Special Commission of Inquiry into Healthcare Funding

Joint statement of Matthew Daly, Joseph Portelli, and Sharon Smith

Name and Occupation: Matthew Daly, Deputy Secretary, System Sustainability and Performance, Ministry of Health (**MOH**)

Name and Occupation: Joseph Portelli, Executive Director, System Purchasing Branch, System Sustainability and Performance, MOH

Name and Occupation: Sharon Smith, Executive Director, System Information and Analytics Branch, System Sustainability and Performance, MOH

1. This statement accurately sets out the evidence that we would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**the Inquiry**) as witnesses and the views expressed are jointly held. The statement is true to the best of our knowledge and belief.

2. Matthew Daly has previously provided the Inquiry with two statements: the first dated 9 April 2024 (**MOH.9999.0976.0001**) and the second dated 6 June 2024 (**MOH.9999.1290.0001**). Sharon Smith has previously provided the Inquiry with a statement dated 9 April 2024 (**MOH.9999.0980.0001**). [Exh D8.] [Exh G.103] [Exh D.9]

A. SCOPE OF STATEMENT

3. This statement is provided in response to the requests contained in the Inquiry's letter to the Crown Solicitor's Office of 24 October 2024 . Specifically, it addresses questions:

   a. 1(c)(i) – the purchasing roadshow process,

   b. 2(a) – the information considered and process for purchasing activity from NSW Health agencies funded on an activity based funding (**ABF**) model,

   c. 4 – The identification of efficiency and the process for Efficiency Improvement Plans (**EIPs**).

4. Where relevant to our role, this statement also addresses Terms of Reference A and C concerning funding models, and the Issues Paper 3/2024.

5. This statement repeats information from the statement of Matthew Daly dated 9 April 2024 and 6 June 2024 and the statement of Sharon Smith dated 6 June 2024, where necessary to explain the issues outlined below. However, this statement should also be read in conjunction with the previous statements of Matthew Daly and Sharon Smith.

B. ANNUAL SERVICE AGREEMENTS

6. The purpose of the annual service agreement with each Local Health District (**LHD**), Specialty Health Network (**SHN**) and NSW Ambulance is to set the service and performance expectations for the funding provided by MOH. It facilitates accountability to government and the community for service delivery and funding.

7. Service agreements with LHDs and SHNs include the:

   a. level and mix of services being purchased (as across ABF streams eg. acute, non-admitted, mental health etc), expressed using the National Weighted Activity Unit (**NWAU**) model, which is the same model developed by the Independent Health and Aged Care Pricing Authority (**IHACPA**), which drives the Commonwealth Contribution to NSW for public hospital services,

   b. corresponding price (expressed as a price per NWAU),

   c. funding and reporting mechanisms,

   d. performance indicators,

   e. quality and service standards expected for the delivery of purchased services,

   f. relevant legislative or policy frameworks that are relevant to comply with, and

   g. items included are aligned and linked to the *NSW Health Future Health Strategy*, *NSW Premier's Priorities* and *NSW Performance and Wellbeing Framework*.

8. The pillar organisations and Health Administration Corporation organisations (excluding NSW Ambulance) have similar annual Performance Agreements and Statements of Service respectively. Agreements with Affiliated Health Organisations (**AHOs**) are managed by the respective LHD in which the AHOs sit, other than St Vincent's Health Network which is managed by MOH in the same manner as a LHD.

9. System Purchasing Branch (**SPB**) takes the lead role in developing the annual Service Agreements between MOH and the LHDs, SHNs, and NSW Ambulance, Performance

Agreements with NSW Health's Pillar organisations and Statements of Service with statewide shared service organisations.

C. SERVICE AGREEMENT ACTIVITY PROJECTIONS AND ASSESSMENT

10. Budgets in the annual Service Agreements with LHDs, Sydney Children's Hospitals Network and St Vincent's Health Network include purchased activity targets and growth funding that is tailored to local factors.

11. The System Information and Analytics (**SIA**) Branch's role is to ensure that NSW Health meets its state and national reporting obligations and maintains high standards of public accountability and transparency in the health system. SIA provides the MOH with data on performance and service utilisation, as well as data analysis including activity forecasting and modelling of health services.

12. Population and ageing growth for each LHD or SHN is calculated using NSW Department of Planning and Environment population growth estimates (developed from Australian Bureau Statistics (ABS) census data). These are adjusted for the relative health usage of different age groups and sexes.

