NSW Health

Shaping the System Together – Clinician Engagement

Recommendation report

August 2026

Contents

Use of AI: Generative AI tools approved by NSW Health were used to support the preparation of this report. No confidential, personal, health or non-public information was provided to public AI platforms. All outputs were reviewed and validated by the authors, who retain full responsibility for the report's content, findings and recommendations.

Secretary's message

Meaningful clinical engagement is central to NSW Health's ongoing ability to provide safe, high-quality care to the many, diverse communities we serve across the state.

When our clinicians contribute their valuable insights, expertise and experience, we make better policy and operational decisions, strengthen patient safety, enhance care, and build greater trust with the people of NSW.

I am fortunate to meet and speak with our clinicians every day, whether it is in meetings, during chats in my regular visits to our great hospitals and health services around NSW, or in one-on-one conversations about issues or concerns.

Our highly skilled clinicians not only have valuable insights, expertise and experience to offer, but they are also hugely committed, compassionate and driven by a shared purpose to give the many people they care for the very best experiences and health outcomes.

Ensuring clinicians can shape patient care, service delivery, and the sustainability of our system is a key priority for NSW Health, and why we undertook this work. We listened directly to our clinicians around the state about opportunities, barriers, and how we can strengthen clinician engagement in the context of the daily realities – and pressures – of working in our public health system.

This report reflects what more than 1,700 clinicians, managers and leaders have told us about their experience of engaging in, and influencing, the decisions that matter for them and the people they care for. On a positive note, we heard that across NSW Health, there are strong foundations already in place and there were many examples where engagement is meaningful and effective, where forums are purposeful, leadership is visible, and clinicians feel genuinely heard and able to influence decisions.

At the same time, we heard many examples where we need to do better. Clinicians told us that engagement is not always experienced consistently across the system. At times, it is unclear where decisions sit, how to escalate issues, or what happens after concerns are raised.

Our focus now is to build on what is already working well, provide greater clarity on decision-making and escalation pathways, and strengthen feedback so clinicians can see how their input contributes to decisions and action.

This is about taking what we have heard and using it to create a more consistent and meaningful approach to clinical engagement, providing an environment where all staff feel safe and supported to speak up and ensuring their valuable input leads to genuine consideration and action.

I would like to acknowledge the many individuals and organisations who have contributed to this initiative. Thank you to Dr Nhi Nguyen and Ellen Rawstron for their leadership; other members of the ACI and Ministry project teams; the Health System Advisory Council; and the many consumers, clinicians, managers and health service partners who generously shared their expertise, experience and insights.

We will use what you have told us to ensure your insights, expertise and experience are at the heart of how we strengthen our health system and continue to enhance care for patients and communities across NSW.

Susan Pearce AM
Secretary, NSW Health

At a glance

Shaping the System Together explores how clinician engagement works across NSW Health — what's working, what's challenging, and the next steps to strengthen and sustain engagement to improve experiences of working in the NSW Health system.

Understanding clinician engagement across NSW Health

Consultation with 1,700+ participants across NSW local health districts (LHDs), specialty health networks (SHNs), Pillars and statewide health organisations.

Key themes from what they told us

1. **How engagement structures are used in practice**
2. **When engagement leads to action**
3. **Feeling safe to speak up**
4. **Alignment between authority and accountability**
5. **Workforce wellbeing under sustained pressure**

Areas for action and improvement

1. **Local reflection and improvement planning**
2. **Using evidence to prioritise action**
3. **System stewardship, strategic alignment and integration with existing initiatives**

Executive summary

This report outlines the findings and recommendations from the statewide consultation for the 'Shaping the System Together – Clinician Engagement' initiative. It explores how clinicians experience being heard across NSW Health, and how formal and informal engagement structures support their contributions to decisions affecting patient care, service delivery and workforce sustainability.

Insights from managers and leaders provide additional context on how these structures function in practice and what supports or constrains their effectiveness.

Overall, the initiative aims to identify what drives effective engagement, what gets in the way, and how routine engagement can be more consistently supported to improve the experience of working across NSW Health.

The consultation involved more than 1,700 participants across NSW LHDs, SHNs, Pillars and statewide health organisations, and identified five key themes that were consistently observed across metropolitan, regional, rural and remote settings.

What clinicians told us

Clinicians consistently expressed a strong desire to be involved and contribute to decisions affecting patient care, service delivery and system sustainability. There are high levels of professionalism and goodwill, including a willingness to raise concerns, risks and ideas through appropriate channels, despite heavy clinical workloads and sustained operational pressure.

Participants said the system has strong foundations to build on. Where engagement forums are clearly scoped, well chaired, connected to decision-makers and supported by visible leadership, engagement is constructive, collegial and worthwhile. Professional escalation pathways and discipline-based networks are also valued where they complement line management and enable advice, support and influence beyond local settings.

When these conditions are aligned, engagement leads to learning and action. However, key challenges were identified where there is variation in:

- how engagement mechanisms are supported
- how clearly authority and delegation are defined
- how reliably feedback is provided after issues are raised.

Where this occurs, participants said they rely on local workarounds and additional individual effort to manage immediate pressures. Some clinicians described frustration with engagement processes and chose to withdraw, highlighting the importance of their input being heard and acted upon.

Clinical managers consistently play a critical role in engagement. Where managers are supported with clear authority, access to capability development and consistent support from the executive, engagement is more effective and sustainable. In these settings, managers translate frontline concerns upward, contextualise system decisions locally, and sustain both formal and informal escalation pathways.

The experiences shared through this initiative demonstrate that NSW Health already has the capability to support meaningful clinician engagement.

Examples across NSW Health, including effective medical staff councils and clinical councils, strong local leadership practice, and clinician engagement during the COVID-19 response, demonstrate what is possible when purpose, authority, protected time and timely follow-through are aligned. These examples highlight the need to strengthen support for existing engagement arrangements, rather than creating new ones.

Key themes

Five themes emerged from what participants told us:

1. **How engagement structures are used in practice**
2. **When engagement leads to action**
3. **Feeling safe to speak up**
4. **Alignment between authority and accountability**
5. **Workforce wellbeing under sustained pressure**

Secondary themes describe the underlying system conditions that help explain why similar patterns occur across settings.

The consultation findings are consistent with available evidence. Both emphasise the role of leadership, communication and workforce conditions in supporting meaningful and sustainable clinician engagement.

Findings and next steps

There is an opportunity to build on what already works to support sustainable clinician engagement across NSW Health, aligned with key initiatives such as People Matter Employee Survey (PMES) action planning, Future Health, the Shared Understanding Project and Time for Care initiative.

In particular, strengthening support for existing engagement arrangements as core business, with more consistent decision-making, feedback, protected time, implementation support and leadership capability.

The recommendations, practical actions and next steps in this report translate these insights into coordinated priorities with clear ownership and accountability. Together, they aim to strengthen how clinician engagement is routinely supported, enabled and followed through across NSW Health.

Introduction

The 'Shaping the System Together: Clinician Engagement' initiative explores how clinicians, managers and leaders across NSW Health experience engagement, and how current mechanisms support or inhibit their ability to influence decisions affecting patient care, service delivery and workforce sustainability.

Meaningful clinician engagement is a critical enabler of safe, high quality and sustainable care. Its impact depends on intent, as well as the conditions, structures and behaviours that help staff feel safe to speak up and know their input is heard and acted on.

Background

This initiative is undertaken in the context of current and emerging NSW Health work focused on clinician engagement, workforce experience and wellbeing. It complements these efforts by examining how engagement structures and processes function in practice.

The initiative considers formal mechanisms, such as clinical councils, medical staff councils, escalation pathways and briefing processes, alongside informal relationships and workarounds that people use when formal pathways don't work as intended. Together, these provide a clearer picture of how engagement operates in practice across NSW Health.

The work is undertaken under terms of reference approved through the Secretary, in consultation with Ministry Executive and the Senior Executive Forum. As such, it does not assess individual performance or propose new governance arrangements; it uses lived experience to illuminate system-level patterns.

The initiative was facilitated by Dr Nhi Nguyen, Clinical Co-Chair, Health System Advisory Council. Other clinical members of the Council also facilitated sessions and site visits. The project and site visits were supported and attended by members of the Agency for Clinical Innovation, Clinical and Innovation and Research Division and the Workforce Planning and Talent Development Branch, People, Culture and Governance Division.

Alignment with PMES

PMES findings have consistently identified issues of trust, voice, leadership visibility, wellbeing and workload across NSW Health, as well as concerns about how survey results are actioned.

The consultation approach for this initiative drew upon PMES findings to add qualitative depth by exploring why these issues persist and how system design, authority and feedback mechanisms shape daily experiences across different roles and settings.

Strategic alignment

The findings align with existing NSW Health priorities, including Future Health and the Time for Care Project. They also complement the Shared Understanding Project, particularly its focus on trust, transparency, communication and more consistent approaches to engagement across the system. Recommendations are framed to reinforce, rather than duplicate, these existing programs of work.

How to read this report

This report is structured as a narrative, grounded in lived experience. It begins with the story clinicians and managers told through facilitated discussion, before examining the structures and system conditions that help or hinder that experience.

The five core themes describe what engagement feels like in practice, why particular patterns persist, and how people adapt when formal systems do not function as intended. The report focuses on strengthening how existing structures are supported, led and connected to action. Secondary themes provide further context.

Note: in this report:

- *'Managers' refers to site and district-level managers without a direct reporting line to the chief executive.*
- *'Leaders' is used broadly to include senior clinicians, executives and others with formal leadership responsibilities.*

Evidence review

Evidence on clinician engagement

A rapid scan of systematic reviews (2015–2025)[1], alongside targeted searches on clinical engagement, found the evidence is fragmented, terminology is inconsistent, and there are relatively few strong empirical studies.

