NSW Health

Shaping the System Together – Clinician Engagement

Practical actions guide

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Introduction

About this guide

This guide is a companion resource to the Shaping the System Together: Clinician Engagement Recommendation Report.

The Shaping the System Together consultation engaged more than 1,700 participants across NSW Health from December 2025 to May 2026. It aimed to better understand experiences of clinician engagement across the system, including what is working well and where improvements could be made. The consultation highlighted a range of practical opportunities to strengthen how clinicians contribute to decisions, service improvement and system change.

The report identified themes, recommendations and eight practical action areas. This guide translates those action areas into practical examples, behaviours, supportive tools and suggested measures that can be adapted across local, statewide and specialty settings. It is designed to help organisations move from insight to action and improvement.

How to use this guide

Reflect on clinician engagement in your setting and identify the challenges you need to address. Use the relevant action areas to select practical strategies, measures and tools that align with your local context and support improvement.

Who might use it	How they might use it
Executives and senior leaders	Set expectations, sponsor action and check that clinician input is connected to decisions
Managers, forum chairs and clinical leaders	Strengthen meetings, engagement processes and follow-through with teams and networks
Project, quality improvement and communications teams	Plan practical engagement, tailor messages, select tools and monitor whether engagement is leading to practical action
Clinicians and team members	Understand how to contribute, what influence they may have, and how to raise issues or ideas
Ministry of Health, Pillars and statewide services	Use the action areas to support consistent, connected engagement practice across the system

How to get started

1. Choose	Select the action area most relevant to your local challenge
2. Check	Use the scenario, core behaviour and reflection prompts to test what is happening now
3. Adapt	Select practical strategies and tools that suit your setting, rather than applying every option
4. Act	Apply the approach through existing forums, meetings, networks projects or improvement processes
5. Learn	Select a small number of measures to track progress and refine the approach over time

Practical action areas

This guide is organised around eight practical action areas identified through the Shaping the System Together consultation. These action areas reflect what clinicians, managers and leaders described as helping engagement work well, and what gets in the way. The guide provides practical examples and tools to support engagement that is purposeful, visible, and connected to decisions and improvement.

1
Feedback loops and decision follow-through

2
Decision authority, escalation and navigation

3
Safe, inclusive and representative engagement

4
Protected time and reduced low-value burden*

5
Enabling clinical leaders and forum chairs

6
System communication and coordination

7
Implementation support for agreed priorities

8
Peer learning and shared practice

* In this guide, “low-value burden” means avoidable work that takes time and attention away from clinical care, meaningful engagement and improvement. This may include duplicated requests, unnecessary or unclear meetings, repeated reporting, administrative tasks, compliance requirements or communication that is not targeted or useful.

How to adapt this locally

Effective clinician engagement is not achieved through a single forum, project or consultation. It is built and sustained through everyday behaviours that make participation meaningful, clarify how input will influence decisions, support timely response and action, and connect clinical insight to improvement.

The example scenarios in this guide are illustrative. They bring together elements of good practice described through the Shaping the System Together consultation and are not intended to represent one specific organisation, team or service; or to prescribe a single model or process. They highlight the behaviours and practices that support meaningful clinician engagement and are applicable to all staff, no matter where they work in NSW Health and irrespective of role and title.

When applying a practical action area, start with the forums, routines, networks or communication channels that people already use and trust. The aim is not to create new processes, but to strengthen how existing ways of working support clear purpose, safe participation, feedback, decision-making, timely response and action.

When adapting a practical action area, consider:

- What challenge are we trying to address?
- What existing forum, meeting, huddle, network or communication channel could this build on?
- Who needs to be involved, and whose voice may be missing?
- What level of participation is being sought: inform, consult, advise, partner or decide?
- What can be influenced, and what has already been decided?
- Who is responsible for the next step?
- How will feedback be provided to the people who contributed?
- What needs to be simplified, stopped, combined or delayed so this does not add unnecessary burden?
- How will we know whether the strategies implemented are helping?

Tip!

Treat the suggested tools and measures as a menu, not a checklist. Choose the options that best fit the local challenge; build on what is already in place; and use existing data, forums or reporting wherever possible.

The aim is to support practical action without creating another layer of work.

Practical action area 1:

Feedback loops and decision follow-through

Why this matters: Feedback loops turn engagement from a one-way request into a two-way conversation. When clinicians can see what happened after they raised an issue or idea, even when the answer is “no” or “not yet,” trust is strengthened, transparency improves and repeated escalation is reduced.

Scenario

A clinician or team raises an issue, idea, risk or proposal through an existing channel. They can understand what was heard, what will progress, what will not progress immediately and why.

Instead of input being collected with no visible response, the person responsible closes the loop, explaining what was raised, what has been considered, what decision was made, what will happen next and when feedback will return.

The issue is recorded in an accessible location, if appropriate. The person or team raising the issue is aware of who is responsible for the next step, in what timeframe and when they can expect a response. Feedback is provided through the agreed channel and timeframe. Where more time is required, an interim update is provided.

