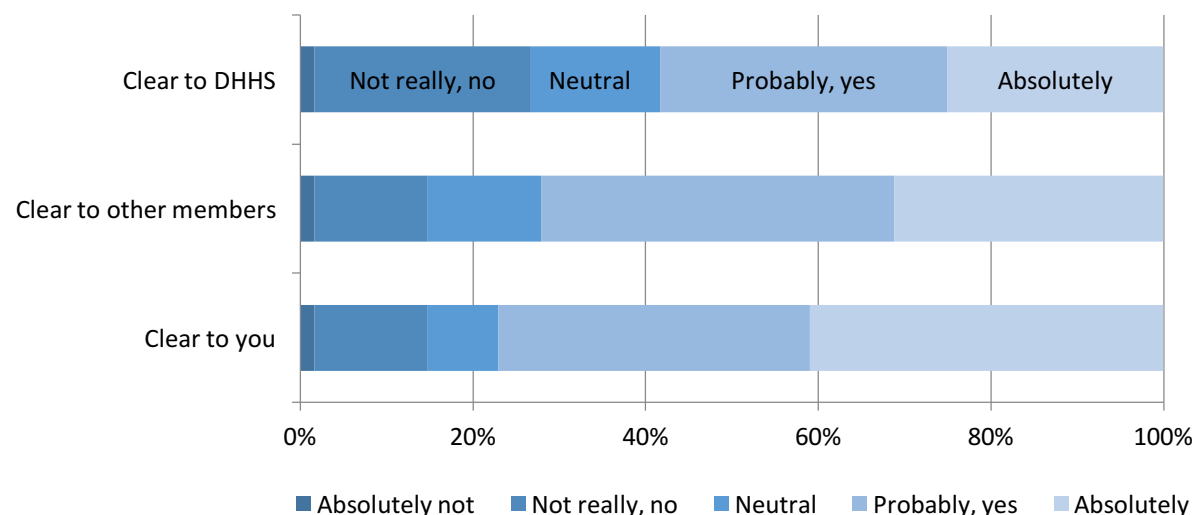

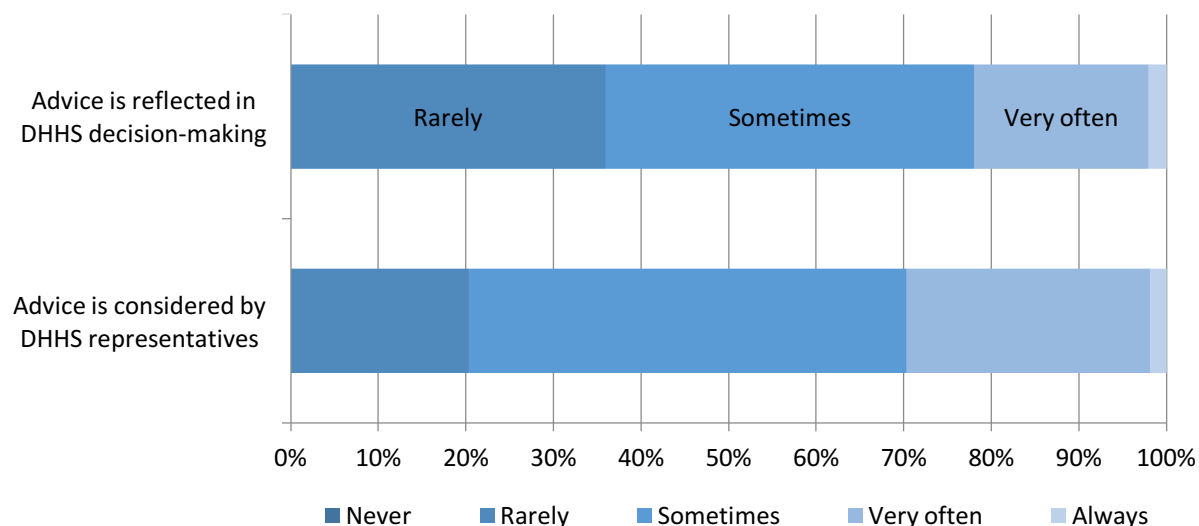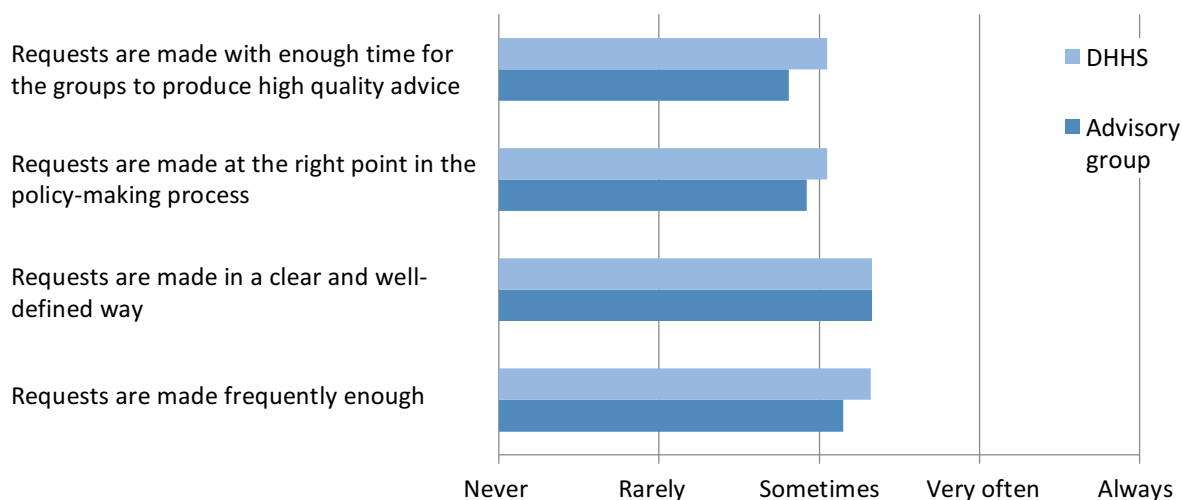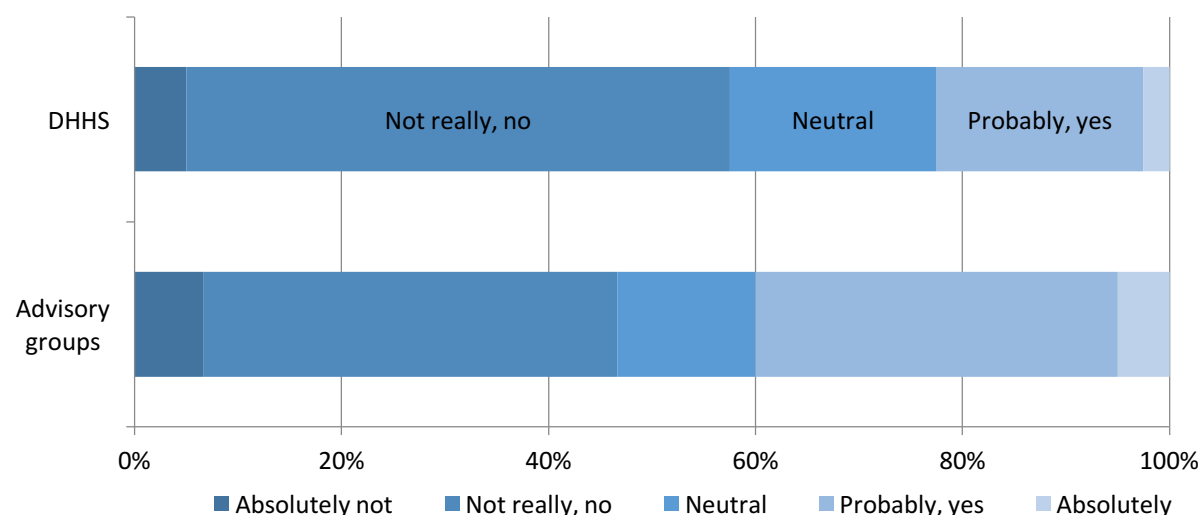Source: survey of select department staff and department and ministerial clinical advisory councils and committees, leadership groups, consultative councils and reference groups.