Across the available literature, stronger clinical engagement is associated with improved patient safety outcomes, stronger organisational culture and other features commonly seen in high-performing healthcare systems.

Enabling elements that are well cited include:

- inclusive leadership
- meaningful clinician involvement in organisational and system decision-making
- open, transparent communication, supported by professional development and peer support.

The literature also describes structural mechanisms used across jurisdictions, such as councils or senates, networks and advisory groups. It highlights the need for clear connection between local and system forums through:

- two-way representation
- clear reporting and feedback loops
- clear escalation pathways, including thresholds and routine review and refinement.

Evidence on clinician workforce wellbeing

Concurrent to this initiative, a rapid review synthesised contemporary international evidence on interventions and strategies to improve staff wellbeing in healthcare organisations.[2] The review searched multiple academic databases for studies published from 2010 to February 2026 and focused on evidence from high-income countries with health systems comparable to Australia.

Evidence on workforce wellbeing is integrated into this analysis to support interpretation of the findings. This is because it consistently links conditions of work to clinicians' capacity to engage in improvement and decision-making.

A key finding is that wellbeing is strongly shaped by conditions of work, including workload, workflow, administrative burden, and fatigue-related factors. Sustained improvement is unlikely to be achieved through individual approaches alone.

The available evidence also suggests that effective clinician engagement is enabled by leadership, clarity and communication, and that sustaining engagement over time depends on work conditions that support workforce capacity and wellbeing.

Methods and approach

This initiative has prioritised listening to lived experience and understanding how engagement structures operate in practice, rather than evaluating individual performance or compliance.

The consultation approach was clinician-led and peer facilitated. It was undertaken in partnership with the Workforce Planning and Talent Development Branch to support a system-wide understanding of how clinical engagement is experienced in practice.

Overview

This report draws on a statewide consultation undertaken between November 2025 and May 2026. The approach combined site-based facilitated discussions with clinicians and local managers, tailored consultation with Pillars and statewide organisations, and targeted follow-up sessions to test and refine emerging themes in selected statewide and specialty network settings.

It aimed to:

- capture the experiences of clinicians, managers and leaders with existing engagement structures and practices
- understand how formal and informal engagement mechanisms operate in practice
- identify cross-cutting system themes alongside local variation.

Across all settings, the approach prioritised listening, reflection and learning from lived experience.

The focus was on understanding how engagement is experienced day-to-day, including what supports it to work well and what limits its effectiveness.

Given the scale of the work and the timeframe available, a rapid but rigorous qualitative approach was used. This enabled large volumes of feedback to be gathered and analysed across multiple sites and teams, while maintaining consistency through shared sense-making, comparison of findings and system-level synthesis.

Data sources

- Site-based listening sessions conducted across LHDs and SHNs.
- Tailored one-hour consultation sessions with Pillar organisations and statewide organisations,
- Review and confirmation of existing formal clinical engagement structures, including those established under the Model By-laws.
- Examples of local engagement practices and approaches identified during sessions.

All data were de-identified before analysis and reporting to protect participant confidentiality.

These sources were used to build an understanding of the formal engagement landscape, as well as the informal ways engagement occurs in practice across different organisational and geographic contexts.

Consultation approach

Sessions were designed to support open, respectful discussion and to capture lived experience of local structures in practice. They were facilitated in a conversational manner, focused on enabling participants to speak candidly about what works well and what limits engagement.

Site-based sessions were tailored to local context and availability of participants, while using consistent framing of questions to support comparison across sites.

Site-based consultations typically included:

- pre-briefings with chief executives and their nominated executives
- facilitated discussions with participants from formal engagement structures
- sessions focused on how clinicians experience informal engagement pathways
- debrief sessions with chief executives to share what had been heard through the facilitated discussions, including key themes, highlights and immediate issues for local consideration and resolution.

In parallel, tailored consultations were undertaken with Pillar agencies and statewide organisations in recognition of their system-wide roles. These sessions focused on system intent, governance arrangements and constraints. They provided context for interpreting the experiences shared by clinicians and managers across sites.

Analysis and synthesis

Data were captured through facilitator and scribe notes, alongside comparison of formal engagement structures, informal practices and lived experience across sites and settings.

Qualitative data were analysed using an iterative thematic synthesis approach. Notes from each engagement session were reviewed sequentially, with recurring issues and patterns identified and progressively grouped into themes. Themes were refined as additional sessions were analysed.

Illustrative examples and direct quotes were captured to ensure the findings accurately reflect participants' experiences and language.

Many participants appreciated the opportunity to share their experiences openly and to be heard in a safe space.

For the purposes of this report, findings were organised into:

- **core themes** describing how clinician engagement is experienced in practice
- **secondary themes** describing the underlying system conditions that shape those experiences across settings.

Limitations

The findings in this report should be interpreted, while considering the following limitations:

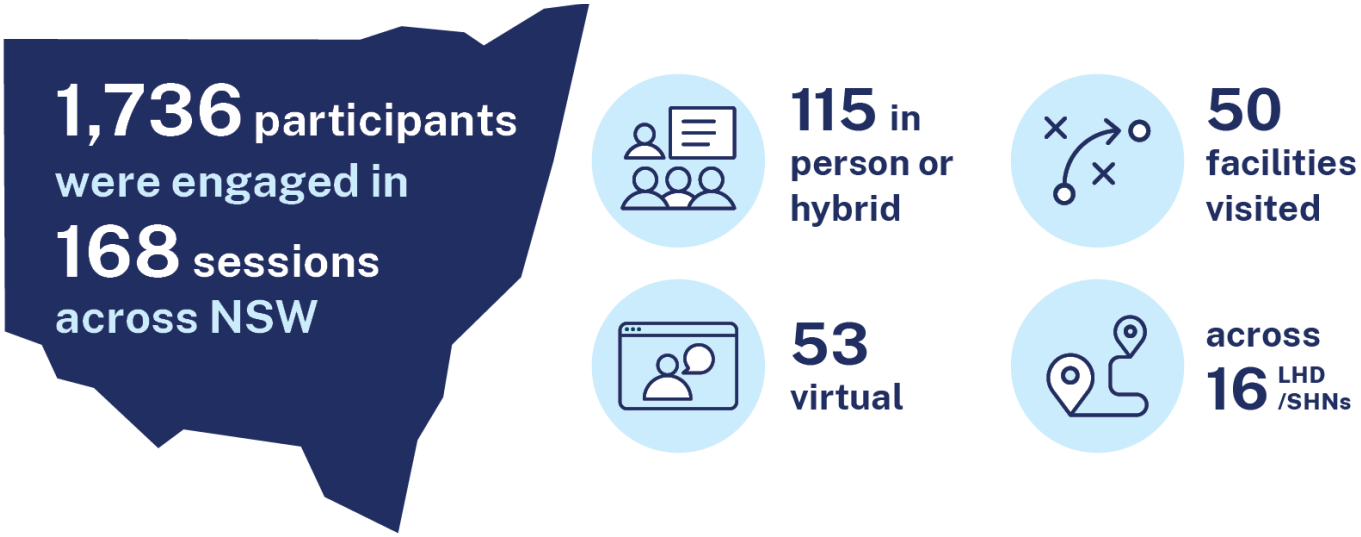
- The work was conducted within a compressed timeframe, with activities occurring alongside significant operational pressures across the system. However, more than 1,700 people participated in the consultation.
- Participation was influenced by clinician availability, competing priorities and local circumstances.
- The scale and complexity of the NSW Health system shaped what was feasible within the timeframe of this work. Consultation occurred across a very large and geographically dispersed workforce, including 24-hour services and shift-based roles, which influenced who could participate and when consultation could occur.
- This report captures how clinicians, managers and leaders described their experiences of engagement. These perspectives provide valuable insight into system functioning but are not used to test, verify or determine individual claims.
- While every effort was made to capture a wide range of perspectives, it was not possible to consult all NSW Health facilities, clinical disciplines or engagement forums that are within scope.
- While managers and senior clinical leaders participated in sessions, they were not routinely targeted as a collective group. As such, the perspectives from roles such as general managers, directors of medical services and directors of nursing were not directly sourced and may be less represented than those of frontline clinicians and local managers.
- The information captured was at a point in time and reflects participants' current views.

Despite these limitations, the consistency of themes across multiple sites, disciplines and settings provides confidence in the system-level patterns identified.

Consultation landscape

Consultation for the Shaping the System Together initiative reflected a broad cross-section of the NSW Health system. This summary outlines who participated, where consultation occurred, and the settings in which clinicians raise issues, share ideas and seek to influence decisions.

Figure 1: Clinician participation in the Shaping the System Together consultation



Participation overview

Clinicians, clinical leaders, unit and department managers from metropolitan, regional, rural and remote settings participated through facilitated group discussions. These were delivered via in-person, virtual and hybrid sessions during site visits and planned engagements.

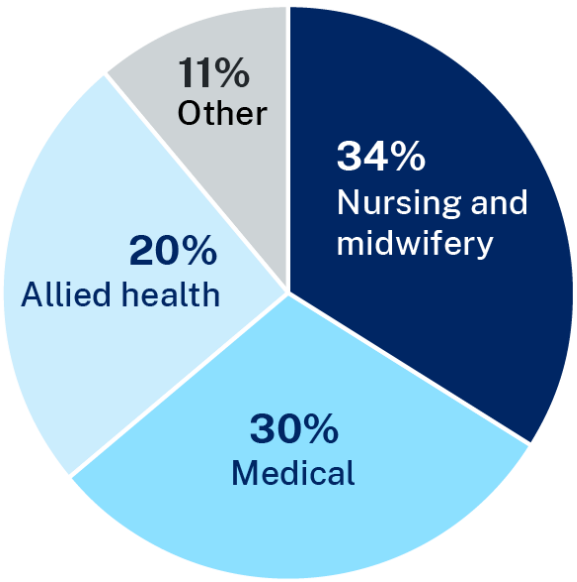
Participants included the following:

- Medical staff (including specialists, junior medical staff and general practitioners)
- Nurses and midwives
- Allied health clinicians
- Aboriginal Health Workers and Aboriginal Health Practitioners
- Senior clinical leaders and managers

While consultation primarily included clinicians from the medical, nursing and allied health professions, not all participants had a clinical background, and not all clinicians identified with these categories.