Desired outcome: through closing the loop, people can see that their input was considered, what happened as a result, and the reason when something cannot progress or cannot progress yet.

Core behaviour shift

Move from:		Move to:
"Thanks for your feedback."		***"You raised this. Here is what happened; this is what will happen next and why."***

What success looks like

Actions are visible

An action log or other simple method shows progress and next steps

Clinicians know what happened

People can see the outcome after raising an issue

Feedback is clear

Teams understand what was accepted, deferred or not progressed; and why

Trust improves

People can see their input was considered

Repeat escalation reduces

Fewer issues are repeatedly escalated without resolution

Practical strategies: Closing the loop after issues are raised

Role	Observable behaviours
Executives and senior leaders	• Set the expectation that issues raised through engagement are acknowledged and followed up • Ask what issues remain open, clarify what can or cannot progress, and ensure the reason is shared back to all the right people
Managers and meeting/forum chairs	• Use an action log or other simple method to record the issue, owner, next step, timeframe and status • Review open and recently resolved actions so participants can see what has changed and what remains outstanding Confirm next steps before closing, including who owns the action and when feedback will be returned
Clinical leaders	• Frame issues clearly: the issue, the impact, the option and the decision needed • Test whether the issue reflects a broader clinical view before escalating
Clinicians and team members	• Learn what each forum can action, ask which pathway applies when this is unclear, and use the forum or pathway best placed to progress the issue • Ask where the issue will go next and when feedback will return • Raise practical examples from the point of care through huddles, handovers or local forums
Ministry of Health, Pillars and statewide services	• Build feedback loops into consultation from the start, explaining what input influenced decisions, what didn't change; and why • Avoid requesting input without a plan to provide feedback to those who contributed

Prompts for local adaption

Questions to guide improvement

- What existing channel could be used to provide feedback?
- Are there other mechanisms for closing the loop?
- Who is responsible for closing the loop?
- What is a realistic timeframe for feedback?
- How will shift workers, visiting clinicians, distributed teams or statewide service clinicians receive the feedback or updates?
- How will “no” or “not yet” decisions be explained respectfully?

Things that can get in the way

- Input is sought after key decisions have already been made.
- Issues are escalated but not tracked.
- Feedback is provided informally to a small group but not to the people who contributed.
- “No” decisions are communicated without rationale.
- Delays occur without interim updates.
- Feedback depends on one person rather than being built into the process.

Potential metrics to track success

Process measures

- Percentage of issues logged with an owner, next step and timeframe.
- Percentage of issues receiving an update within the agreed timeframe.
- Number of issues closed with rationale, including “no” or “not yet” decisions.

Outcome and experience measures

- Clinician’s report knowing what happened after raising an issue.
- Forum members report that agenda items are relevant to the forum’s purpose, and issues that are out-of-scope are redirected appropriately.
- Reduction in repeat escalation of the same issue

Tools to support practice

- **Meeting close-out prompt**: ensures each meeting ends with clarity about what was agreed, what needs escalation and when feedback returns.
- **Action log template**: records issue, date raised, owner, next step, due date, status and feedback provided.
- **“You raised / what happened” template**: provides a simple format for reporting back what was heard, what will or will not progress, and why.
- **Consultation feedback summary**: summarises what was asked, who contributed, what was heard, and what did and didn’t change.

Practical action area 2:

Decision authority, escalation and navigation

Why this matters: Clear decision and escalation pathways help clinicians understand where an issue goes, who owns the next step and what can be decided locally. When pathways are visible and feedback returns as promised, issues are less likely to stall, duplicate or rely on informal relationships to progress.

Scenario

A clinician has an idea that could improve patient outcomes, support more efficient care and improve workflow. They are not sure where the idea should go or what information is needed for it to progress. The manager or forum chair helps identify the appropriate pathway, such as a local clinical council, service meeting, executive sponsor or other decision-making route.

The forum chair makes the pathway visible: who owns the issue or proposal; what other information is needed; what can be decided locally; what needs escalation; where it goes next; and when feedback will return.

The item is recorded in a simple action log or pathway tracker. The person or team raising the issue is told what will happen next, who is responsible and how and when they will hear back.

Desired outcome: Clinicians and managers can navigate decision and escalation pathways with confidence. They can see where an issue or idea goes, what information is needed, who owns the next step, and how the outcome will return with a decision, update or rationale.