13. Additionally**,** SIA calculates the relative health needs of each LHD's population are estimated by taking the consumption of hospital services by that population and comparing it to the NSW average. This incorporates adjustments to account for the population's age and sex as well as socio-economic factors that influence the quantity of services required. Where a population is consuming fewer health resources than the average (after accounting for/adjusting for these demographic factors), additional activity-based funding is normally allocated to the relevant LHD. This calculation is called the Equity Adjustor (an evolution of the previous Resource Distribution Formula) LHDs/SHNs are provided with full data inputs and calculations every year by SIA. LHDs/SHNs can also use this detailed information to provide feedback and suggestions during Roadshows or at any other time during the purchasing process.

14. The Equity Adjustor aims to estimate whether the residents of some LHDs are consuming less than other LHDs, when taking into account their LHDs demographics. It is not designed to suggest an ideal level of consumption.

15. The Equity Adjustor data is updated periodically. While the Equity Adjustor effectively does reassess the base each year, a complete re-allocation of the historical base is not necessary or possible within a yearly allocation because:

a. This could result in shifts back and forth between LHDs, leading to instability for planning and workforce. Whilst not all LHDs and SHNs are funded to 100% of what the Equity Adjustor predicts, a growth approach which moves the dial over a number of years is more stable and realistic for service growth, notwithstanding the budget and timing issues discussed later in this statement.

b. From a practical perspective, if changes were to be material, it is unclear what the required action would be. For example, if the Equity Adjustor did suggest a major realignment, it would not be feasible within a year to shut down a major portion of a principal referral hospital (or possibly shut down a local hospital) and move those funds to another area of the state. There are significant implications for workforce and infrastructure that take significant time to plan and implement, on both sides of that transaction.

c. Reallocation of base funding based on population need does not factor in geography and how people live their lives. Allocations based on population need would be attributed to a resident's LHD, however that does not address accessed needs when travelling, working or leisure activities away from home. A patient who has a car accident in the city is taken to the nearest appropriate hospital. Major trauma is taken to the nearest trauma hospital. These patients are not taken back to their home LHD. For example, approximately 30% of the unplanned admissions in Sydney LHD come from patients residing in other parts of the state, compared to 4% for Hunter New England LHD and 8% for South Western Sydney LHD (using 2022-23 FY data).

16. Factors raised by LHDs, SHNs or from emerging evidence or government policies and programs are also incorporated in the purchasing model. Instances where the ABF model does not adequately cover costs, or a new government initiative increases service delivery, are also considered. Examples include:

a. Additional funding for radiation oncology in Murrumbidgee LHD to support a government commitment to remove out of pocket costs for patients,

b. Additional funding for aeromedical transport in Far West LHD, given the substantially higher costs compared to other LHDs and modes of transport,

c. Additional funding to address the impact of the Parramatta Light Rail splitting the mental health campus, necessitating additional staff for security and rapid response teams on both sides of the rail line.

17. New Policy Proposals (**NPP**) are part of an investment framework that informs the policy and budget setting in New South Wales. NPPs within NSW Health are managed by Financial Services and Asset Management (**FSAM**) Division and led by the Deputy Secretary FSAM and Chief Financial Officer (CFO). Submission of NPPs to Treasury are required to outline their impact on both funding and performance metrics.

18. MOH policy teams develop NPPs for submission to Treasury through FSAM. For those NPPs that are successful, additional funding is included in the relevant Service Agreements for the respective years. Where the NPP results in an expected related activity uplift, the increased activity / NWAU is also incorporated into Service Agreements and performance is monitored through the Quarterly Performance meetings with the LHDs and SHNs.

D. SERVICE AGREEMENT PROCESS

(i) Purchasing of services

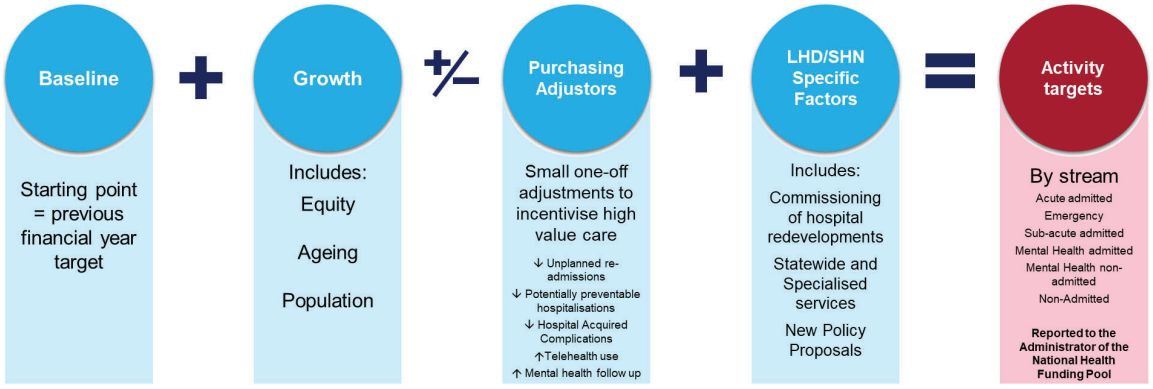
19. SPB is responsible for operationalising the *NSW Health Purchasing Framework* (**MOH.0100.0291.0001**) ***(Purchasing Framework)*** through the purchasing process that contributes to the budget in annual Service Agreements. [MOH.9999.0939.0001] [Exh D1.194]

20. The intent of the *Purchasing Framework* is to determine the annual mix and volume of services that should be purchased from LHDs and SHNs in order to deliver the objectives, goals and outcomes of NSW Health and NSW Government.