This involved individuals who regularly participate in formal governance forums, such as councils and committees, as well as those whose engagement with decision makers is more informal or ad hoc.

Figure 2: Participants, by role type



Where possible, sessions also included clinicians who were not actively involved in existing structures. This aimed to capture a broader range of perspectives across disciplines, employment models and roles on how engagement is experienced and accessed.

Participation varied depending on the local workforce mix, service arrangements, timing and how sessions were organised in each setting.

There were common themes across sites and disciplines, irrespective of the service size, geography and organisational context. This provides confidence that the themes explored in this report reflect system-level dynamics, rather than isolated local experience.

Pillar and statewide organisation perspectives

Two sessions were held with the following NSW Health organisations to provide system context on intent, constraints and observations about clinician engagement:

- Agency for Clinical Innovation
- Clinical Excellence Commission
- Bureau of Health Information
- Cancer Institute NSW
- Health Education Training Institute
- HealthShare NSW
- eHealth NSW

Key points highlighted by this group:

- Engagement is most effective when it is purposeful, time-limited and clearly linked to outcomes. It must include timely feedback to clinicians on how their input was used, respecting their time and expertise.
- Capacity and system "noise" were described as constraints, particularly where clinicians are engaged repeatedly by multiple parts of the system.
- There is value in leveraging and refreshing existing networks and trusted intermediaries, rather than creating new structures.
- Clearer delegations can reduce bottlenecks and engagement fatigue.
- Clinician-led approaches, such as those used during the COVID-19 response, are good examples of what can be achieved when purpose, authority and feedback are aligned.

Statewide health services, including NSW Ambulance, NSW Health Pathology and Justice Health Forensic and Mental Health Network, as well as St Vincent's Health Network, helped to test the core themes and described similar patterns in how engagement is experienced.

They reinforced that engagement within these models relies on:

- deliberately supported networks
- structured operational touchpoints
- prioritised communication
- visible feedback.

This reinforces how the core themes apply across different contexts, while the supporting conditions may need to be adapted to size and spread.

Engagement across organisations and settings

Participants described engaging at multiple levels of the system, including unit, facility, district, network and statewide forums. Engagement patterns differ by setting and role.

- **In smaller or rural services**, participants described closer day-to-day access to local decision-makers but note challenges escalating issues beyond the local level.
- **In larger metropolitan or networked services**, engagement is often more structured but described as further removed from decision authority.

Across all settings, engagement was shaped by workload, clinical demand and available time.

Participants noted that attending formal forums often competes with clinical and managerial responsibilities. This influences who can attend consistently and whose voices are most often represented.

Informal engagement plays an important complementary role, particularly where formal processes are less accessible or slower to respond. The following section describes the operating context and governance structures in which these engagement patterns occur.

Current state

Operating context and clinical engagement structures

This section describes the environment and structures within which clinical engagement occurs across NSW Health. It aims to provide context for the findings that follow, rather than assess effectiveness or performance.

Operating context

Clinical engagement across NSW Health takes place within a large, complex and diverse health service delivery environment. Participants consistently described engagement occurring alongside sustained operational pressure. This includes workforce shortages and turnover, increasing patient complexity, competing service demands, and heightened performance and financial constraints.

These pressures affect clinicians' capacity to engage and how engagement structures are experienced. Availability, clinical load and cognitive demand influences:

- who can attend forums consistently
- how prepared participants are to contribute
- how engagement is prioritised alongside clinical and managerial responsibilities.

As one participant described, *"All some people can focus on is showing up and doing the job"*.

Clinical engagement by location

Participants described distinct operating environments across metropolitan, regional, rural and remote settings; each influencing how clinical engagement is structured and experienced in practice. While formal engagement frameworks were broadly consistent across the system, day-to-day practice varies depending on service scale, workforce configuration, geography and proximity to decision-makers.

Clinical engagement structures under the Model By-laws

The Model By-laws provide a consistent framework for clinical governance and engagement across NSW Health. They mandate a range of formal structures, including clinical councils, medical staff councils and other advisory and governance forums. This supports transparent and credible pathways for clinicians to raise concerns, contribute to decision-making and influence service quality and safety.

Participants generally viewed these structures as important and necessary. Their presence was not questioned; rather, participants focused on how they operate and are supported in practice.

However, participants described variation in how these structures operate in practice.

In some settings, participants said clinical councils and medical staff councils function effectively, particularly where purpose, membership and escalation pathways are clear and supported.

In other settings, councils were described as operating primarily as information-sharing forums, without sufficient opportunity for discussion, influence or escalation.

Participants described the following challenges:

- Difficulty achieving quorum.
- Limited continuity of membership.
- Councils becoming procedural or compliance-focused, rather than serving as active forums for decision-making and influence.

Participants referred to the role of statewide medical staff executive councils as part of the broader engagement landscape. However, awareness of, and connection to, these structures vary. These differences are understood to reflect local context, scale and resourcing, rather than the intent of the Model By-laws themselves.

Thematic findings

Clinician perspectives

Consultation for the 'Shaping the System Together' initiative identified a set of interconnected themes that describe how clinicians experience engagement, decision-making and leadership across the system. These themes highlight where current structures and behaviours support meaningful engagement, and where conditions vary and system pressures limit consistency.

Overview

The findings illustrate that engagement is not experienced as a single process or forum, but as a series of everyday interactions shaped by leadership behaviour, authority, trust, follow-through and local context. Where these conditions are aligned, engagement supports shared understanding, timely action and collective problem-solving. Where they are less aligned, pressure is more likely to be absorbed locally through workarounds, caution and reliance on individual effort.

Throughout this report, engagement, communication, collaboration, improvement and leadership activities are recognised as integral components of clinical practice and patient care, rather than tasks separate from core clinical work.

The following core themes describe these dynamics; from how engagement structures are used, through to the conditions that influence them and the impact on workforce sustainability. Across the themes, participants' experiences reflect both formal structures and processes, and the local norms and behaviours that shape how decisions are made and how safe it feels to engage.

Theme 1: How engagement structures are used in practice

Across settings, teams described how effective engagement supports meaningful clinical influence. They highlighted constructive discussion, shared problem-solving, and informed decision-making grounded in clinical expertise.

Engagement occurs through formal structures, including clinical councils, medical staff councils, advisory groups and quality and safety committees. These occur alongside informal approaches, such as direct conversations with managers, clinical leaders and executives, and interaction through professional networks. Formal and informal structures consistently function together as an interconnected system:

- Formal structures provide governance pathways, transparency and accountability.
- Informal engagement supports more immediate communication, builds relationships and enables issues to be explored and progressed in real time.

Across all settings, effectiveness depends on how these structures are used in practice.

Key enablers:

- Clarity of purpose
- Strong chairing
- Appropriate representation
- Visible connection to decision-makers

When engagement is working well

Participants described forums functioning as genuine spaces for discussion, challenge and shared problem-solving – where purpose is well understood, discussions extended beyond information sharing and contributions are expected to inform decisions.

> *"When it's clear why the meeting exists and what authority it has, people come prepared and the conversation matters."* (Medical)

Strong chairing was consistently noted as critical to effective engagement. Chairs who manage hierarchy, invite diverse perspectives and maintain focus create inclusive, constructive environments. Visible involvement from leadership reinforces the value of these forums and strengthens confidence in engagement processes. In practice, this includes leaders being present, participating consistently, providing context for decisions, responding to issues raised and reinforcing the purpose and value of engagement in ways that made sense in the local setting.

Informal engagement is equally valued for enabling immediate, accessible communication and connection to decision-makers, particularly for clinicians who may not participate in formal governance.

> *"The communication is pretty transparent and informal – I can pick up the phone or walk into an office to have a chat. When someone sends an email then it almost feels out of sync."* (Participant)

Professional escalation pathways complement formal and informal engagement structures, by providing recognised mechanisms for issues requiring broader or system-level consideration.

Where variation occurs and there are opportunities to strengthen engagement

In some settings, participants experience engagement structures that mainly serve as information sharing, with limited clarity about how they influenced decision-making.

> *"We go to the meeting, but it's not always clear what can actually be decided there."* (Nursing)

Participants varied in their awareness of how forums, committees and escalation pathways connect to one another. In some areas, clinicians were uncertain about how structures operate, who represents their discipline, or how issues are followed through. This reflects differences in how the engagement system is understood and communicated, not in its existence.

Variation in leadership behaviour and local implementation is key to shaping these experiences. This consistently reflected local context rather than lack of commitment to engagement.

> *"In some areas this works really well. In others, it depends on how it's set up and supported."* (Medical)

Where formal structures feel less responsive, participants rely more on informal approaches to progress issues. While effective, this is dependent on relationships and access, meaning experiences varied across roles, settings and tenure.

What this means in practice

Where engagement structures are clearly defined, well led and supported by formal governance and strong relational engagement, they enable shared understanding, timely action and meaningful clinical influence.

There is an opportunity to strengthen the consistency, clarity and connection of existing engagement structures, rather than create new ones. Effective engagement is already demonstrated across a range of settings. Consistently supporting enabling conditions creates a clear pathway to build trust, improve efficiency and ensure engagement more reliably leads to action.