Core behaviour shift

Move from:	Move to:
"Raise it through the usual channels."	***"This is where it goes, who owns it and when feedback will be provided."***

What success looks like

Pathways are visible

Clinicians and managers know where to raise issues, ideas and proposals

Ownership is clear

Action logs or pathway trackers show the issue, owner, next step, due date, status and outcome

Decisions are clearer

Clinicians have a clear understanding of how they can participate and the influence they will have on decisions

Issues progress

Fewer issues stall because pathways are unclear or rely on informal relationships

Trust improves

Feedback returns to the people or forums that raised the issue

Practical strategies: Making escalation and decision pathways clearer

Role	Observable behaviours
Executives and senior leaders	• Set expectations for visible decision and escalation pathways, with clear ownership and response timeframes • Clarify what can be decided locally, what needs escalation, and who can approve the next step • Provide a mechanism for ideas to be discussed early, i.e. before clinicians are asked to develop a detailed brief or business case
Managers and meeting/forum chairs	• Use an action or pathway tracker to record the issue, decision needed, owner, pathway, next step, timeframe and status • Review unresolved items and confirm whether they need a local decision, escalation or more information
Clinical leaders	• Frame matters clearly: what is happening, why it matters, what the risks are, what options exist, what decision is needed and where it should be escalated. • Check broader clinical views before escalating, then share the pathway and outcome with colleagues
Clinicians and team members	• Ask which pathway applies, who will consider the issue, what decision is needed and when an update will return • Raise examples through agreed channels so issues can be triaged, escalated and connected to the right decision-maker
Ministry of Health, Pillars and statewide services	• Make statewide, Pillar or Ministry pathways visible when local issues need system-level input or approval • Explain what information is needed, who will consider the issue, what can be decided and how the outcome will be shared

Prompts for local adaption

Questions to guide improvement

- What issues are most frequently raised by clinicians, and which can be addressed locally?
- What information is needed before a proposal, brief or business case can progress?
- Are clinicians clear about who can influence or decide, and which forum or pathway to use?
- Who owns the next step once an issue is escalated?
- How will the person or team who raised the issue know what happened?
- Which issues need district, network, Ministry, Pillar or statewide support?

Things that can get in the way

- Forums provide a way to share information but do not clarify decisions, next steps or escalation pathways.
- Clinicians are told to escalate but are not clear where or how.
- Decision-making authority is unclear or assumed.
- Briefs, business cases or proposals stall because the pathway, decision needed or supporting information is unclear.
- Similar issues are raised in multiple forums because the pathway or who the decision makers are is not clear.
- Resolution depends on personal relationships rather than a clear, visible process.

Potential metrics to track success

Process measures

- Percentage of issues/ideas logged with an owner, pathway, next step and timeframe.
- Percentage of escalated issues updated within the agreed timeframe.
- Proportion of agenda items labelled as information, consultation, advice or decision.

Outcome and experience measures

- Number of repeat escalations for the same unresolved issue.
- Clinicians report they know where to raise issues.
- Clinicians report knowing what can be decided locally and what needs escalation.

Tools to support practice

- **Issue or idea pathway map**: shows where common issues or ideas can be raised, who can help triage them, what can be decided locally, and when escalation or executive sponsorship may be needed.
- **Decision pathway guide**: explains whether an item is for information, consultation, advice or decision.
- **Issue triage prompt**: helps clinicians and managers frame the issue, impact, risk, options and decision needed.
- **Brief readiness checklist**: helps assess whether a proposal has the information needed to progress.

Practical action area 3:

Safe, inclusive and representative engagement

Why this matters: Engagement is stronger when the right people are involved early, they understand their role and feel safe to speak honestly. Diverse clinical input helps surface different risks, impacts and practical solutions, leading to advice that is more balanced, credible and useful for decision-making.

Scenario

A service wants to strengthen an existing forum, so participation is purposeful, inclusive and representative. The chair and executive sponsor work with participants to clarify the forum's purpose, what can be influenced, who needs to be involved and whether members are expected to contribute from their own experience or are representing a broader group.

They review who is represented in the forum, conduct member check-ins and seek feedback to identify missing perspectives and improve participation. During the meeting, the chair actively seeks views from members, reinforces expectations and explores safe ways to contribute at each meeting. These elements are captured in a simple document, such as a 'terms of reference', which is reviewed as needed, to reflect any changes in the forum's purpose, membership or contribution options.

Changes are made to strengthen the forum, and the chair regularly uses two minutes at the end of each meeting to collect qualitative feedback from members.

Desired outcome: participants feel safe to contribute, ask questions and raise different perspectives. They understand the purpose of the engagement, what they can influence, whose voices need to be included, and how input will be considered.

Core behaviour shift

Move from:	Move to:
"We invited a representative."	***"We checked who needs to be involved, whose voice is missing, how people can contribute and what they can influence."***

What success looks like

Purpose is clear

Participants know why they are contributing and what they can influence

Participation is representative and inclusive

Participation includes the right voices for the topic; and membership and contribution options are reviewed, as needed, to achieve the purpose

Participation feels safe

People are invited to contribute, ask questions and raise different perspectives in ways that feel safe and appropriate

Representatives bring broader views

People representing a group seek views from their peers and colleagues before meetings and share outcomes afterwards

Confidence and capability grow

A broader range of clinicians gain experience, confidence and familiarity with engagement processes