Notes: Advisory group n = 61, DHHS n = 40. Respondents who answered 'don't know' to a question (advisory group n = 1) were excluded from the results presented here.

Comments from advisory group members

In general, these echoed the quantitative results and the comments from Department of Health and Human Services staff. It was felt that the department needed more clinical advice:

> 'The Duckett Review has only been about safety and quality, but a broader review is required to determine how departments communicate. Advisory groups are vital, but only if they can represent the clinical community from which they are drawn, and if DHHS actually listens (and can understand) to the advice it receives. The few people within DHHS with any technical expertise are spread so thinly that they do not have any capacity to achieve much except to respond to disasters.'

Some members were angry at how they felt treated, including being involved in 'artificial' consultations with apparently predetermined outcomes:

> 'The group has enormous potential and goodwill; however, these are not respected by DHHS staff. The coordination, communication and general management of the group by DHHS is woeful and disrespectful and in fact fuels clinician disengagement.'

There were requests from respondents for more diverse group members, including a greater representation from rural and regional areas, the private sector and younger members ('Right now, all have been practising for 15+ years'). They also wanted more consistent DHHS liaison and more meetings with senior Department of Health and Human Services staff (for example, the secretary once a year). An interviewee who had been on the Ministerial Advisory Committee on Surgical Services commented that because of the lack of 'department heavyweights' the group felt 'they were in a vacuum'.

> 'More time together as a group and more engagement with policy makers to set the right strategic context. Greater (experiential and expertise) diversity. Less of 'usual suspects' on the group, who are variously jaded, cynical and self-serving… We need to expand the advisory group "gene pool".'

There was a strong request for clarity in regard to advisory group processes and a desire to see their work have influence including the desire for specific tasks rather than 'only reporting of papers'.

Clearer advisory group processes and more influence were requested

Some respondents were almost defeated:

> 'It is all too complicated and the chain of communication is really not clear… often the many different layers of the DHS make it almost impossible to achieve good outcomes.'

Others were extremely clear about the processes they would like to see:

> 'A timeframe for action; a methodology for action; feedback to the advisory group on where advice goes and what impact it has; clarity about the department's thinking about the future of the sector in relation to funding, service model, interface with consumer-directed care, move to greater package-based services, etc. – and engaging the advisory group on real co-design of the future structure.'

'For the advice of advisory groups to be actually made into policy. For ministers to actually sign off on the advice and for policy to be actually formulated and ultimately implemented, monitored and measured. For departmental employees to be given the opportunity to develop policy in accordance with their role and expectations of the public of Victoria and consumers of the Victorian public health system.'

A few were keen for their work to be clearly constituted as advisory to the health system, not just to the Department of Health and Human Services, asking for:

'Greater independence from the department… Greater transparency; for example, publish the minutes of meetings, consider holding public meetings once or twice a year.'

Possible new ways of working for a consultative council

'If we asked clinical staff from each major hospital/health care service to attend a meeting with us at least once/twice a year so that they understand what we do. We should use social media more effectively to communicate with health care services and ask all of them to contribute material/cases for us to review. We should take the initiative and speak, face to face, with staff (clinical) at each health care service/hospital, to show that we are not merely pseudo-bureaucrats, meeting in Melbourne in the CBD, divorced from the practicalities of working as a clinician… We should liaise with patient advocate groups/organisations… to help us to deliver our message to the health care community. We should be fearless in asking for information and help, and suggesting improvements to how things might be done more effectively and efficiently. For instance, writing good reports, writing good clinical observations, inclusive, gender-neutral language, giving clinicians tablets so that trying to read another s handwriting isn t a barrier to understanding a colleague's notes… listening to, and giving a louder voice to people from country Victoria… Asking consumer advisory committees for their thoughts and suggestions and reimbursing them… Help the government to improve the health literacy of ALL Australians so that we may make informed decisions about our medical care.'

Conclusion

Some senior Department of Health and Human Services staff interviewed seemed unable to conceive of change or improvement to the limited processes currently in place. Others, especially those who responded to the survey, were frustrated and able to contribute detailed solutions. Communication energies overall in the department seem internally focused, and as internal stakeholders become the main target for work, limitations on its relevance to the broader sector almost guaranteed. Currently, the department website is user unfriendly and dull. Most of the good work the Department of Health and Human Services does is not publicly available or is extremely hard to find – and if you cannot find a carefully developed guideline or framework it is not doing its job. Accessibility is the first step in any implementation process. Much excellent work is simply invisible. There are some stronger areas on the department website; for example, public health – for instance, the immunisation page, which is easily found using Google. It clearly serves to connect with the community to achieve an important informational objective.

The health services have some excellent communication on their work (for example, as part of their annual reports). Multiple internal interviewees complained about this state of affairs and that working with the relevant department branch was exhausting and slow.

If a co-production approach to policy development is commenced, as was suggested as being the future intent, this will require changes to style, language and quantity of department communications (alternately, inefficient parallel practices will be necessary). This is also a process of power sharing which may sit awkwardly at times with the regulatory and oversight function of the Department of Health and Human Services.

In addition to the fragmented department organisational structure, fussing over quite artificial distinctions between operations, program, policy, performance and strategy seemed to at times distract from the improvement work the health system needs the Department of Health and Human Services to support and drive.