This is consistent with broader evidence that the effectiveness of councils, networks and advisory forums depends on how they are led, connected and used in practice, including clarity of purpose, inclusive leadership and visible linkage to decision-making.[1,3]

Theme 2: When engagement leads to action (or doesn't)

Participants described engagement translating into timely action, informed decision-making and visible outcomes across formal and informal pathways. This includes councils, committees, escalation processes and direct conversations with clinical leaders and executives.

Whether engagement leads to action depends on how these pathways are supported.

Key enablers:

- Timely feedback
- Clarity of the process
- Visible decision-making
- Connection to those with authority

Where these are present, engagement feels purposeful and worth the time. Where they are absent, experiences vary significantly across roles, settings and organisations.

When engagement is working well

Engagement works when there is visible follow-through. This involves action, progress updates or clear explanations, even when the outcome differs from what was proposed.

> *"Even if it's a no, at least you know what's happened. That makes a big difference."* (Allied Health)
>
> *"When they come back and say, 'This is where it landed', people keep showing up."* (Medical)
>
> *"I got an email back from the [General Manager] saying thank you and that all ideas would be considered. Then feedback was provided explaining why some weren't progressed. That felt really good – asking, the answer and the feedback."* (Participant)

Administrative support and executive sponsorship also matter. For example, well-coordinated forums maintain momentum and outcomes are communicated consistently. Early conversations to clarify likely progress helps to align expectations and reduce wasted effort. Participants noted these conditions are achievable within existing structures.

Where variation occurs and there are opportunities to strengthen engagement

Participants described raising concerns or submitting proposals with limited visibility of what happens next, i.e. no acknowledgement, unclear timelines, and uncertainty about whether input has been received or acted on.

> *"You put a lot of work into a brief, and then it just disappears."* (Participant)
>
> *"We keep raising the same things because we never hear back."* (Allied Health)

This was most evident in two scenarios:

- Operational and clinical issues, where visibility reduces once matters move beyond the immediate team.
- Service improvement proposals, where approval processes are time-intensive and difficult to navigate.

In both cases, absent feedback creates extra work – repeated escalation, follow-up and duplication – and gradually influences how and whether clinicians engage.

> *"After a while you stop trying; not because you don't care, but because nothing changes."* (Medical)

Where follow-through is less visible, clinicians rely more on informal pathways to seek updates. While often effective, this depends on relationships and access, meaning experiences vary across roles and tenure.

What this means in practice

Visible outcomes are central to whether clinicians continue to engage over time. Where feedback is timely and transparent, engagement reinforces trust and enables meaningful participation. Where it isn't, engagement becomes harder to sustain. Participants described becoming more selective and relying more on local problem-solving; not from disengagement, but from repeated experiences where effort wasn't matched by response.

The system already demonstrates that responsive engagement is achievable. Strengthening feedback loops, clarifying response expectations and ensuring forums are supported to communicate outcomes will build on existing capability and reinforce trust across NSW Health.

Theme 3: Feeling safe to speak up

Participants described many examples where they can speak up, ask questions and contribute perspectives. This enables early identification of issues, shared problem-solving and more informed decision-making.

This was consistently identified as key to effective engagement. While formal structures provide forums for discussion, the experience of safety depends on how they are led and experienced day-to-day. This is shaped by leadership behaviour, forum design, chairing quality and how contributions are received.

This isn't about avoiding challenge or disagreement. Rather, it's about whether raising concerns or alternatives is seen as a helpful contribution to better decisions, not something that carries personal or professional risk. Experience of safety varies both within and between organisations.

When engagement is working well

Across metropolitan, regional, rural and statewide settings, participants described environments where different perspectives are actively encouraged and open discussion is the norm.

> *"There's a culture in that meeting that says, 'Tell us what you think'. You're not shut down for being honest."* (Medical)

Strong chairing was consistently identified as critical, i.e. chairs who set clear expectations, manage hierarchy and ensure inclusive participation create environments where people feel confident to contribute. Approachable leaders willing to explain decisions, including the constraints and competing priorities, reinforce trust, even when outcomes aren't as hoped.

Follow-up also matters. Where contributions are acknowledged and responded to, people feel more confident that speaking up is valued.

> *"On the clinical council, there is a feeling of safety: 'Tell us what you think'. It's the loop-back that really helps."* (Participant)

In these environments, people actively support speaking up and treat constructive disagreement as part of effective decision-making.

Where variation occurs and there are opportunities to strengthen engagement

In other settings, uncertainty about whether it is safe to raise concerns shapes whether issues are raised at all.

> *"Who you are matters. It shouldn't, but it does."* (Allied Health)

Hierarchy, professional discipline, employment arrangements and local culture all influence whose voices are heard. Participants described adapting their engagement to manage perceived risk.

> *"I feel safer raising other people's issues than my own."* (Allied Health)

Some had stepped back from formal forums following experiences where speaking up led to discomfort; escalation without support; or limited response.

"You learn pretty quickly what not to bring to the table." (Medical)

Confidence to speak up is particularly fragile in forums without clear purpose, strong chairing or visible executive support. These experiences are consistently linked to leadership behaviour and forum design, not a lack of professionalism or willingness to engage.

Together, these patterns reflect what is widely described as psychological safety – the everyday judgement clinicians and managers make about whether raising concerns, asking questions or challenging decisions feels safe.

What this means in practice

Where people feel safe to contribute, engagement supports early identification of issues, shared understanding and timely escalation. Where that sense of safety is less consistent, issues may be raised later, concerns moderated, and opportunities for early discussion missed. Clinicians will then rely more on informal channels or selective engagement.

Participants were clear this reflects the conditions of engagement, not a lack of commitment. Strengthening those conditions – consistent leadership behaviour, clear expectations, strong chairing and reliable feedback – represents a critical opportunity to build on existing system capability, reinforce trust and enable clinicians to contribute more fully across NSW Health.

This aligns with broader evidence that leadership behaviour, team climate and how contributions are acknowledged shape whether individuals feel able to speak up and engage in shared decision-making.[1,2] Evidence also links stronger staff engagement with improved patient safety outcomes, reinforcing the value of environments that support speaking up.[4]

Theme 4: Authority without agency

Participants consistently described how alignment between accountability and decision-making authority enables effective clinical engagement. It supports clinicians and managers to respond to emerging issues, manage risk proactively and adapt services to meet local needs.

Authority and accountability are closely linked to how engagement functions in practice. While formal governance structures define escalation pathways and delegation, participants said that effectiveness depends on how clearly authority is understood, delegated and enacted day-to-day.

Participants described authority as being shaped by a combination of formal delegation, access to decision-makers, organisational trust and clarity about the scope of decision-making at each level. Where these elements are aligned, clinicians and managers feel able to act with confidence and take appropriate responsibility for outcomes. At the same time, participants described variation in how consistently authority and accountability are aligned across roles, settings and organisations. These differences influence how people engage with escalation processes, governance structures and improvement activity.

When engagement is working well

Participants described environments where decision-making authority is clearly defined and delegated within agreed boundaries. In these settings, clinicians and managers can act decisively, make pragmatic trade-offs and resolve issues without unnecessary escalation.

“When you know what you’re actually empowered to do, you can get on with it.” (Nursing)

Clear delegation of authority, supported by access to decision-makers and trust from senior leaders, enables timely problem-solving and more efficient use of resources. Participants described a stronger sense of ownership, reduced duplication of effort and greater confidence that engagement would lead to practical outcomes. Clarity about where authority sits was also highlighted as critical, particularly where decision-making aligns with operational responsibility and service context.

"When it's clear why the meeting exists and what authority it has, people come prepared and the conversation matters." (Medical)

In these environments, decision-making is experienced as proportionate, responsive and closely connected to patient care and service delivery. Engagement processes are more efficient, as issues could be addressed at the appropriate level without unnecessary escalation or delay.

Where variation occurs and there are opportunities to strengthen engagement

Participants described variation in how consistently authority aligns with accountability in practice. In some settings, clinicians and managers felt responsible for managing risks, workforce pressures and service delivery without having the authority to address underlying causes.

"We're accountable for what happens on the floor, but the decisions that would actually fix it aren't ours to make." (Medical)

Decisions related to recruitment, workforce profiles, funding approvals, service redesign and risk mitigation were often described as sitting beyond the local level, requiring multiple layers of approval. Participants described investing significant time in escalation, briefing and governance processes, with limited visibility or momentum once issues progress beyond their immediate control. In fast-paced clinical environments, these delays place additional strain on local managers and senior clinical leaders, who continue to manage the impact of unresolved issues without additional authority or support.

Participants noted these constraints extend beyond frontline roles. Managers and senior leaders were described as operating within their own limits of authority, governance requirements and system constraints, shaping what decisions could be made and how quickly. This complexity contributes to frustration across multiple levels of the system.

Variation in this experience was observed both between and within organisations. Some services reported greater autonomy than others operating within the same broader system. This reinforced the perception that authority is not always applied consistently. Some statewide and specialty services described the added complexity of operating as statewide providers within LHDs where local planning and service decisions could affect their work, but they were not always engaged early as clinical partners in shaping those decisions.

Participants noted that challenges are not solely related to formal authority. In some cases, limited access to information, data, system knowledge or implementation supports affected confidence and capability to act, even where authority formally exists.

"You end up managing the risk rather than fixing the problem." (Allied Health)

What this means in practice

Alignment between authority and accountability is fundamental to effective clinician engagement. Where decision-making authority is clear, appropriately delegated and supported, clinicians and managers are better able to respond to risks, implement improvements and contribute meaningfully to system performance.

Where this alignment is less consistent, participants described adjusting how they approach escalation and decision-making over time. Some become more selective in what they escalate, focusing effort on issues they believe are more likely to be addressed. Others prioritised short-term workarounds to maintain service delivery, rather than investing in longer-term solutions that require higher-level approval.

