Clinician engagement: Scoping paper

Executive summary

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

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

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.[2] 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'[3]. 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.

[2] 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.[4] 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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[4] 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.[5] 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)

[5] 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,[6] 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 departmental 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

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

with the health system found that while the majority has a wealth of experience and frequent contact with the health system, 38 per cent have never worked in the sector,[7] 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.[8] 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.

[7] 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.
[8] 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).[9] 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'.[10] 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.

[9] 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.

[10] 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 leader 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.