Only in Mental Health, which has embraced its responsibility for sector quality and safety, was there a considered and appropriately multilayered approach to engagement. While MH has special legislation, there is no legislation preventing other areas from taking greater ownership and accountability for communicating for engagement. Fear of offending the CEOs was given as a reason, and internal informants described past events where offended CEOs complained to the department and staff who had attempted to engage directly with clinicians were censured. The concept of all communications with a sector as large and complex as health occurring through the CEOs is unrealistic, anachronistic and cannot satisfactorily accelerate improvement in a complex system.

Comment was made by several senior internal interviewees about the performance branch being 'secret business' and restricting the oversight of others on operations and clinical care.

The support given by the department for the process of examination by survey was impressive and reflected a real desire to engage more effectively. However, that such a simple process of enquiry was novel was sobering. There needs to be a more whole of department view on engagement. Some senior staff members were surprised and irritated when a list of advisory bodies was requested for this investigation. In some organisations, overall engagement would be supported and monitored by a specialist group. Engagement practices undertaken in every area create and affect the overall perception of the department.

Currently, advisory structures and processes blend an instrumental purpose with an attempt to also build legitimacy and support. This may sometimes be effective, but separating those activities and involving different groups would strengthen the engagement. Ideal practice might involve department pre-preparation of evidence synthesis and problem scoping and definition. Then, a diverse group, including younger clinicians and academics, could be facilitated to come up with a range of creative solutions or consider the applicability of established models for use in Victoria (this could be a one-day workshop, and participants could be asked to pre-prepare some material prior). A separate governance group including senior clinicians could consider the options presented to them, ask for more data, cost analyses and so on. This group would then also oversee implementation and education and a proper communications strategy. Having senior clinicians on a governance group cannot represent sufficient communication to the health care sector. Processes like this seem likely to ensure enthusiastic participation. Clinicians are keen to engage 'There are wonderful opportunities working with government for clinicians' (rural medical specialist).

Sometimes crisper engagement will be appropriate. A metropolitan CEO commented:

> 'I want to challenge the idea of standing committees. We should go as far as possible from standing committees and instead recruit people to work on key pieces of work. These groups should be very focused; for example, we say you'll have three meetings, and you can teleconference in between, to solve problem x. The best work occurs when it's around specific programs of work – or better yet, around specific questions.'

There is clearly a place for more clinician secondments into the Department of Health and Human Services, with a network chair commenting 'there is a massive advantage sending clinicians into the department – they 'learn how to get things done' and it improves the acumen, knowledge and comfort of department staff.

Currently, much engagement with clinicians lacks breadth and depth. Clinicians are not recruited onto advisory groups in an open and accessible way, and views represented to the department are not as complete as they need to be. Decision making needs to be informed by accurate information that is available to a broad suite of department decision makers on the needs and attitudes of clinicians in the health system, rather than relatively few individuals and anecdotes derived from personal relationships or hearsay.

A sample six question screen has been constructed, something similar could become a routine part of project planning.

Think you need clinician engagement? You probably do! Six queries

1. Who is the piece of work for? Were clinicians and consumers engaged in making decisions to do this (i.e. priority setting)? If not, can this be reconsidered? If this cannot be, perhaps you are looking for a rubber stamp group, and this can make clinicians cynical.

2. What advisory process do you need? Do not automatically set up an advisory committee and labour over terms of reference and suitable meeting dates, but first ask whether the Department of Health and Human Services has access to this advice already, via clinician staff or existing advisory groups,[25] and whether the advice is better obtained by literature review, survey or field visits.

3. If you need to set up an advisory group, can you make the engagement short and sharp by establishing a clear problem definition and preparing evidence summaries and relevant data?

4. When determining group members, ask whether you are looking for endorsement, authentic information or creative solutions? This makes a big difference to the nature of the group you put together, remembering that for policy success, the quality of the policy is more important than senior stakeholder involvement in development.

5. Are there many clinician stakeholders? If so, involving a larger number in the advisory phase will assist with implementation.

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[25] Lists of these need to be available; there are, for instance, clinicians in the Aged Care Branch who are underutilised for this purpose

6. How can you make clinician participation rewarding? This happens when the work feels real, makes a difference to patient care, where there is a good group process so everyone feels their views mattered and when there are clear advice outcomes.

There has been a reduction worldwide in trust in professionals and in traditional top-down centralised institutions. A government bureaucracy like the Department of Health and Human Services is such an institution. Trust is more likely where there is verification (authentic human interactions), connections (people in common) and shared interest and values. The Department of Health and Human Services is not a highly trusted institution, as a result of too many changes in structures (and personnel), the appearance of politically-driven rather than patient-driven decisions and the recent dominant cost focus. However, its lack of credibility results most especially from the opaqueness of its processes and its facelessness. For instance, there are many clinical staff working at the department, but the sector is not aware of this (except in specific areas such as Mental Health). Sanitised documents with no authors make their way slowly, if at all, into the public domain and the clinical networks have struggled to work out how to have a voice.

The devolved approach taken to health system governance appears to have left the department with little social capital. Large providers though have a high degree of confidence about their own performance. Some seek validation from overseas and interstate experts and spend money on study tours and importation of such experts. Some benchmark comprehensively (for example, health round table), but this approach provides no comprehensive accountability for quality and safety in Victoria.

Efforts to 'build capacity' in the sector, whether by training a handful of clinicians in redesign or small short-term project grants are of limited efficacy to enable the department to achieve either improved clinician engagement across the system or more reliable safety and quality. The key to both engagement and the communication strategy needed to allow the department to influence is the provision of statewide data. This then needs to be associated with statewide improvement work.

Networks of all kinds running a rich range of face-to-face and technology-mediated activities, and including policy makers will enable participants to build relationships and trust. Department of Health and Human Services staff members with clinical backgrounds have informal networks in the health system; these should be preserved and developed. Some had felt stifled by rules preventing them doing so. The anxiety about 'system capture' should be minor compared to the risks of poor policy resulting from inadequate clinical engagement. A complexity theory approach supports the value of seeking engagement at multiple levels.

Recommendations

Develop a clinician-focused communications strategy. *Safer Care Victoria should build on Better Care Victoria's communications strategy to develop an approach that spans the department and new Better, Safer Care agencies. It should highlight how to make communications accessible, relevant and meaningful for clinicians. This strategy should apply to all forms of communications, including data publication, and should indicate when testing with clinical audiences is needed before release.*

Make department information, reports and contact information easy for clinicians to find and use. Renovate web presence so that the priorities, products, decisions and engagement structures of the department are visible and regularly updated. This should include an easily located list of contacts for the Victorian Clinical Council, the Net–works, advisory groups and program areas.

Publish analysis, advice and reports developed through clinician engagement structures. Publish data analyses and reports requested or developed by clinical networks, the Victorian Clinical Council and advisory groups by default (except by the request of the relevant group, where publication would compromise privacy, or when overruled by the Secretary or relevant agency head).