Importantly, participants were clear that this dynamic does not reflect a reluctance to take responsibility. Rather, it reflects the conditions in which decisions are made and the extent to which authority supports the responsibilities individuals are expected to carry.

Aligning authority more consistently with accountability supports more timely decision-making, reduces duplication and escalation burden, and reinforces trust in engagement processes. This enables safer and more responsive care across NSW Health. Evidence on clinical engagement also emphasises the value of clear escalation pathways and well-understood decision roles to support effective engagement and resolution of organisational issues affecting care delivery.[1]

Theme 5: Workforce wellbeing and sustainability

Workforce wellbeing was closely linked to engagement capacity, with participation in improvement and decision-making shaped by willingness and the conditions in which people are working. Participants were clear that ongoing reliance on individual and team effort was not limitless, reinforcing the importance of work conditions that are sustainable over time.

When engagement is working well

Strong collegial relationships and shared purpose are key enablers of wellbeing and resilience. Teams with stable staffing, strong local identity and effective communication support one another through peaks in demand and maintain a collective focus on care.

Visible, engaged leadership also matters. Where leaders are present in practice – through rounding and direct team engagement – and acknowledge peoples' effort, staff feel more valued and better able to manage ongoing pressure.

> *"Recognition, visibility and access to leadership reinforced that effort was seen and that concerns could be raised."* (Participant)

These conditions don't remove pressure but make it more manageable and support a sense of shared responsibility. Participants described them as protective factors that help sustain teams through periods of high demand.

Where variation occurs and there are opportunities to strengthen engagement

Participants described the cumulative impact of prolonged pressure and ongoing reliance on individual effort.

What began as short-term adaptation had become normalised, particularly in areas experiencing persistent workforce shortages, increasing demand or slow decision-making.

> *"You can keep going for a while, but not forever."* (Medical)

Operating in "survival mode", teams focused on sustaining day-to-day delivery rather than improving how systems function. This limits time for recovery, development, innovation and participation in engagement beyond immediate clinical priorities. Some stepped back from forums and leadership opportunities; others questioned the long-term sustainability of their roles.

Participants also described the emotional load of sustained pressure, such as:

- distress about being unable to provide the care they believed was needed
- ongoing anxiety about risk and accountability
- persistent vigilance contributing to fatigue beyond physical workload.

These experiences were consistently framed as system-driven and attributed to sustained workload, administrative burden and accumulated unresolved risk, not a lack of resilience.

In smaller, rural and remote services, fewer options to redistribute workload makes these pressures more acute.

> *"There is only so much goodwill — we are running on empty."* (Nurse)

Evidence around clinician wellbeing also indicates that workforce capacity to participate in improvement and engagement activity is strongly shaped by conditions of work (including workload and workflow), and that sustained improvement is unlikely to be achieved through individual approaches alone.[4]

What this means in practice

Where staff are supported, recognised and operating within manageable conditions, engagement can be sustained and contribute meaningfully to improvement and decision-making. Where pressures are prolonged, engagement becomes more selective and participation in improvement, leadership and governance is harder to sustain alongside clinical demands. This creates a cumulative risk of fatigue, disengagement and attrition among the experienced clinicians most relied upon for service stability.

This is closely connected to the preceding themes. Where engagement structures are inconsistent, follow-through is limited, speaking up feels risky and authority doesn't align with accountability, and pressure is more likely to be absorbed at the frontline.

Strengthening wellbeing therefore requires attention to the broader system conditions shaping engagement, not workload alone. This includes recognising that some barriers to sustainable engagement sit beyond local influence and require broader system support to be addressed consistently in practice. Recognising effort, supporting implementation, aligning authority and strengthening follow-through are practical opportunities to support more sustainable clinician engagement across NSW Health.

This is consistent with evidence indicating:

- sustained improvement requires system-level conditions, not individual-level approaches alone
- higher workforce engagement is linked with improved health service outcomes.[2,5]

Secondary themes shaping clinician engagement

While the core themes describe how engagement is experienced day-to-day, participants also identified underlying system conditions that shape these experiences across settings. These secondary themes are outlined below.

Clinicians, managers and leaders emphasised that engagement occurs within busy, pressured environments; and is influenced by how time, resources, leadership support and system processes are configured. These conditions provide important context for:

- understanding variation in experience across services and roles
- identifying practical ways to strengthen consistency within existing structures.

These themes are intended to support learning by highlighting the conditions that enable engagement to be meaningful, credible and sustainable in practice.

Time, workload and capacity

Across disciplines, engagement was reported as consistently competing with patient care, staffing shortages and increasing non-clinical workload. For many, participation in councils, forums or improvement activity occurs alongside already full clinical and managerial roles rather than being integrated into everyday work.

As a result, engagement is often selective or intermittent, particularly for frontline clinicians, shift workers and those covering multiple roles or sites. This was particularly evident in smaller services, where clinicians are required to span multiple functions and engagement is embedded within day-to-day operational work rather than supported through dedicated forums.

> *"We are overstretched – [clinicians] hear about engagement, but they don't have the capacity to be part of it."* (Participant)

Participants also described examples where engagement was easier to sustain. This was more likely where leaders:

- recognised it as core business
- aligned requests for input with operational realities
- provided practical support that reduced additional load.

Participants also described the value of short, structured touchpoints that integrate engagement into day-to-day operations rather than adding extra meetings. For example:

- daily huddles and brief operational check-ins that build shared situational awareness; support rapid clarification of issues; and reduce the cognitive and administrative effort required to escalate routine operational concerns
- visible leadership presence in clinical areas (combined with clear follow-through) helps engagement feel more timely and less burdensome in already pressured environments.

Participants were clear that constrained engagement reflects workload, rather than lack of interest or commitment. This aligns directly with the intent of Time for Care, which recognises that reducing low-value burden and creating space in the working day is foundational to enabling meaningful engagement, improvement and leadership participation.

Participants also described a lack of dedicated support for project and change implementation. Many initiatives were described as approved in principle but left to be delivered by clinicians and managers alongside existing workloads, without backfill, project staff or protected time.

This was particularly evident in local improvement work, pilots and service redesign initiatives, and is consistent with the survey themes from Time for Care, where local changes were not always experienced consistently by frontline clinicians, particularly where barriers sat beyond local control.

> *"We're expected to implement it, but there's no one actually funded to do the work."* (Allied Health)

Administrative burden and system "noise"

A growing administrative load was described across roles, including documentation requirements, reporting obligations, mandatory training and high volumes of emails. While well-intentioned, this cumulative system "noise" was widely viewed as reducing time and cognitive space for clinical preparation, improvement activity and meaningful engagement.

Heavy reliance on broadcast communications was frequently raised, with clinicians noting that important messages were often lost among competing requests for input and information.

> *"You spend half your time trying to work out which emails matter today."* (Allied Health)

In practice, time is being diverted from higher-value work to triaging and responding to competing requests.

> *"Information overload … leads to disengagement. A regular newsletter now exists with packaged up emails, rather than lots of broadcast messages."* (Participant)

Participants also described examples where the impact of system "noise" was reduced.
For example:

- settings where leaders prioritise and streamline communications, clarify expectations about what requires action, reduce duplication across forums and reporting processes, and provide practical administrative support so clinicians' time and attention can be directed to clinical work and meaningful engagement
- targeted and packaged communication approaches, e.g. consolidating messages into a regular update rather than multiple broadcast emails.

The drivers of administrative load, and the need to rationalise, prioritise and better align these demands echoed the objectives and findings of Time for Care, reinforcing that engagement will remain constrained unless time and attention are deliberately protected.

The evidence also indicates that small, routine documentation requirements can consume substantial time at scale, so systematic approaches to identify and retire low-value administrative tasks can reduce cumulative burden. Broader wellbeing evidence also links administrative and workflow burden to reduced capacity for staff to participate in improvement activity.[6]

Leadership capability, stability and behaviour

Leaders were generally seen as having positive intent; however, participants said it is their lived experience of leadership behaviour that matters most in practice. They described engagement as functioning best where leaders are visible, consistent, responsive, and able to bridge clinical and organisational perspectives.

Participants described the leadership practices that strengthened engagement and supported confidence over time. For example:

- leaders making time to be present in clinical environments, listening actively, communicating decisions and constraints clearly, and closing feedback loops so staff could see what happened after issues were raised
- practical actions, such as clarifying expectations, streamlining communications, and using simple mechanisms to track follow-up so progress is visible.

Managers were described as having a particularly challenging role in this environment. They are working closest to frontline realities, filtering information, holding competing priorities, and often being the person who needs to have the difficult conversation – especially where the answer is constrained, delayed or "no". Where managers are not clearly backed, left without clarity and support, or expected to absorb frustration without authority, engagement is harder to sustain for both staff and managers.

Dual-role arrangements were also raised, e.g. clinical leaders who hold both clinical and managerial/administrative responsibilities, including clinical director roles. While these roles are valued for maintaining credibility and connection to care delivery, participants noted they can be difficult to sustain without clear role design, protected time and practical support. Conversely, where leaders retained an appropriate clinical connection and visibility, participants described this as improving understanding of frontline realities and supporting more informed and trusted decision-making.

Participants emphasised the importance of deliberate leadership development and succession planning.

Where emerging leaders are given exposure, mentoring and structured opportunities to grow (alongside clear delegations, induction and handover) participants described greater continuity, stronger confidence in decision-making, and more sustainable engagement over time. Frequent leadership changes or prolonged acting roles lead to engagement processes repeatedly resetting.