Practical strategies: Creating safe and representative engagement

Role	Observable behaviours
Executives and senior leaders	• Sponsors and chairs check who needs to be actively involved, whose perspective may be missing and what participants can influence before engagement starts • Encourage more than one input route when decisions affect shift workers, smaller sites, visiting clinicians or under-represented disciplines
Managers and meeting/forum chairs	• Open each discussion by naming the purpose, level of influence and type of input needed • Invite quieter voices, ask for views from different disciplines or sites, and offer written or follow-up input when people cannot attend or speak in the meeting
Clinical leaders	• Check views with colleagues before speaking on behalf of a group • Bring practical examples about care, workflow, safety, staff experience or implementation, and help colleagues choose safe ways to contribute
Clinicians and team members	• Ask what the engagement is for, what can still be influenced and whether you are contributing as an individual or representing others • Share practical examples and ask for another way to contribute if the timing, format or group dynamic makes participation difficult
Ministry of Health, Pillars and statewide services	• Plan engagement around affected services, disciplines, sites and work patterns, rather than relying only on existing contacts or broadcast consultation • Provide plain language information about purpose, influence and time commitment, including options, such as pre-reading, short surveys, targeted conversations or written input.

Prompts for local adaption

Questions to guide improvement

- Who is affected by the issue, decision or change?
- Who is already involved, and whose voice is missing?
- Are early career clinicians, shift workers, visiting clinicians, smaller sites, distributed teams and under-represented disciplines able to contribute?
- If using an existing forum, does it have the right membership to provide an informed view?
- Is the purpose clear: inform, consult, advise, partner or decide?
- What can still be influenced, and what has already been decided?
- How will feedback return to the people who contributed?

Things that can get in the way

- The same small group is repeatedly asked to represent broader views.
- Engagement happens after key decisions have already been made.
- Participants are unclear whether they are being informed, consulted, asked to advise, partnered with or included in a decision.
- Forums are dominated by senior or loud voices, particular disciplines or people with established relationships.
- Relevant stakeholders outside the forum do not receive feedback.
- Chair unable to surface alternate views from membership.
- Meeting not established with safe ways of working.

Potential metrics to track success

Process measures

- Evidence the right mix of roles, disciplines, career stages, sites and service settings are involved in the decision or activity.
- Percentage of engagement activities that have a clear purpose and level of influence.
- Percentage of forums or consultations offering more than one way to contribute.
- Evidence that representatives sought broader views before contributing and shared outcomes afterwards.

Outcome and experience measures

- Clinicians report they understood why they were asked to contribute and how input would be used.
- Clinicians report the forum or process felt safe and purposeful.
- Percentage of engagement activities where feedback was collected from participants.

Tools to support practice

- **Inclusive chairing prompts**: supports chairs to create safe purposeful environments, set expectations and capture diverse views.
- **Representation check**: maps who is included across roles, disciplines, sites, career stages and work patterns.
- **Participation role prompt**: clarifies the level of input sought (e.g. advising, decision-making, partnering) and whether people speak as individuals or representatives.
- **Meeting feedback via QR code**: collects end-of-meeting feedback, e.g. access to relevant information, timing, respectful and relevant discussion, different perspectives and questions.

Practical action area 4:

Protected time and reduced low-value burden

Why this matters: Clinician input is an important part of improving care, not an add-on to clinical work. Effective engagement recognises this by valuing clinicians' time, making participation straightforward and reducing unnecessary burden. Here, low-value burden refers to avoidable administrative work, duplicated requests, unnecessary meetings, repeated reporting and communication that is not targeted or useful.

Scenario

A service wants clinical input into a winter strategy affecting patient flow, staffing and workflow. Clinicians have useful insights, but many are working shifts, covering busy services, moving between sites or balancing clinical and non-clinical responsibilities. Before planning another meeting, the manager and clinical lead check where clinicians already come together and what input has already been gathered. They use existing huddles, handovers, department meetings, clinical forums, online communication channels (such as Microsoft Teams channels), or capture written input where possible. When a separate discussion is needed, the purpose, preparation, time commitment and level of influence are clear.

The organiser reduces duplication by acknowledging feedback already provided and showing that clinicians' time is valued. They do not ask people to repeat feedback unless further clarification or input is needed.

They consider protected time for complex, high-risk or high-impact issues and offer realistic contribution options for people who cannot attend.

Desired outcome: clinicians can contribute through existing workflows, understand what is being asked, and see that their time and input are valued and used effectively.

Core behaviour shift

Move from:

"Can you find time to come to a meeting so we can get your input?"

Move to:

"We use existing workflows where possible, make the request clear and respect the time needed to contribute."