Adopt a white paper process to engage clinicians in policy debates. Develop a white paper process used as a normal part of change agendas. Topics will be nominated by Safer Care Victoria, the department or the Victorian Clinical Council, with calls for public submissions and dedicated discussions of white papers by relevant clinical networks and advisory groups, as well as the emerging clinical leader group alumni.

Develop a strategy to build the department's clinical engagement capability. This would include:

- *active generation and promotion of secondment opportunities from the department into the sector (this could include offering subsidised secondments as part of all Better Care Victoria innovation projects, and approaching a wide range of providers)*[26]

- *creating some roles that clinicians can be rotated through or that are specifically designed for half-time clinicians*

- *training and mentoring for new managers in roles that involve clinician engagement.*

The department should:

- *track the extent and currency of clinical experience within the department*

- *track the inclusion and progress of clinician engagement skill development priorities within professional development plans for relevant staff*

- *provide an annual brief to the heads of health branches on the extent, currency and development of clinician engagement skills among their staff.*

Develop and standardise the use of contemporary approaches to departmental engagement with clinicians. This would include:

- *preparation of evidence summaries prior to group discussion*

- *facilitated deliberative dialogues*[27]

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[26] This should extend beyond conventional thinking– a private sector (not-for-profit) CEO said he'd be delighted to have someone from the DHHS work with his finance department so they really understood how things worked in the private sector. Another suggested secondment of project officers for capital projects.

[27] A type of group process that can help to integrate and interpret scientific and contextual evidence for the purpose of informing policy.

- *the use of a range of mechanisms other than establishing advisory groups, such as undertaking focus groups and site visits, and the use of the Delphi process to allow large groups to participate in priority setting.*

Build the capability of clinicians already engaged with the department. *Provide training and mentoring for the chairs of all networks and advisory groups in meeting and group practice, system influence and policy design.*

Expose junior clinicians to the department's work. *Provide a structured secondment program for junior clinicians into Safer Care Victoria or the department to work on discrete projects while receiving concurrent training in systems influence and policy design.*

Create pipelines to develop the skills of clinical experts in system and policy influence. *For example, use Better Care Victoria's Emerging Clinical Leadership Group as one inflow, with annual intakes (with staggered two-year terms to maximise networking opportunities). Also:*

- *ensure that the group is diverse in terms of clinical profession, cultural background, LGBTI, Aboriginal and Torres Strait Islanders and consumer experience*

- *provide the group with intensive mentoring and training in systems thinking, influence and policy design*

- *proactively target alumni for membership on advisory groups and clinical networks, with all groups to have at least one alumni member by 2020*

- *involve alumni in the white paper process proposed.*

Provide clinical advisory groups with clearer roles and best practices for operation. *The department should develop a set of clear guidelines to govern the development, resourcing and management of its advisory groups. These guidelines should establish:*

- *a requirement to have a publicly available list of all current advisory groups and their membership (over time, lists of past groups and their members should be archived on the web page)*

- *a taxonomy of the different kinds of advisory groups (including taskforces, leadership groups, consultative councils, ministerial advisory committees, and reference groups) the department will use and the delineation of their roles, size and operation*

- *protocols for establishing these groups (including threshold requirements for establishing new groups, rather than using existing groups or other resources) and timelines for their review and dissolution*

- *templates and clear standards for terms of reference to ensure role clarity. These should be accompanied by decision-support frameworks to ensure that meeting frequency and format, secretariat support and participant remuneration (if any) are commensurate with the group's responsibilities and its members' workloads and availability*

- *protocols for recruitment and re-appointment of group members, including minimum attendance requirements, skills assessment matrices and skill development plan templates for the members and chairs*

- *requirements for ensuring a sufficient diversity of age, gender, professional expertise (including consumer experience and expertise) and experience on each group, as appropriate to the function of each group*

- *specified term limits for members and chairs*

- *secretariat guidelines on minimum requirements, principles and best practices for supporting advisory groups.*

Appendix A What is meant by work and employee engagement?

The original concept of employee engagement was a behavioural perspective on employee motivation.[4] Engaged employees are attentive, connected, integrated and focused in their role performances.[124] Their degree of engagement results from experiencing three psychological conditions: meaningfulness (feeling worthwhile, useful, and valuable), safety (able to fully engage themselves in a role without fear of negative consequences to their self-image, status or career) and availability[124, 4] (the belief that they have the physical, emotional, and psychological resources required to invest themselves in performing a role).[124]

Engagement, or 'work engagement' is a more active concept than job satisfaction,[6] which represents a more passive form of employee wellbeing[125] (Bakker 2011) or attitude.[124] It has also been distinguished from organisational commitment (an emotional attachment to one's organisation) and job involvement (the degree to which one's job is central to one's identity).[124] The engagement literature is relatively new and was largely nonexistent just 10 years ago. There are several competing definitions of work engagement but one commonly used is:

> 'A positive, fulfilling work-related state of mind that is characterised by vigour, dedication and absorption (Schaufeli) cited in [5].

Organisational citizenship behaviour

Effective organisational performance depends on role-based behaviours implied in job descriptions, and also individual discretionary contribution (called organisational citizenship behaviour (OCB), extra-role behaviour or pro-social organisational behaviour).[126] OCB is considered likely to be an outcome of the 'dedication' component of work engagement. While there have been redefinitions of OCB that sidesteps the issue of discretion (by defining it simply as behaviour that supports the social and psychological context of the organisation), most still prefer to conceptualise it as behaviour that is relatively voluntary and less likely to be formally rewarded.[127] OCB has a number of dimensions:[128]

- altruism – for example, helping new staff or helping patients with personal matters
- conscientiousness – for example, punctuality
- sportsmanship – willingness to tolerate less than ideal circumstances and avoid complaining
- civic virtue – responsible participation in the life of the organisation – attending meetings, reading emails
- courtesy.

Other OCB include compliance (obeying rules when no one is looking), loyalty, making constructive suggestions for change (voice) and becoming involved with organisational improvements.[127, 126]

It is known that if an organisation is supportive, employees perform extra-role activities more readily.[129] However, individual motivations for performance of volunteer extra-role behaviours are very variable. Functional motives for voluntarism include:

- genuine concern for a particular group – this so called 'other-oriented function' is relevant – a clinician may be bitter or disengaged from the hospital/employer/department, but have persisting concern for, and interest in, patient outcomes

- career-related benefits

- opportunities for increasing personal learning and understanding

- fulfilment of social needs: 'Volunteer work also affords opportunities for people to meet their social needs by serving with friends or by gaining the approval of important others who view voluntarism favourably'[129]

- ego enhancement motives – these have been shown to predict frequency of volunteering. They include the desire to feel needed, feel important and to increase self-esteem. Helping others does this.