"Every time the role changes, you start again." (Medical)

Participants indicated that engagement challenges mostly reflect role complexity, competing demands and insufficient organisational conditions to support engagement responsibilities, particularly for managers. This is consistent with contemporary evidence, which emphasises leadership capability and team climate as central to staff experience and engagement. It highlights the role of visible leadership commitment and adequate implementation support to sustain improvement over time.[1,2]

System literacy and transparency

Participants reported uncertainty about governance pathways, prioritisation processes, constraints shaping decisions and where authority ultimately sat. Where rationale was unclear, clinicians and managers described difficulty tailoring proposals, anticipating likely outcomes or explaining decisions back to teams, even when decisions were reasonable.

"If we understood the why, we could explain it properly." (Manager)

Clearer system literacy, including decision pathways, constraints and accountabilities, supports more effective engagement and improves confidence in processes. This aligns with Future Health's emphasis on trust, clarity and shared accountability.

Participants described how transparency supports engagement when leaders take time to:

- explain decision pathways
- provide context for constraints
- clarify what decisions can be made at which level, and within what timeframes.

Where this is present, participants reported greater confidence in processes and find it easier to focus effort on the issues and proposals most likely to progress. Participants emphasised the importance of transparency about process, current status, expected timeframes and decision criteria. They also expressed frustration when issues stall without visible progress.

> *"Business case / ideas – they go up after you have spent weeks writing it... and then you just never hear back. There's a lack of transparency about what happens to it."* (Participant)

Participants also noted that system literacy was often developed late, in acting or first-time management roles, rather than earlier in frontline practice. This meant knowledge was often learned reactively and under pressure, rather than being built proactively through routine system communication and leadership development.

Evidence on clinical engagement similarly shows that transparent communication and clear links between engagement structures and decision-making, backed by reporting and feedback mechanisms, enable more effective engagement. [1]

Reliance on informal relationships and social capital

Built over time, informal relationships were said to support direct communication, faster clarification and timely problem-solving; particularly in smaller or more contained settings where proximity enabled frequent interaction.

Informal connection was described as strengthening engagement when it complements formal arrangements. This includes:

- leaders and managers making time for accessible, relationship-based engagement
- clinicians testing and refining ideas informally before raising them through formal pathways
- professional networks sharing knowledge; connecting people across teams; and reducing duplication.

Where these relational pathways are paired with clear structures and reliable follow-through, they were described as a legitimate and valuable part of the engagement landscape.

> *"Everything is built on relationships and communication, leaders who are present, and trust."* (Participant)

As services grow and become more complex or distributed, participants noted these informal pathways could be harder to rely on consistently. In these contexts, it is difficult to navigate the system when pathways are unclear or not easily accessible, and reliance on personal relationships is increasingly difficult to sustain.

Participants also noted that relying on personal networks can lead to unequal access to influence. New staff, rotating clinicians and those without established networks are less able to use informal pathways effectively.

> *"It works, if you know the right person."* (Nursing)

Reliance on informal pathways can also concentrate workload on a small group of experienced clinicians and managers who become default problem-solvers. While goodwill and relationships help work continue day-to-day, they cannot substitute for clear structures, authority and adequately supported implementation in the longer term.

Evidence on clinical engagement also describes relationship-based mechanisms, such as networks and advisory groups, as common in large health systems. It recognises the need for clear connections, good communication and regular feedback to keep things consistent and fair as the work expands.[1]

Competing priorities and change overload

While the many concurrent initiatives are viewed as important, their combined impact causes pressure, fragmentation and difficulty sustaining focus. Competing timelines, overlapping requests for input and high volumes of communication leads to duplication and reduces clarity about what matters most at any given time.

Engagement is sometimes experienced as an additional demand rather than core business; particularly where initiatives are poorly sequenced or require repeated input without visible progress.

> *"Everything is a priority, which means nothing really is."* (Medical)

Participants said there are too many initiatives because priorities aren't clear. They stressed the need to decide what to pause, stop or delay so there's enough capacity.

> *"[We] need to talk about what we stop."* (Participant)

At the same time, people shared examples where the number of initiatives felt manageable. These involved:

- clearer prioritisation and sequencing
- fewer competing requests
- visible leadership decisions about what would be paused, stopped or deferred to create capacity.

Where implementation support and coordination is available, engagement is more purposeful and less likely to stall. Participants noted that without coordinated project and implementation support, initiatives compete for limited capacity. This can slow work down, split efforts or rely too much on individual effort to keep going.

The literature similarly indicates that:

- sustained improvement is more achievable when priorities are coordinated and sequenced over time with adequate implementation support
- engagement is harder to sustain when initiatives compete for limited capacity or rely on additional discretionary effort.[1,2]

Conditions for sustainable engagement

Time constraints, administrative burden, leadership stability, transparency, implementation support and competing priorities interact to influence who can participate, how engagement occurs, and whether it leads to timely action and follow-through.

Where pressure, system "noise" and unclear pathways are present, engagement becomes more selective and episodic, with greater reliance on informal channels, repeated escalation and local workarounds. Where these conditions are deliberately managed, engagement is more likely to be purposeful and sustained.

Overall, the findings suggest that strengthening engagement does not require additional structures, but more consistent attention to the conditions that enable existing structures to work well.

Evidence on clinical engagement and workforce wellbeing emphasise the enabling role of leadership, transparent communication and feedback mechanisms. It indicates that workload and administrative burden constrain capacity to participate and sustain engagement over time.[1,2,6]

Case study: COVID-19 response

During the COVID-19 response, engagement was described as more immediate and closely integrated with operational decision-making. Clinicians reported that information, concerns and practice changes were discussed and acted on rapidly, often through peer-level networks and communities of practice that connected clinicians across sites and disciplines.

Participants noted that state-level communities of practice enabled clinicians to share emerging issues and adapt practice in real time. In several accounts, clinical teams described modifying practice based on peer discussion before formal guidance filtered through executive channels, allowing services to respond more quickly to evolving clinical risks.

This form of engagement reduced delays commonly associated with layered approval processes and reinforced clinicians' confidence that their input was shaping decisions as events unfolded. Participants also described engagement during COVID-19 as being supported by more frequent, structured touchpoints (e.g. briefings and huddles) and clearer escalation pathways. This created a shared operational picture, enabling faster decisions at the appropriate level.

Enabling conditions

Participants consistently identified several conditions that enabled effective engagement during the COVID-19 response.

Clear purpose and shared focus

Engagement aligned closely with patient safety, workforce protection and service continuity. Participants described a clear and common understanding of priorities, which reduced ambiguity and enabled decisions to be made quickly and collectively.

Defined decision authority and escalation pathways

Clinicians reported clearer lines of decision-making and escalation. Knowing who could make decisions, and at what level, reduced uncertainty and enabled faster responses to emerging risks. Reduced "decision paralysis" also helped action keep pace with rapidly changing conditions.

Peer-level clinical networks

Communities of practice and peer networks were described as central to engagement. These structures helped people quickly share clinical insights and solve problems. This supplemented formal governance mechanisms and supported more consistent practice across settings.

Rapid feedback and visible action

Participants described high confidence in engagement processes because concerns raised were acknowledged quickly and translated into visible changes. Even where decisions were constrained, clarity and responsiveness supported trust and reduced the need for repeated escalation.

Engagement treated as core work

Time spent in huddles, briefings and peer discussion was legitimised as essential operational activity. Engagement was not experienced as optional or additional, but as integral to managing risk and delivering care. This protected time and set clear expectations for participation, even under pressure.

Implications for practice

Participants were clear that the conditions present during the COVID-19 response were not sustainable or desirable as a permanent state. However, they emphasised the effectiveness of engagement during this period was not accidental, nor driven by goodwill alone. Rather, it reflected deliberate alignment of purpose, authority, communication and feedback.

The COVID-19 experience demonstrated that when engagement is embedded in decision-making, supported by clear authority and enabled through appropriate structures, clinicians are willing and able to contribute meaningfully, even under extreme pressure.

Many participants said there is an opportunity build these enabling conditions into everyday practice, including:

- clarity of delegation
- rapid feedback loops on issues raised
- structured peer networks that connect clinicians across settings, without relying on emergency conditions.

Methodological note

This case study draws on multiple participant reflections shared during the Shaping the System Together engagement process. It synthesises recurring insights about clinician engagement during the COVID-19 response rather than representing a single site, role or event.

Implications for the NSW Health system

Findings from the consultation indicate that clinician engagement is occurring broadly across NSW health, with many examples of effective engagement in practice. However, engagement is not always supported or sustained consistently by design.

Clinicians, managers and leaders demonstrated strong commitment to contributing to decisions affecting patient care, service delivery and workforce sustainability. Whether engagement feels worthwhile depends on whether the system conditions enable participation to translate into timely action and clear follow-through.

Improving clinician engagement isn't about adding more forums or asking for more input. It's about how we set up decision-making, time, support and feedback across the system. Where these elements are aligned, engagement is credible, efficient and productive. Where they are less aligned, engagement relies more heavily on goodwill, informal workarounds and individual effort.

Findings also indicate that clinician engagement is inseparable from workforce wellbeing and sustainability. For example, fatigue and disengagement occur over time when:

- issues are raised repeatedly without visible follow-through
- there is unresolved risk
- staff are expected to implement change without adequate support.

This decreases confidence in engagement mechanisms and limits capacity to participate meaningfully; in particular, for those who are relied upon to stabilise services and lead change.

These findings are consistent with themes emerging from the PMES, particularly in relation to trust, voice, leadership visibility, workload and confidence that feedback leads to action. Where PMES identifies what staff are experiencing, this initiative provides additional insight into how engagement structures, authority, workload and feedback mechanisms operate in practice.

From a system perspective, strengthening clinician engagement requires coordinated action beyond individual services or roles.

Efforts to respond to PMES results and strengthen engagement will be most effective when they focus on enabling conditions, including:

- clarity of decision-making authority
- timely feedback
- protected time for engagement
- appropriate implementation support.