What success looks like

Purpose is clear

Requests explain why input is needed, what it will inform and the expected benefit

Existing channels are used

Input is gathered through current forums, workflows or communication channels where possible

Burden reduces

Duplicate requests, long preparation and unnecessary meetings are reduced. Engagement requests are designed to avoid repeated demands on the same clinicians

Time is respected

Time commitment, preparation and contribution options are realistic and valued

Participation improves

More clinicians can contribute because engagement fits how they work

Practical strategies: Creating time and reducing low-value burden

Role	Observable behaviours
Executives and senior leaders	• Set expectations that engagement is purposeful, proportionate and respectful of clinical time • Support protected time where issues are complex, high risk or likely to affect care, workforce or implementation
Managers and meeting/forum chairs	• Use existing huddles, handovers, department meetings, forums or written channels before creating a new meeting • Keep requests short and clear, outlining the purpose, input needed, time required, what can be influenced and how input will be used • Manage meeting time by acknowledging what input has already been captured, clarifying what additional input is needed, and redirecting duplicated discussion, where appropriate
Clinical leaders	• Help identify the easiest way for colleagues to contribute • Advise when a topic needs protected discussion time because it is complex, high risk or affects care delivery; and then make time for it
Clinicians and team members	• Ask what input has already been collected, what additional input is needed, how long it will take and how it will be used • Suggest simpler ways to contribute when requests are duplicated, unclear or difficult to fit into clinical work
Ministry of Health, Pillars and statewide services	• Design statewide requests so they are clear, targeted, proportionate and coordinated through existing networks, where possible • Avoid broad or duplicative requests unless the purpose, audience, influence and feedback route are clear

Prompts for local adaption

Questions to guide improvement

- Is this request necessary, or has input already been gathered?
- Can input be gathered through an existing forum, workflow or channel?
- What information do clinicians need so that their input is useful?
- What duplicated, administrative, reporting or communication burden could be stopped, simplified, combined or redirected?
- Does the topic need protected time because it affects care, safety, workforce or implementation? If yes, how will this time be provided to ensure participation?

Things that can get in the way

- Another meeting is added without checking existing channels.
- Requests are long, unclear, duplicated or disconnected from decisions.
- The same clinicians are repeatedly asked to contribute.
- Meetings or deadlines exclude shift workers, visiting clinicians or distributed teams.
- Time is called 'protected' but is not supported in rosters, workloads or service expectation.

Potential metrics to track success

Process measures

- Number of requests combined, streamlined or redirected through existing forums.
- Percentage of activities that state purpose, time commitment and how input will be used.
- Percentage of activities offering more than one way to contribute.
- Evidence that protected time was considered for high-impact issues.

Outcome and experience measures

- Clinicians report requests are clear, purposeful and proportionate.
- Clinicians report they had realistic time and opportunity to contribute.
- Reduction in duplicated consultation requests.
- Contribution patterns across disciplines, roles, sites and work patterns.

Tools to support practice

- **Protected time decision scale:** helps decide the level of time and support needed for an engagement request.
- **Low-value burden review**: identifies duplicated requests, unnecessary meetings, repeated reporting, administrative tasks or communication that could be stopped, combined, shortened, simplified or redirected.
- **Engagement request template**: clarifies the purpose, input needed, time required, influence and how input will be used.
- **Contribution options checklist**: helps people to choose practical ways to contribute when they cannot attend engagement forums in person.

Practical action area 5:

Enabling clinical leaders and forum chairs

Why this matters: Clinical leaders and forum chairs help turn clinician input into advice, decisions, escalation and timely action. When they are supported with role clarity, practical tools and clear pathways, forums are more purposeful, inclusive and connected to decisions.

Scenario

A clinical forum has the right people involved, but meetings do not always lead to action. Items are discussed, but the purpose is not always clear, i.e. for advice, decision, escalation or follow-up. The chair is new to the role and is expected to manage the conversation, balance views and keep momentum but has limited practical support.

The executive sponsor works with the chair and clinical leaders to strengthen the way meetings are prepared, run and followed up. Agenda items are labelled by purpose. Clinical leaders help frame issues clearly, including the impact, options and decision or advice needed. The chair uses simple prompts to confirm actions, owners, timeframes and escalation points; and is supported to review the terms of reference with the group to ensure it is clear.

After the meeting, actions are tracked and outcomes are shared back through agreed channels. Chairs are supported with orientation, peer learning, close-out prompts and escalation advice for complex issues. Co-chairing, shadowing and planned rotation are used to build capability, share the load and give more clinicians experience leading purposeful engagement.

Desired outcome: chairs and clinical leaders are actively supported to guide respectful, purposeful discussions where people feel able to contribute, diverse perspectives are sought, issues are escalated appropriately, and clinician input informs advice, decisions and timely action,

Core behaviour shift

Move from:	Move to:
"The Chair leads the meeting."	***"The Chair and clinical leaders are supported to turn discussion into action."***

What success looks like

Purpose is clear

Agenda items/ discussions are clear about whether they are for advice, decision, escalation or follow-up