Recently, the notion of citizenship fatigue has been developed. OCB involves a choice to invest cognitive, emotional and physical resources in activities that go beyond what is technically required. When these resources are scarce, an internal tension develops and concerns about the fairness and utility of engaging in the OCB result in feelings of fatigue and resentment.[130]

The work of health care workers is intrinsically prosocial – they experience the impact of their actions daily, and are rewarded by 'the experience of making a positive difference in the lives of others through one's work'.[127] In health care, behaviours may be described that involve stepping outside formal policies and procedures to deliver a good service to patients.[126] One study in health care found that participants, especially at higher levels of the organisation, reported no upper limit to role requirements;[126] that is, some very engaged senior executives considered that there were no behaviours that were discretionary.

Theoretical models of work engagement

One theoretical model for work engagement is social exchange theory. This views relationships between employees and employers as based on norms of reciprocity. Where employees feel that they are being treated well and valued, they are likely to increase their engagement.[6] This theory has utility, and is not incompatible with the major theoretical model in use which is explored in more detail below.

The job demands-resources (JD-R) model[6] describes how job strain (burnout) and work engagement are produced by two sorts of working conditions: job demands and job resources. Job demands are the physical, social or organisational aspects of the job that require sustained physical and psychological (that is, cognitive or emotional) effort. Job

resources refer to those physical, social or organisational aspects of the job that may: 1) reduce job demands; 2) be functional for achieving work goals; or 3) stimulate personal growth, learning, and development (these include both autonomy and feedback). Too many demands and too few resources predict burnout,[7, 8] (and thus illness and absences),[9, 14] and result in employees working less safely.[8] Burnout is a well-recognised problem for health care workers[11 12] and unsafe work practices in health care can result in harm to patients as well as staff themselves. There is a large body of literature on burnout in health care workers, but in the context of this investigation it is worth noting the importance of organisational factors in burnout; for instance, a Mayo clinic study illustrated the importance of the leadership qualities of immediate supervisors in doctor wellbeing (preventing burnout).[131]

Increases in job resources predict work engagement, and there is a positive cycle where initial work engagement predicts an increase in job resources.[7] Engaged workers may redesign and improve their jobs (including, for example, how they work with others; thus also potentially increasing resources available to others).[7] Work engagement also improves the psychological wellbeing of individuals.[132]

There are some important additions to this simple model. First, the concept of personal resources – an individuals' sense of their ability to successfully control and have an impact on their environment[6] (for example, self-esteem, self-efficacy, locus of control and the abilities to perceive and regulate emotions) – is a positive predictor of work engagement. Such individuals are better able to perform 'job crafting', which consists of seeking challenges and resources (such as support and feedback) and reducing demands. However, this latter manoeuver is not easy to do in health care and often viewed unfavourably by colleagues.[13]

Second, there are 'trait' differences in characteristics such as proactivity, conscientiousness and self-efficacy, which influence the desire to become engaged – antecedents of work engagement.[5] On top of traits are attitudes, for example, those who give priority to work/life balance may explicitly seek to minimise their engagement with the organisation.

Third, jobs consist of numerous tasks, and employees will be more engaged in performing some tasks than others; for example, academics who are more engaged in research than teaching.[124] Job demands have even been differentiated by employees into 'challenge' and 'hindrance' stressors. This distinction seems most relevant to the engagement of health care workers. Challenges are stressful demands that workers consider have the potential to promote mastery, personal growth or future gains. Demands such as a high workload, time pressure and high levels of job responsibility are often perceived as opportunities to learn, achieve and demonstrate competence. People 'may work very passionately to respond to challenge demands because they believe doing so is meaningful and important, even though they simultaneously recognise that doing so may also leave them feeling exhausted'.[14] This sounds like much clinical work.

Conversely, hindrances are stressful demands that have the potential to thwart personal growth, learning and goal attainment; for example, role conflict, organisational politics and 'red tape'. Hindrance demands are 'negatively related to engagement because they result in

negative emotions and passive, emotion-focused coping styles that reflect withdrawal.[14] Hindrance demands and the possibility of addressing them are perceived as exhausting.[14] Much organisational or system improvement work involves wrestling with hindrances.

The politics of employee engagement

The concept of employee engagement has been popularised (and heavily marketed) by the Gallup organisation using 12 'actionable' work-level facets of job satisfaction[5] (this has alternatively been described as a measure of management practices rather than engagement[124]).There are distinct problems with popularisation by management consultants of the concept of employee engagement. First, fully engaged employees are rare; second, it can be used to reduce work relations to individual attributes and failings, ignoring systemic problems:[7]

> 'It is disingenuous to portray work in the positive glow of engagement without recognising the very different experience of many who fail to be engaged often for very good reasons. Problems of job insecurity, zero hours contracts and real pay reductions for many do not get recognition, and studies of work engagement are, in the main, a-contextual.'[7]

Some academics find the Gallup focus on organisational performance (rather than employee wellbeing) offensive. The work is also a-theoretical, making it impossible to recommend or prove the effect of defined improvements.[5] In fact, 'for all of the hoopla about how to 'drive' employee engagement and its consequences, we have very little evidence'. There are known factors in the work environment positively related to engagement and 'positive relationships between employee engagement and work outcomes; however, we are not in a position to say that employee engagement causes a particular outcome, nor can we even be sure of the direction of causality where there exists an association between engagement and a job attitude or behavior'.[124]

The UK government has supported the concept of employee engagement, responding to anxieties about an 'engagement deficit' and the need to improve productivity and competitiveness in the UK. They commissioned an influential report,[16] and the consultants have developed this work further (see: http://engageforsuccess.org/). The definition used in the report included employee wellbeing:

> '…a workplace approach designed to ensure that employees are committed to their organisation's goals and values, motivated to contribute to organisational success, and are able, at the same time to enhance their own wellbeing.'[16]

Those authors undertook further work examining health and wellbeing with metrics, including turnover, staff absences and illness. Case studies provided include introducing activities to make workers happier (for example, a choir) so they were then more productive. However, it is inarguable that 'work is the primary activity for many people during their waking hours, so their engagement levels affect the extent to which they enjoy their lives'.[133, p. 21]

Evidence that work/employee engagement matters

There have been multiple studies across many sectors that have found performance-based outcomes associated with engagement. Ignoring the methodological issues, the magnitude of the Gallup work impresses and illustrates some of the domains that are studied. The 2016

Gallup meta-analysis has recently been released.[134] It combines 339 research studies across 230 organisations in 49 industries in 73 countries. Each study statistically calculated the business/work-unit-level relationship between employee engagement and organisations performance outcomes. In total, 82,248 business/work units that included 1,882,131 employees were studied. There were 61 health care organisations, with 12,619 work units and 281,995 employees studied. Only nine organisations provided measures of patient safety (for example, patient falls, medical errors, infection rates and risk-adjusted mortality rates). Median differences between top-quartile and bottom-quartile units are shown in Figure 46 below.