Without these in places, local planning may rely on workarounds instead of addressing the underlying issues that affect engagement. The following recommendations focus on shared responsibility across the system and align with existing priorities, such as Time for Care, the Shared Understanding Project and Future Health more broadly, to support sustainable improvement in clinician engagement and workforce experience.

Recommendations

The recommendations and practical action areas below identify high-level opportunities to strengthen clinician engagement within existing structures and ways of working. They provide a starting point for action, rather than a complete implementation plan.

Table 1 outlines the system-level recommendations to strengthen clinician engagement across NSW Health. Each recommendation identifies the primary level best placed to lead action, while recognising that implementation needs shared responsibility and coordination across local services, districts, networks, the Ministry, Pillars and statewide organisations.

The linked practical action areas provide a bridge between the recommendations and implementation. In addition to this report, a more detailed action and implementation plan will be developed, including practical examples, case studies, evidence-informed approaches, sequencing, responsibilities and measures of progress. This next phase will align with, and avoid duplicating, a range of work occurring across existing programs.

Table 1: System-level recommendations to strengthen clinician engagement

Recommendation	What needs to change	Responsibility to act*	Linked practical action areas
1. Clarify and align decision-making authority and escalation pathways	Make delegations, escalation pathways and thresholds for local versus system action clearer and more consistent, including where issues are frequently raised or span organisational boundaries	**Primary**: LHD/SHN Executive **Secondary**: Managers, clinical leaders, MoH, Pillars and statewide organisations where system clarification is needed	• Decision authority, escalation and navigation • System communication and coordination • Safe, representative and influential engagement
2. Strengthen feedback loops so engagement leads to visible outcomes	Set clear expectations that issues raised through councils, forums, briefs and system-level engagement processes are acknowledged, tracked and responded to, including where decisions are constrained, pending or not progressed	**Primary**: Managers, clinical leaders and forum chairs **Secondary**: LHD/SHN Executive; MoH and Pillars for system-level engagement processes	• Feedback loops and decision follow-through • Enabling clinical leaders and forum chairs • Implementation support for agreed priorities
3. Protect time and reduce low-value burden to enable meaningful engagement	Reduce avoidable administrative burden and recognise engagement activity as core work, not an add-on, including protecting time where feasible	**Primary**: LHD/SHN Executive **Secondary**: MoH, Pillars, statewide organisations and program owners	• Protected time and reduced low-value burden • System communication and coordination
4. Provide dedicated support for implementing change and improvement	Ensure initiatives arising from engagement are supported by appropriate implementation capability, such as project support, coordination, improvement expertise, data support and clear ownership	**Primary**: MoH and Pillars for system-level initiatives; LHD/SHN Executive for local priorities **Secondary**: Managers, clinical leaders and improvement teams	• Implementation support for agreed priorities • Peer learning and shared practice • Feedback loops and decision follow-through

Recommendation	What needs to change	Responsibility to act*	Linked practical action areas
5. Strengthen leadership capability, chairing and stability to support engagement	Enable executive leaders, heads of department, forum chairs, clinical leaders and newer managers with practical support, role clarity, development, chairing capability and continuity	**Primary**: LHD/SHN Executive **Secondary**: MoH, Pillars, People and Culture, HETI and leadership programs	• Enabling clinical leaders and forum chairs • Safe, representative and influential engagement
6. Coordinate engagement requests and reduce duplication and system noise	Coordinate system-wide engagement requests, communications, consultation and reporting so clinicians are not approached repeatedly by multiple parts of the system on related issues	**Primary**: MoH, Pillars and statewide organisations **Secondary**: LHD/SHN Executive, managers, communications leads and program owners	• System communication and coordination • Protected time and reduced low-value burden • Peer learning and shared practice
7. Build capability in system literacy and transparency	Provide clear, accessible guidance on how decisions are made, where authority sits, expected timeframes, constraints and how to navigate escalation pathways	**Primary**: LHD/SHN Executive **Secondary**: MoH, Pillars, managers, clinical leaders and People and Culture.	• Decision authority, escalation and navigation • Safe, representative and influential engagement • Peer learning and shared practice

* Primary responsibility identifies the level best placed to lead, coordinate or initiate action. Secondary responsibility recognises that delivery is shared and may require support, coordination, guidance or enabling action from other parts of the system.

Note: Theme alignment is reflected in Appendix 1. Linked practical action areas are intentionally high-level. Detailed action planning will set out practical examples, sequencing, responsibilities and measures of progress.

Implementation considerations

These recommendations will only be effective if they are supported by deliberate prioritisation and actions focused on outcomes. Implementation should build on existing engagement structures and ways of working, rather than creating additional layers of activity.

This will require clarity about what can be progressed locally; what requires system support; and what may need to be stopped, simplified or delayed to create capacity to act. The recommendations should be progressed through existing governance, planning and improvement processes, rather than being treated as a separate or additional work program.

The recommendations are interconnected. Progress in one area, such as feedback loops, decision authority or protected time, will support progress in others. For this reason, implementation should focus on a small number of practical priorities that can be sustained, measured and adapted over time.

Practical actions to support implementation

The practical action areas below provide a high-level bridge between the recommendations and implementation. They group the practical shifts most consistently raised through the consultation and stakeholder testing, including clearer feedback loops, decision authority, representative engagement, protected time, leadership support, system coordination, implementation support and peer learning.

The action areas are not intended to be implemented all at once. They provide a starting point for local services, districts, networks, the Ministry, Pillars and statewide organisations to identify where action is most needed; where existing work can be strengthened; and what may need to be sequenced, simplified or delayed.

The practical action areas in this report are intentionally high level. A companion practical actions guide has been developed to support implementation. It provides practical examples, case studies, tools and suggested measures that can be adapted locally and used alongside existing system priorities and program work.

Action area 1: Feedback loops and decision follow-through

Make follow-through visible by tracking issues, decisions, owners, status and rationale.

Examples

- “You raised / here’s what happened” updates.
- Action logs with owner, due date and status.
- “Go / not yet / no” responses with rationale.
- Feedback built into forums, briefs and consultations from the start.

Roles

- **Local**: forum chairs, managers and clinical leaders close the loop and communicate decisions or rationale.
- **System**: MoH, Pillars and statewide organisations model feedback loops in system-level consultation and engagement.

What success looks like

- Clinicians know what happened after issues were raised.
- Fewer repeat escalations.
- Decisions and constraints are visible.
- Trust in engagement processes improves.

Action area 2: Decision authority, escalation and navigation

Clarify where authority sits, what can be decided locally, what needs escalation, and how cross-boundary issues move through the system.

Examples

- Map escalation pathways for common issue types.
- Clarify local vs system-level decision points.
- Orientation to councils, medical staff councils (MSCs), clinical councils and escalation routes.
- Use minutes and/or action records to document agreed actions.

Roles

- **Local**: LHD / SHN executives clarify local decision rights and escalation routes.
- **System**: MoH, Pillars and statewide organisations clarify pathways that cross organisational boundaries.

What success looks like

- Clinicians and managers know where to raise issues.
- Fewer matters stall because pathways are unclear.
- Authority and accountability are clearer.
- Issues are escalated with the right information, to the right level, earlier.

Action area 3: Safe, inclusive and representative engagement

Broaden participation, clarify the level of participation being sought, and involve relevant clinical expertise early where decisions affect clinical workflow or service delivery.

Examples

- Rotate membership and use open expressions of interest for councils and working groups.
- Invite broader clinical voices, including emerging leaders and under-represented disciplines/sites.
- Use anonymous or embedded feedback options where speaking up feels unsafe.
- Clarify whether participants are speaking as individuals or representing a broader group.

Roles

- **Local**: LHDs/SHNs and forum chairs broaden participation and create safe meeting conditions.
- **System**: MoH, Pillars and statewide organisations model inclusive engagement and avoid relying on the same small group of clinicians.

What success looks like

- More diverse participation in councils, forums and working groups.
- Fewer engagement opportunities rely on unpaid after-hours contribution.
- Clinicians and managers can contribute safely.
- Advice better reflects collective views, not only individual views.

Action area 4: Protected time and reduced low-value burden

Recognise engagement as core work where feasible and reduce avoidable administrative, communication, reporting and compliance burden.

Examples

- Recognise engagement and improvement activity as core work where feasible.
- Identify tasks, meetings, reporting or duplicate requests that could stop or simplify.
- Review selected mandatory training and compliance burden through a Time for Care lens.
- Sequence engagement requests to avoid repeated demands on the same clinicians.

Roles

- **Local**: services identify low-value local burden and make engagement manageable in rosters, schedules or role expectations.
- **System**: MoH, Pillars and statewide organisations review statewide requirements, duplicated asks and high-burden processes.

What success looks like

- Engagement is more manageable alongside clinical work.
- Low-value tasks are stopped, simplified or better coordinated.
- Protected time is clearer in different clinical settings.
- Clinicians experience less administrative burden.

Action area 5: Enabling clinical leaders and forum chairs

Support chairs, clinical leaders, managers and new or acting leaders with role clarity, practical tools, chairing guidance, handover and administrative support.

Examples

- Orientation, buddying or mentoring for acting/new leaders and forum chairs.
- Chairing guidance for two-way discussion, psychological safety and clear follow-up.
- Clear role descriptions and expectations for MSCs, clinical councils and engagement forums.
- Administrative support for agendas, minutes, action logs and follow-up.

Roles

- **Local**: LHDs/SHNs support chairs, clinical leaders and managers with induction, admin support and role clarity.
- **System**: MoH, HETI, Pillars and People and Culture align leadership development and share common principles and tools.

What success looks like

- Chairs run meetings that enable input and follow-through.
- New and acting leaders understand decision pathways and expectations.
- Councils and forums have better preparation and documentation.
- Leadership support is more consistent across NSW Health.