Chairs are supported

Chairs have tools, prompts, advice and feedback to run purposeful meetings

Meetings lead to action

Actions, owners and timeframes are confirmed and followed up

Leadership is shared

Co-chairing and rotation reduce reliance on one person

Capability grows

Shadowing and rotation build confidence to chair or co-chair

Practical strategies: Enabling clinical leaders and forum chairs

Role	Observable behaviours
Executives and senior leaders	• Define what chairs and clinical leaders are expected to do before, during and after forums, including preparation, facilitation, close-out and follow-up • Invest in building capability for forum chairs through orientation, co-chairing, shadowing, peer support and access to advice when discussions are complex • Build in feedback, role refresh and succession planning so chairing capability is sustained over time
Managers and meeting/forum chairs	• Prepare agenda items with a clear role for the forum: shape, test, advise, decide, endorse or escalate • Use chairing prompts to manage time, invite contribution, summarise the discussion and confirm what has been agreed
Clinical leaders	• Help chairs shape clinical issues into workable discussion items, with the context, options and advice needed • Support new or rotating chairs by co-chairing, shadowing, debriefing and sharing practical facilitation tips
Clinicians and team members	• Help chairs understand what support would make forum participation easier, clearer and more useful • Take up opportunities to co-chair, shadow or lead a small agenda item to build confidence over time
Ministry of Health, Pillars and statewide services	• Design statewide requests so forum chairs receive concise facilitation notes, decision context and suggested discussion questions • Offer reusable chairing tools, briefing prompts and debrief questions that can be adapted by local forums and networks • Provide resources to support chair onboarding; access to development opportunities; and practical guidance that local forums and networks can adapt

Prompts for local adaption

Questions to guide improvement

- Are the terms of reference for the forum aligned with the understood purpose of the group?
- What support do forum chairs need, before, during and after meetings?
- Are agenda items clear about whether they are for information, advice, decision or escalation?
- How are actions, owners and timeframes confirmed and tracked?
- How are co-chairing, shadowing or rotation used to build capability and share the load?
- What escalation advice is available when issues are complex or cross boundaries?

Things that can get in the way

- Chairs are expected to lead complex discussions without orientation, tools or support.
- The purpose and desired outcome of agenda items isn't clear.
- Actions are discussed but not assigned to an owner or given a timeframe.
- Leadership relies on one person rather than shared roles, co-chairing or planned rotation.
- Escalation pathways are unclear when issues need support beyond the forum.

Potential metrics to track success

Process measures

- Percentage of agenda items labelled by purpose.
- Percentage of meetings using close-out prompts to confirm actions, owners and timeframes.
- Number of chairs or co-chairs supported through orientation, shadowing or peer learning.
- Evidence that co-chairing or rotation arrangements are in place.

Outcome and experience measures

- Chair and clinical leaders report they understand their role and feel supported.
- Increased number of people who volunteer or feel confident to chair or co-chair; understand their role and know how succession will be supported.
- Clinicians report meetings are purposeful and lead to clear action.

Tools to support practice

- **Chair role guide**: clarifies the chair's role before, during and after meetings.
- **Labels for agenda items**: items are labelled as information, consultation, advice, decision or escalation.
- **Meeting close-out prompt**: confirms decisions, actions, owners, timeframes, escalation and feedback routes.
- **Co-chairing, shadowing and succession plan**: orientation, buddying or mentoring to support shared leadership, planned rotation and capability building.

Practical action area 6:

System communication and coordination

Why this matters: Coordinated communication helps clinicians quickly see what matters, what needs action, what has changed and where to go next. When messages are targeted, clearly labelled and sequenced, clinicians and managers can respond more easily, reduce duplication and stay focused on patient care and service priorities.

Scenario

A service needs to share multiple updates to clinicians. Previously, these were sent separately through emails, meeting papers, online communication channels (such as Microsoft Teams channels) and newsletters. This created scattered messages and missed information. The service sets up a simple coordinated process led by the most appropriate person or team. This may be a communications team, project team, manager, clinical lead or nominated coordinator, depending on the setting and the type of update.

The format is agreed upfront and kept proportionate to the need. Clinicians and managers can submit items through a short template, then related updates are brought together in a regular update, such as a short email digest, Microsoft Teams post, manager briefing note, huddle talking points or newsletter that clinicians know to expect. The digest uses clear headings and plain language, and is quick, engaging and easy to scan.

Each item is labelled by purpose and shows the audience, action, timeframe and contact point. Content is adaptable for different audiences, such as manager briefing notes, huddle talking points, email, Teams posts or quick references. Clinicians get a predictable place to find the right message, in the format that works best for them.

Desired outcome: communication is coordinated, streamlined and easy to navigate. Clinicians know where to look for key updates; they can quickly identify what requires action; and are less likely to experience information overload or miss important messages.

Core behaviour shift

Move from:

"We send lots of updates to keep people informed."

Move to:

"We coordinate messaging, so the right people get the right message, in the right way, at the right time."

What success looks like

Messages are clearly labelled

Clinicians can see whether a message needs action, awareness, feedback or escalation

The right audience is reached

Messages reach the right people through the right channel at the right time

Duplication is reduced

Similar updates are combined, shortened or coordinated before they reach clinicians

Local relevance is clear

Managers and clinical leaders can explain what a system or organisational message means for local teams