Figure 46 Median differences in performance between organisations with the strongest and weakest engagement

Source: Gallup (2016).[134]

Notes: 'Strongest' and 'weakest' organisations are those with engagement scores in the top and bottom quartile, respectively.

Appendix B Clinicians and management

From the 1960s to the late 1980s, hospitals were managed by the clinicians, elite professionals who had the power and influence to control their organisations. Such organisations were known as professional bureaucracies.[135] Introduction of professional management occurred in parallel with the development of extraordinary complexity in the processes of health care delivery – not just in patient conditions and therapies offered, but in types of providers, funding vehicles, data resources and technologies.

Tensions between clinicians and managers – in particular between doctors and managers – appear in all health systems. A recent NZ survey, completed by more than 10,000 clinicians revealed considerable hostility towards management.[136] Clinicians felt controlled, that consultation was merely 'lip service', and mentioned a lack of training and time as barriers to partnership.

The concept of clinical leadership, though, is pretty much synonymous with clinician engagement. It has been suggested that doctors once provided leadership in health care without question; however, 'when administrative logic became more prominent, and especially when administrators renamed themselves managers, this [is] no longer self-evident'.[137] certainly, this has been a troubled area over the last 20 years, and there has been enormous focus on leadership 'competencies' for doctors.[138] These form parts of many training programs.

Yet there are significant cultural obstacles, and putting these competencies into more general use is not straightforward.[139] Much leadership training for doctors is perhaps 'wasted' because they do not return to roles where they are encouraged and enabled to use their new skills.[138] The employment arrangements for the majority of senior Australian doctors do not greatly enable them to use leadership skills to influence the health care system. In contrast, high-performing health systems tend to have salaried medical staff[140] who are embedded and engaged.

There has also been a recent trend to designate many formal authority positions in health care structures as leaders.[141] This is problematic:

> 'The denigration of management and resulting tendency to call everyone a leader, while expecting stability and consistency with expectations of adherence/compliance, may be problematic for both functions and render both less meaningful – management becomes less effective and leadership becomes merely an espoused value.'[142]

One strategy to reduce tensions is to integrate doctors into formal administrative structures. This can potentially transform them into powerful influencers. In the UK most NHS trusts report that between 10 and 20 per cent of medical consultants were involved in formal leadership roles.[143] (In other countries, where research and private practice are associated

with much more status and income, it may be more difficult to enlist doctors to a relatively poorly valued role.[144])

The following potential benefits have been suggested for the increased involvement of medicine in management:[144]

- For funders, it offers a possibility of enhanced control. Co-opting doctors into management and leadership provides a low-cost means of regulation, with them better able to influence practice and gain compliance amongst communities of fellow professionals.

- Doctors identify more strongly with the goals of macro care of populations as opposed to the traditional clinical focus on the micro care of individuals.

- Protection of patients against managerial change that could endanger their safety and quality of care.[122] An OECD study found doctor-managers with formal decision-making responsibilities were positively associated with implementation of quality management systems.[112]

The concept of clinical governance includes the assumption that clinicians will also be given, and willingly take on, responsibility for resource allocation, service organisation and associated decision making — perhaps in full or in partnership with management.[136] There are many clinical managers who combine professional with managerial responsibilities. However, a recent OECD study of doctors' involvement in hospital governance and implications for quality management[112] reveals that medical doctors held a broad range of managerial roles, but these were only partly accompanied by formal decision-making responsibilities.[112]

Budget responsibility is a key issue, and if there is no signing authority for the budget, it may lead to perceptions of a weak leadership (or managerial) role (although some medical leaders may be satisfied with a focus on clinical delivery outcomes[142]). There is a psychology-based approach to management accounting that focuses on the experience of ownership, and an Italian hospital study found clinical managers' budgetary participation directly associated with their affective commitment toward their managerial role.[145] The authors suggest budgetary participation means:

> 'The managerial culture can be progressively absorbed by clinicians and become part of their psychological and motivational structure, thus influencing their attitudes and behaviours toward organisational goals.'[145]

Practising medical clinicians in management roles also face identity struggles, with 'manager' sometimes seen as an anti-identity to 'doctor'.[137] The basic logic of managers' work is bureaucratic order, and they create processes to create control.[137] There is also a managerial career: 'climbing the ladder'.[137] There are a substantial number of skills employed by managers,[146] but modern managers work by building relationships and acting through and with others to get things done, rather than by exercising individual responsibility – the normal mode of operating for doctors.[147, 144] Doctors usually see themselves as autonomous individuals within a system, and although they may incorporate management as a 'trivial' subset of their existing skills, they usually maintain a primary identities as a

clinician.[137] When identity is confused it can be stressful to act.[137] Australian doctors who have made a career of management describe the distressing experience of being seen by former colleagues as having 'gone over to the dark side', and subsequently not feeling valued or supported.[148]

Nurses are more likely to see a managerial career as an alternative career, and their professional identity is considered more compatible with a manager identity.[137] Some individuals manage better in creating complex hybrid identities. Willing hybrids challenge and disrupt institutionalised professionalism, and integrate professionalism and managerialism.[149] They will challenge and audit the work of other professionals; thus they can be powerful change agents.

It is suggested that obtaining the commitment and alignment of doctors in integrated health care delivery models:

> '…requires simultaneous efforts at coupling physicians and health care systems at several fronts including economic, structural (formal roles in organisational leadership structures and clinical governance), process-related (for example, involvement of physicians in quality improvement initiatives) and policy levels.'[142]

This work is required to achieve clinician engagement in a complex system. It is important not to ignore the issues of identity and power sharing that must be negotiated to achieve this.

Appendix C Using data for engagement

While high-performing health systems internationally have been shown to be data driven and, importantly, to return data to clinicians,[140, 150] most Victorian clinicians receive little information on outcomes and rates of unintentional harm. It has been suggested that where 'there is a lack of engagement, it is at least partially explained by a paucity of robust clinical data at the local level to motivate change'.[151]

Clinicians often do not appreciate the extent of quality problems found in major published studies, or believe these findings do not apply to their local practice.[152] The lack of benchmarks or other comparative performance data leads to clinical complacency. Equally, the historical practice of seeking only to identify 'errors' or poor performance has left clinicians wary of being blamed for poor outcomes when causation is complex.