Action area 6: System communication and coordination

Coordinate statewide communication, consultation, reporting and change activity to reduce duplication and system noise.

Examples

- Coordinate statewide requests before they reach LHDs/SHNs and clinical teams
- Use “action required / for awareness” signalling
- Reduce duplicate broadcast emails, surveys and overlapping consultation requests
- Target communication streams to relevant clinical and specialty contexts

Roles

- **Local**: communications leads and managers package local messages and target distribution
- **System**: MoH, Pillars and statewide organisations coordinate statewide communications, consultation requests and reporting asks before local dissemination

What success looks like

- Fewer duplicate requests reach local services
- Clinicians can quickly identify what requires action
- Communications are clearer and more targeted
- Clinicians and manager report less system noise

Action area 7: Implementation support for agreed priorities

Ensure agreed priorities have clear owners, proportionate implementation support, sequencing and progress measures, and clarify what is in scope now, later or not progressing.

Examples

- Name owners, timelines and support needs for endorsed priorities.
- Provide the level of project, improvement, data or coordination support needed to deliver the priority. Clarify what is in scope now, later or not progressing.
- Use evidence-informed approaches and practical measures of progress.

Roles

- **Local**: LHDs/SHNs identify owners and support needs for local priorities.
- **System**: MoH and Pillars provide implementation support for system-level initiatives and help remove barriers where authority or coordination sits centrally.

What success looks like

- Agreed priorities have owners, timelines and support requirements.
- Fewer approved initiatives stall due to lack of capacity.
- Progress is visible over time.
- Implementation is supported, not reliant on goodwill alone.

Action area 8: Peer learning and shared practice

Share examples, tools and case studies showing what good engagement looks like, using existing networks and communities of practice where possible.

Examples

- Share case studies showing what good looks like in different settings.
- Strengthen communities of practice and peer networks with clear purpose.
- Create a repository of templates, examples and practical tools.

Roles

- **Local**: LHDs/SHNs contribute examples, adapt tools and share learning across services.
- **System**: MoH, Pillars and statewide organisations curate examples, support networks and maintain shared resources.

What success looks like

- More diverse participation in councils, forums and working groups.
- Fewer engagement opportunities rely on unpaid after-hours contribution.
- Clinicians and managers can contribute safely.
- Advice better reflects collective views, not only individual views.

Next steps

This report is intended to support action by clarifying the structural and cultural conditions that enable meaningful clinician engagement, rather than prescribing a single implementation pathway.

A companion Practical Actions Guide supports implementation by translating the recommendations and practical action areas into examples, tools and suggested measures that can be adapted across local, statewide and specialty settings. Further implementation planning can build on these resources while recognising variation in local context, capacity and priorities.

Using clinician insights to inform system and local action

The findings, recommendations and practical action areas are designed to support action in three complementary ways:

1. **Local reflection and improvement planning**

   At the LHD, SHN and statewide organisation level, the report provides a framework to reflect on how existing engagement arrangements are functioning in practice and where targeted improvements could strengthen trust, follow-through and workforce experience. This should focus on improving how existing structures are used and supported, rather than introducing additional mechanisms or layers of activity. LHDs, SHNs and statewide organisations can also leverage the report received after their site visits as additional evidence for where to target local efforts.

2. **Using evidence to prioritise action**

   Available evidence on workforce wellbeing and clinician engagement can be considered alongside the consultation themes to support prioritisation of actions that are evidence-informed and grounded in lived experience.

3. **System stewardship and alignment with existing priorities**

   At the Ministry, Pillar, statewide organisation and Board levels, the report supports system stewardship by translating broader NSW Health priorities into observable conditions, behaviours and decision-making arrangements that enable meaningful clinician engagement. This includes strengthening coordination, feedback, decision clarity, implementation support and reduction of low-value burden.

   The findings also align with related work across the system focused on trust, transparency, communication, reducing low-value burden and strengthening coordination. This includes Future Health, Time for Care and the Shared Understanding Project.

Roles and shared responsibility

This initiative reinforces that clinician engagement cannot be strengthened by any single role or level alone. Progress relies on shared responsibility:

- **Ministry of Health, Pillars and statewide organisations** provide system stewardship, coordination and implementation support.
- **LHD and SHN executives** clarify decision rights, model engagement behaviours and create enabling local conditions.

- **Managers and clinical leaders** translate engagement into practice and require clarity, stability and support to do so consistently.
- **Boards and governing bodies** provide oversight and assurance that engagement is supported through timely response and action, and reliance on goodwill is reducing over time.

Monitoring progress and learning over time

Monitor progress through PMES results alongside practical indicators, such as:

- closing feedback loops
- clarity of decision-making and escalation pathways
- reduced reliance on informal workarounds
- reduction in duplicated requests or low-value burden
- feedback from clinicians and managers about workload, responsiveness and engagement credibility.

Learning should be shared across the system to build confidence and consistency, supporting broader system learning and improvement over time. The detailed PMES action plan identifies specific measures of progress and practical ways to share learning across the system.

Sustaining progress

Participants were generous in sharing their experiences and explicit in their expectation that this work would lead to learning and action. Sustaining momentum will depend on making early, practical improvements while maintaining focus on the conditions that support engagement over time.

Embedding the recommendations and practical actions from this report into existing governance, planning and improvement processes provides an opportunity to move from reliance on goodwill toward a deliberate, supported and sustainable approach to clinician engagement across NSW Health.

The challenge ahead is not whether authentic clinician engagement is possible, but how consistently the system can create and sustain the conditions that allow it to thrive in everyday practice.

References

1. Critical Intelligence Unit. Evidence brief: Clinical engagement. NSW Health; 2025 Aug 1.
2. Cheek C, Clay-Williams R, Mitchell R, et al. Interventions and strategies to improve staff wellbeing in healthcare organisations: an Evidence Check rapid review brokered by the Sax Institute for the NSW Ministry of Health. Sydney: Sax Institute; 2026 Apr. doi:10.57022/guyi7668.
3. Brown BB, Patel C, McInnes E, et al. The effectiveness of clinical networks in improving quality of care and patient outcomes: a systematic review of quantitative and qualitative studies. BMC Health Serv Res. 2016;16(1):360. doi:10.1186/s12913-016-1615-z.
4. Janes G, Mills T, Budworth L, et al. The association between health care staff engagement and patient safety outcomes: a systematic review and meta-analysis. J Patient Saf. 2021;17(3):207–216. doi:10.1097/PTS.0000000000000807.
5. Bell S, Garud N, Pati R, et al. Happier workers, healthier patients: an analysis of healthcare worker engagement and health service outcomes in Victoria. Safer Care Victoria & Victorian Managed Insurance Authority; 2022. doi:10.6084/m9.figshare.18830621.
6. Ashton M. Getting Rid of Stupid Stuff. N Engl J Med. 2018;379(19):1789–1791. doi:10.1056/NEJMp1809698.

Appendix 1: Recommendations mapped to themes and practical action areas

Table 2 shows how the consultation themes, system-level recommendations and high-level practical action areas align. It demonstrates how the recommendations are grounded in the report findings and how the practical action areas provide a bridge to implementation.

The mapping is not intended to prescribe a single implementation pathway. Many recommendations respond to more than one theme, and several action areas support multiple recommendations. This reflects the interconnected nature of clinician engagement across NSW Health.

The practical action areas are intentionally high-level. The companion practical actions guide provides further detail, including examples, tools and suggested measures to support local adaptation and implementation.

Table 2. Recommendations mapped to themes and practical actions

Recommendation	Theme alignment	Practical action areas
1. **Clarify and align decision-making authority and escalation pathways**	**Theme 1**: How engagement structures are used in practice **Theme 4**: Alignment between authority and accountability **Secondary**: System literacy and transparency	• Decision authority, escalation and navigation • System communication and coordination • Safe, representative and influential engagement
2. **Strengthen feedback loops so engagement leads to visible outcomes**	**Theme 1**: How engagement structures are used in practice **Theme 2**: When engagement leads to action **Theme 3**: Feeling safe to speak up	• Feedback loops and decision follow-through • Enabling clinical leaders and forum chairs • Implementation support for agreed priorities
3. **Protect time and reduce low-value burden to enable meaningful engagement**	**Theme 5**: Workforce wellbeing under sustained pressure **Secondary**: Time, workload and capacity **Secondary**: Administrative burden and system noise	• Protected time and reduced low-value burden • System communication and coordination
4. **Provide dedicated support for implementation of change and improvement**	**Theme 2**: When engagement leads to action **Theme 4**: Alignment between authority and accountability **Theme 5**: Workforce wellbeing under sustained pressure **Secondary**: Competing priorities and change overload	• Implementation support for agreed priorities • Peer learning and shared practice • Feedback loops and decision follow-through

Recommendation	Theme alignment	Practical action areas
5. Strengthen leadership capability, chairing and stability to support engagement	**Theme 1**: How engagement structures are used in practice **Theme 3**: Feeling safe to speak up **Theme 5**: Workforce wellbeing under sustained pressure **Secondary**: Leadership capability, stability and behaviour	• Enabling clinical leaders and forum chairs • Safe, representative and influential engagement
6. Coordinate engagement requests and reduce duplication and system noise	**Theme 5**: Workforce wellbeing under sustained pressure **Secondary**: Administrative burden and system noise **Secondary**: Competing priorities and change overload	• System communication and coordination • Protected time and reduced low-value burden • Peer learning and shared practice
7. Build capability in system literacy and transparency	**Theme 1**: How engagement structures are used in practice **Theme 2**: When engagement leads to action **Theme 4**: Alignment between authority and accountability **Secondary**: System literacy and transparency	• Decision authority, escalation and navigation • Safe, representative and influential engagement • Peer learning and shared practice

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