Information is easier to act on

Clinicians know what changed, what to do and where to go for more detail

Practical strategies: Reducing communication noise

Role	Observable behaviours
Executives and senior leaders	• Set expectations that communication is coordinated, targeted and clear about action, awareness, consultation or implementation updates • Support teams to combine, sequence or stop messages when requests are duplicated or competing
Communications team or nominated communications lead and project teams	• Coordinate communications digest via the agreed channel, combining, sequencing or stopping updates to reduce duplication • Make it easy to submit items using a short template that captures audience, purpose, action, timeframe and contact point
Managers, meeting/forum chairs and clinical leaders	• Identify what needs local action, discussion, escalation or reinforcement before sending another message or adding to an agenda • Use existing forums, huddles, newsletters, Teams channels or other methods to explain what messages mean for local teams, so all relevant clinicians get the messages they need
Clinicians and team members	• Ask what action is needed when a message is unclear • Flag duplicated, confusing or missing local information
Ministry of Health, Pillars and statewide services	• Look for ways to consolidate messages from central agencies, Pillars and statewide programs before they are sent out to local teams • Provide short message packs that state the audience, action, timeframe, local implications and contact point for statewide initiatives

Prompts for local adaption

Questions to guide improvement

- What does the message need clinicians to know, do or decide?
- Who is the primary audience, and who only needs awareness?
- Can this be combined with another update or sent through an existing trusted channel?
- What local meaning needs to be added so clinicians know what has changed?
- How will urgent, high-risk or time-critical information stand out from general updates?

Things that can get in the way

- Messages are sent because information exists, not because the audience or action is clear.
- Several teams send similar updates through different channels.
- Action requests, consultation requests and general updates look the same.
- System messages are not translated into local workflow, role or service implications.
- Important information is buried in long emails, attachments or meeting papers.

Potential metrics to track success

Process measures

- Percentage of messages labelled by purpose and audience.
- Number of updates combined, shortened or redirected through existing channels.
- Percentage of action requests that include audience, action, timeframe and contact point.

Outcome and experience measures

- Clinicians report communication is clear, relevant, and easy to understand and act upon.
- Reduction in duplicated or competing communication requests.
- Managers report they can translate system messages into local action.

Tools to support practice

- **Message purpose label**: labels messages as action required, for awareness, consultation, decision made or implementation update.
- **Local message checklist**: checks whether local impact, audience, action, timing and support are clear.
- **Communication coordination checklist**: checks whether updates can be combined, sequenced, shortened or stopped.
- **Audience and channel checklist**: supports decisions about who needs the message and which channel is most useful.

Practical action area 7:

Implementation support for agreed priorities

Why this matters: Implementation support helps turn agreed priorities into practical change. It ensures teams have the time, capability, coordination, sponsorship and information they need to deliver the work and manage barriers as they arise.

Scenario

A group of clinicians participate in a service redesign initiative and several solutions for implementation are agreed. Clinicians can see their input influenced the direction, but it is not yet clear how the priorities will be delivered. Teams are unsure where to start, who owns the work, what support is available, what capability is needed and how progress will be reviewed.

The project team uses an existing project, redesign or improvement structure to move from agreement to delivery. Clinicians, manager, project or improvement staff and sponsors work together to confirm priorities, identify ownership, clarify governance, agree roles and responsibilities, and determine what practical support is needed. This may include project coordination, improvement support, data analysis, communications support, clinical time, coaching, training or access to relevant subject matter expertise.

Implementation risks are identified early and escalated through the appropriate sponsor, manager or governance pathway. Progress updates are built into existing meetings and reporting arrangements, where possible, so implementation does not become a separate reporting burden. Clinical leaders are supported to identify barriers, test solutions, escalate issues and share practical lessons as implementation progresses.

Desired outcome: teams have the support they need to turn agreed priorities into practical change. People are clear about what needs to happen next, who is leading the work, what help is available, and how barriers will be addressed along the way.

Core behaviour shift

Move from:	Move to:
"The decision has been made, now it needs to happen."	***"The decision has been made, and people are supported to make it happen."***

What success looks like

Priorities move to action

Agreed priorities become actions, not recommendations that sit on a list

Ownership and support are clear

Sponsors, roles, timeframes and practical support needs are agreed early

Teams are supported to deliver

Teams have the practical support they need to deliver change initiatives

Barriers are managed

Risks, dependencies and resource issues are identified early and actively managed

Progress is visible

Clinicians can see how decisions are being translated into practice

Practical strategies: Supporting implementation

Role	Observable behaviours
Executives and senior leaders	• Confirm priorities, sponsorship, resourcing and decision authority so agreed actions can move into implementation • Remove barriers early, including unclear ownership, competing priorities, missing capability or resource constraints
Project teams	• Turn priorities into an implementation plan with owners, milestones, risks, dependencies, readiness checks and measures • Use small tests of change, implementation check-ins and visible progress updates to identify barriers and maintain momentum
Managers, meeting/forum chairs and clinical leaders	• Break agreed priorities into practical local actions that fit workflows, roles, available resources and service pressures • Share progress, barriers, decisions and lessons learnt through existing forums so clinicians can see what is changing
Clinicians and team members	• Advise what will make implementation easier, safer and more sustainable, including workflow, patient care and workforce impacts • Test, refine and give feedback on whether changes are practical, useful and working as intended in day-to-day care
Ministry of Health, Pillars and statewide services	• Provide practical support, such as guidance, tools, coaching, improvement expertise, implementation advice or communities of practice • Keep reporting fit-for-purpose, using it to support learning and remove barriers to implementation, not to create unnecessary burden

Prompts for local adaption

Questions to guide improvement

- Which actions are the highest priority?
- Who owns delivery and who supports it?
- What barriers, dependencies or resources need attention?
- What capability, coaching or tools are needed?
- How will progress and learning be shared?