Historically, funders and system managers have relied on *indicators* of safety and quality to motivate clinician engagement with quality improvement efforts. However, many indicators are hospital-wide, rather than specific to what clinicians consider 'my' patients. Accountability for outcomes is thus diffuse, with indicators that are often not directly relevant to many clinicians' area of practice. National or systemwide indicators may miss important local problems and have been shown to lead to disappointing improvement results and clinician resistance.[153] Large-scale Dutch safety research suggests more opportunity for clinical improvement at the unit level rather than the hospital level.[154]

Clinicians are responsive to using comparative data on their patient outcomes if they get the right kind of reports. A 2012 report to the US Agency for Healthcare Research and Quality (AHRQ) evaluated factors that support better clinician engagement in QI using data on outcomes.[155] These principles were evaluated in the context of confidential individual performance reports, but are broadly applicable to other kinds of reporting that work for clinicians. Data on clinical outcomes must be local, relevant, comparative and timely. It is desirable to provide access to patient-level data and enable doctors to correct this data. It is recommended that feedback reporting is embedded as an integral part of QI. Timeliness of data is especially important for management of patient care. For performance assessment, longer measurement intervals are often needed to gather enough data for reliable assessment, but timeliness of data feedback is important to doctors' perceptions of the meaningfulness of the data.[155]

Simply circulating reports on comparative performance is not sufficient,[156] and processes are needed that encourage change. Smaller quantities of highly punctual and locally relevant measurement, coupled with dialogue routines, have been found to work best to translate data into improvement.[157] Dialogue routines can occur at multiple levels, but discussion in small groups at unit level is critical. Comparative unit and individual level data both 'both create the need for clinician leadership and [can] be the starting point'.[156] Granular data that offers the ability to compare subpopulations to test small-scale improvement initiatives is an ideal support in the system and for the work of the networks.

Credible data motivates improvement,[69] but there was considerable anxiety among Victorian medical practitioners about data quality. In the UK it has been suggested that:

> 'One of the reasons for poor data quality is clinical disengagement. Poor quality data leads to lack of confidence in the data, mistrust and rejection. Consequently, there is further neglect of the process, the situation does not improve and clinicians disengage further. This is termed the vicious cycle of poor data quality.'[158]

The only solution to this is to start working with the data available, accepting that it may have lower levels of reliability, and work through the issues that could be responsible for variation. Variation can be due to differences in documentation and coding, differences in underlying case mix (thus requiring additional risk adjustment), differences in the resources available to 'underperforming' units or hospitals, and finally, differences in outcomes related to performance of individual health care workers or units. After all,

> 'Transforming healthcare organisations for improvement is in itself a political act. Renewing governance requires the installation of countervailing powers that counter the forces of inertia. Patient/citizen involvement and increased reliance on evidence of quality have the potential to challenge these forces.'[157]

Finally, there is 'growing recognition of the importance of cross-fertilisation between clinical and organisational assets' – that is where 'clinical expertise and managerial know-how are blended to achieve quality improvement'.[157] This is created by mechanisms that align interests and priorities of these groups – and provision of excellent data is the major mechanism for this, and for clinician engagement overall.

Appendix D Full list of recommended proposals for action

The following list describes indicative areas for action, for the consideration of Safer Care Victoria, the Victorian Clinical Council and the Department of Health and Human Services (DHHS).

SET THE AGENDA – Develop objectives, expectations and good measures

1. State the definition, objectives and principles of clinician engagement, possibly as a compact describing roles and expectations.

Note: rebalancing the statement of priorities with increased emphasis on safety and quality and patient experience versus performance – as agreed in Better, Safer Care – is a critical driver for clinician engagement.

2. Set standards for clinician involvement in safety and quality.

Develop a statewide memorandum of understanding (or similar) setting out the expectations of clinicians who operate and consult in the public sector regarding their involvement in safety and quality improvement and consumer engagement.

3. Set minimum responsibilities for health service boards in regard to clinician engagement.

These may include:

- a minimum response rate to the improved People Matter Survey or other tool that offers sufficient granularity
- reporting their engagement survey results together with their planned response
- review of the membership of their senior executive to ensure that there is appropriate multidisciplinary clinician representation
- developing an annual schedule of visits so that they can hear concerns from all parts of their organisation
- considering whether the structural preconditions for engagement are being met by:
  – minimising very part time employment arrangements
  – supporting high involvement work practices (people and culture)
  – ensuring management structures that support engagement are in place (for example, clinical directorates)
  – minimum requirements in statements of priorities.

4. Improve data collection on clinician engagement.

Improve the People Matter Survey so it is more useful for health service providers. This would include:

- removing irrelevant sections from the survey in order to decrease its length and increase response rate

- developing a much shorter and engagement-focused 'pulse check' version to allow organisations to monitor and address the effect of organisational change when they feel they need to

- promoting the opportunity to collect the service unit of respondents, which would permit more granular and actionable analysis of survey results

- the VPSC consulting with public and private health services using commercial survey products (such as Best Practice Australia's) instead of the People Matter Survey in order to better understand perceived gaps in the survey and reporting

- permission for the private sector to use the redeveloped survey(s) on a cost-recovery basis, and promotion of participation.

5. Use data to monitor clinician engagement and give underperforming organisations targeted support to improve.

The department uses People Matter Survey data to monitor clinician engagement in health services and identify underperformers for targeted support from Safer Care Victoria. If a health service uses a different survey, it should be invited to supply the results of that to the department instead.

6. Engage with private providers and clinicians working in private organisations to explore development of a strategy for their sector.

7. Engage with community-based providers and clinicians working in community-based organisations to explore development of a strategy for their sector.

This would include investigation of how the department can strengthen its understanding of clinical engagement in community settings and with community-based practitioners (including general practitioners) prior to development of a strategy designed to strengthen engagement in this sector.

INFORM – Provide information and data to support engagement

8. Provide clinicians and provider organisations with better patient outcomes data to inform and motivate clinician engagement.

9. Expand access to and improve navigability of the PROMPT portal, and use it to share agreed statewide guidelines and local protocols with clinicians and provider organisations.

10. Develop a clinician-focused communications strategy.

Safer Care Victoria should build on Better Care Victoria's communications strategy to develop an approach that spans the department and new Better, Safer Care agencies. It should highlight how to

make communications accessible, relevant and meaningful for clinicians. This strategy should apply to all forms of communications, including data publication, and should indicate when testing with clinical audiences is needed before release.

11. Make department information, reports and contact information easy for clinicians to find and use.

Renovate web presence so that the priorities, products, decisions and engagement structures of the department are visible and regularly updated. This should include an easily located list of contacts for the Victorian Clinical Council, the networks, advisory groups and program areas.

12. Publish analysis, advice and reports developed through clinician engagement structures.

Publish data analyses and reports requested or developed by clinical networks, the Victorian Clinical Council and advisory groups by default (except by the request of the relevant group, where publication would compromise privacy, or when overruled by the secretary or relevant agency head).

13. Share improvement project findings and resources to drive peer-to-peer engagement.

This should include department-funded improvement projects being contractually required to share all developed materials, including via the Better Care Victoria website, by responding to enquiries and hosting visits.

INVOLVE – Improve structures, processes and support for consultation and debate

14. Clarify the role and function of statewide clinical networks: to reduce unwarranted practice variation at the statewide level (that is, not just among organisations represented by members).

15. Structure statewide clinical networks to maximise reach and involvement of clinicians.

They will enhance their abilities to influence practice by:

- defining their constituencies and then setting ambitious, measurable targets for engagement with those constituencies (which they will monitor and report on together with measures of influence)
- developing regional subgroups within the statewide networks, and also smaller communities of practice and time limited collaboratives to work on discrete areas of concern
- ensuring half of the members of their steering groups are 'grassroots' clinicians, patients or carers, with adequate representation from the private, primary and community sectors and of nursing and allied health clinicians
- developing agile and modern communication practices that inform and increase interest in their work.

16. Provide clinical advisory groups with clearer roles and best practices for operation.

The department should develop a set of clear guidelines to govern the development, resourcing and management of its advisory groups. These guidelines should establish:

- a requirement to have a publicly available list of all current advisory groups and their membership (over time, lists of past groups and their members should be archived on the web page)

- a taxonomy of the different kinds of advisory groups (including taskforces, leadership groups, consultative councils, ministerial advisory committees and reference groups) the department will use and the delineation of their roles, size and operation

- protocols for establishing these groups (including threshold requirements for establishing new groups, rather than using existing groups or other resources) and timelines for their review and dissolution

- templates and clear standards for terms of reference to ensure role clarity. These should be accompanied by decision-support frameworks to ensure that meeting frequency and format, secretariat support and participant remuneration (if any) are commensurate with the group's responsibilities and its members' workloads and availability

- protocols for recruitment and re-appointment of group members, including minimum attendance requirements, skills assessment matrices and skill development plan templates for the members and chairs

- requirements for ensuring a sufficient diversity of age, gender, professional expertise (including consumer experience and expertise) and experience on each group, as appropriate to the function of each group

- specified term limits for members and chairs

- secretariat guidelines on minimum requirements, principles and best practices for supporting advisory groups.

17. Adopt a white paper process to engage clinicians in policy debates.

Develop a white paper process used as a normal part of change agendas. Topics will be nominated by Safer Care Victoria, the department or the Victorian Clinical Council, with calls for public submissions and dedicated discussions of white papers by relevant clinical networks and advisory groups, as well as the emerging clinical leader group alumni (see Recommendation 27).

18. Ensure clinicians have multiple ways to voice system concerns to the department.

This may include:

- expanded reach of clinical networks

- engagement with Victorian Clinical Council

- clinician participation and engagement in other department/health service interactions, including those involving senior departmental staff

- special purpose forums and meetings.

19. Develop a strategy to build the department's clinical engagement capability.

This would include:

- active generation and promotion of secondment opportunities from the department into the sector (this could include offering subsidised secondments as part of all Better Care Victoria innovation projects, and approaching a wide range of providers)[28]

- creating some roles that clinicians can be rotated through or that are specifically designed for half-time clinicians

- training and mentoring for new managers in roles that involve clinician engagement.

The department should:

- track the extent and currency of clinical experience within the department

- track the inclusion and progress of clinician engagement skill development priorities within professional development plans for relevant staff

- provide an annual brief to the heads of health branches on the extent, currency and development of clinician engagement skills among their staff.

20. Develop and standardise the use of contemporary approaches to departmental engagement with clinicians.

This would include:

- preparation of evidence summaries prior to group discussion

- faciitated deliberative dialogues[29]

- the use of a range of mechanisms other than establishing advisory groups, such as undertaking focus groups and site visits and use of the Delphi process to allow large groups to participate in priority setting.

21. Improve access to department staff, consultation and engagement for rural stakeholders with multi-site videoconferencing facilities

EMPOWER – Invest in skills, capabilities and opportunities to lead change

22. Empower clinical networks with tools, resources and policy influence.

Statewide clinical networks are supported in their work by:

- a consumer engagement strategy and toolkit appropriate to the networks' focus as clinician practice influencers

- being allowed to develop brand identities and to communicate freely and publicly about their work

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[28] This should extend beyond conventional thinking– a private sector (not-for-profit) CEO said he'd be delighted to have someone from the DHHS work with his finance department so they really understood how things worked in the private sector. Another suggested secondment of project officers for capital projects.

[29] A type of group process that can help to integrate and interpret scientific and contextual evidence for the purpose of informing policy.

- provision of usable data and by development of standards for data supply in response to system requests (for example, timeliness and ease of access)

- being able to propose regulatory or performance accountability measures when necessary to ensure that guidelines and improvements reach the whole sector (for example, through data collection requirements or statement of priorities conditions) and receive formal responses from the relevant part of the department or other agency

- development of an accessible and navigable portal for sharing agreed state guidelines and local protocols.

- Safer Care Victoria leading coordination and oversight of Clinical Network work plans to ensure that there is time and capacity to implement improvement activities sustainably (reduce the number of small projects).

23. Promote best practices in clinician engagement in the workplace.

Safer Care Victoria identifies best practices in engagement and promotes them across the sector, including through a statewide meeting in 2017 to celebrate best practices in clinician engagement.

24. Increase the availability of training in quality improvement for clinicians.

25. Build the capability of clinicians already engaged with the department.

Provide training and mentoring for the chairs of all networks and advisory groups in meeting and group practice, system influence and policy design.

26. Expose junior clinicians to the department's work.

Provide a structured secondment program for junior clinicians into Safer Care Victoria or the department to work on discrete projects while receiving concurrent training in systems influence and policy design.

27. Create pipelines to develop the skills of clinical experts in system and policy influence.

For example, use Better Care Victoria's Emerging Clinical Leadership Group as one inflow, with annual intakes (with staggered two-year terms to maximise networking opportunities).

- Ensure that the group is diverse in terms of clinical profession, cultural background, LGBTI, Indigenous and consumer experience.

- Provide the group with intensive mentoring and training in systems thinking, influence and policy design.

- Proactively target alumni for membership on advisory groups and clinical networks, with all groups to have at least one alumni member by 2020.

- Involve alumni in the white paper process proposed (Recommendation 17).

28. Investigate a systematic approach to engaging health professional students in improvement.

Approach health professional schools to see if a systematic approach to engaging students in improvement is possible. Medical schools and students have the most discretionary time in their curriculum, but involvement of all health professional students would be ideal.

29. Conduct statewide quality improvement collaboratives involving all services and the private sector to build improvement capacity at scale.

30. Identify and address barriers to engagement caused by workplace and system inefficiencies, freeing up clinician time for engagement.

Investigating the clinician time costs of departmental and local compliance requirements as part of BCV re-design projects would be a good first step.

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