Things that can get in the way

- Too many priorities are pursued at once.
- Asking people to take on something new without stopping something else.
- Ownership, resources or timeframes are unclear.
- Implementation capability is assumed, not built.
- Progress is not visible to clinicians.
- Reporting becomes more important than delivery or learning.

Potential metrics to track success

Process measures

- Percentage of actions with owner and timeframe.
- Percentage of milestones achieved.
- Number of barriers identified and resolved.

Outcome and experience measures

- Clinicians report implementation support is useful.
- Evidence of sustained adoption over time.
- Improvement in relevant clinical, operational or workforce measures.

Tools to support practice

- **Project implementation plan**: helps teams define objectives, ownership, risks, dependencies and success measures before implementation begins.
- **Readiness checklist**: checks whether the people, systems, resources and processes for implementation are in place.
- **Implementation tracker**: tracks milestones, owners, status and issues requiring escalation.
- **Lessons learnt template**: captures practical insights, what worked, barriers and improvements that can inform future work.

Practical action area 8:

Peer learning and shared practice

Why this matters: Peer learning helps clinicians find relevant examples, understand what made them work and apply the learning in their own context. It creates practical ways to share what works, connect people facing similar challenges and spread improvement across teams, sites and services.

Scenario

A clinical team develops an effective approach to improving communication during care transitions. The change leads to better coordination of care and fewer avoidable delays. The team documents the problem they were trying to solve; the approach they tested; what they learnt; the challenges they faced; and what they would do differently next time. The example is then discussed through a clinical network, community of practice or existing forum where other services can consider whether the approach might help address similar issues in their own context.

The focus is on learning rather than promoting a perfect solution. Teams are encouraged to share successes, challenges and lessons learnt so others can adapt and improve rather than start from scratch.

Desired outcome: lessons learnt are captured, shared, discussed and used rather than remaining isolated within one team or service.

Core behaviour shift

Move from:	Move to:
"Our team solved this problem."	***"Our team learnt something that others might be able to adapt."***

What success looks like

Examples are visible	Learning is practical	People adapt, not copy	Networks connect teams	Improvement spreads
Useful practice examples and tools are easier to find across services and networks	Teams share what worked, what did not and what they would do differently	Shared examples are tested and tailored to local context	Communities of practice and forums support exchange and problem-solving	Teams build on existing learning instead of starting from scratch

Practical strategies: Sharing what works

Role	Observable behaviours
Executives and senior leaders	• Create opportunities for teams to share practical examples, challenges and lessons learnt across organisational boundaries • Recognise learning, collaboration and adaptation; not only successful outcomes
Managers and meeting/forum chairs	• Build time into existing meetings, forums or networks for teams to share examples and lessons learnt • Prompt discussion about what others could adapt, rather than what they should copy or reproduce
Clinical leaders	• Share practical experience, including what worked, what did not and what was learnt • Connect services facing similar challenges and support others to adapt examples locally
Clinicians and team members	• Contribute examples from the point of care, including improvements, challenges and practical insights • Seek out ideas from other teams before developing a new solution from scratch
Ministry of Health, Pillars and statewide services	• Make it easy for services to find relevant case studies, tools, templates and lessons learnt • Create cross-boundary opportunities for peer learning, adaptation and knowledge sharing

Prompts for local adaption

Questions to guide improvement

- What useful examples already exist locally?
- What information would help another team adapt the example?
- What networks, forums or communities of practice could support shared learning?
- How can smaller sites and under-represented services contribute?
- How will people know examples are available and easy to use?

Things that can get in the way

- Examples remain local and are not shared.
- Successes are shared but challenges and lessons learnt are not.
- Teams copy solutions without adapting them to context.
- Practical implementation details are not captured.
- Sharing becomes a reporting exercise rather than a learning opportunity.

Potential metrics to track success

Process measures

- Number of examples, case studies or lessons learnt shared.
- Participation in peer learning activities, networks or communities of practice.
- Diversity of contributing services, disciplines and sites.

Outcome and experience measures

- Clinicians report examples are useful, relevant and easy to find.
- Number of teams adapting examples from other services.
- Evidence that shared learning informed local decisions or implementation.

Tools to support practice

- **Good practice summary template**: provides a simple structure to capture the issue, approach, lessons learnt, outcomes and advice for others.
- **Peer learning discussion guide**: structures conversations about challenges, adaptation and practical application.
- **Recurring issue tracker**: helps identify common issues being raised across multiple teams, services or sites; and opportunities to share solutions.
- **Adaptation planning tool**: helps teams assess whether a shared example fits their context and what changes may be needed to adapt before implementation.

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