21. The *Purchasing Framework* guides the proposed budget allocations for the next financial year. Prior to the pandemic, the *Purchasing Framework* was reviewed annually to respond to emerging priorities and evidence. With the rapidly changing health landscape and additional costs of the COVID-19 pandemic response, increased uncertainty around the budget size and timing limited the ability to make strategic changes to the framework. As a result, review of the Purchasing Framework has been on hold until the system returns to a stable state.

22. Activity purchased under the *Purchasing Framework* is done using NWAU. For new models of care arising from clinical innovation where the ABF model is not appropriate (either due to low service volume or high variation in clinical needs), services can be purchased through block funding.

23. The purchasing process sets activity targets and allocates any growth funding, as shown below.



24. The core components of the purchasing model are population, ageing and equity growth:

    a. Population – factors in population growth within a particular region,

    b. Ageing – factors in demand increases as the population ages, and

    c. Equity – an increase in purchased activity to increase the health service utilisation of a population (relative to the state average).

25. The combination of these three elements generally make up the bulk of an LHD's and SHN's growth activity allocation, from which services can be enhanced or commenced based on local prioritisation.

26. NSW Health is upgrading and developing new, purpose-designed, contemporary health facilities to drive improved health outcomes and enhance patient and staff experience. As these redevelopments become operational, these are priorities for growth funding allocations.

27. Some statewide and specialised services are specifically funded (such as heart/lung transplants) as they provide value to residents in all of NSW, rather than a local population, and hence budget is allocated accordingly.

28. Activity targets (expressed in NWAU) established through this process are multiplied by the State Efficient Price, calculated annually by MOH's FSAM division. The State Efficient Price calculation utilises the most recent costing data from public hospitals in NSW, averaged across the state and indexed for the upcoming year.

(ii) Purchasing process to inform Service Agreement inclusions

29. SPB leads the annual purchasing process over nine months, usually starting in August with planning, and commencing formally in December with the Purchasing Workshop

held with LHDs and SHNs. SPB works consistently on the purchasing process in consultation with LHDs and SHNs through to the issuing of the Service Agreements on or around NSW State Budget Day which is usually in June the following calendar year. An important feature of this process is the detailed discussion with each LHD, SHN and organisation. These discussions enable the escalation of local issues that may be systemic in nature or issues that require special consideration (such as the opening of a major hospital redevelopment). The various stages of this process are set out in detail below.

30. Throughout the purchasing process, key MOH teams meet regularly to make decisions on elements of the Service Agreements (including KPIs, possible growth allocations etc), and discuss any emerging issues. This takes place in the Purchasing and Service Agreement Executive Group (**PSAEG**). The agenda items change depending on the stage of the process and can include:

    a. Update on the financial environment, including NPPs and budget available for growth

    b. Feedback from sites on the Service Agreement structure or the KPIs

    c. Proposed changes to the purchasing model

    d. Purchasing adjustor updates

    e. NPPs and their inclusion in the purchasing model

    f. Preliminary purchasing model and growth allocations

    g. Preparation for presentations to Ministry Executive for approval.

    Membership of the PSAEG group include Executive Directors from SPB, SIA and Finance teams, as well as technical advisors from those teams and the Director, Specialty Service and Technical Evaluation team.

MOH setting of priorities

31. The annual purchasing process commences each year with planning via internal consultation with program and policy areas in MOH, pillar organisations and statewide shared service organisations to identify emerging priorities or evidence. Generally, the bulk of activity purchased is recurrent activity. Whilst new health care services and needs

arise, disease profiles change incrementally based on demographics which is reflected in the activity generated.

Purchasing Workshop

32. The first stage of the collaborative purchasing process is formal consultation with LHDs and SHNs at a "Purchasing Workshop", usually taking place in December each year. The MOH conveys the fiscal environment and NSW Health priorities to LHDs and SHNs and updates to the purchasing model are discussed. Key members of the SPB, SIA and MOH Finance teams attend and present at this workshop.

33. Following the Purchasing Workshop, MOH incorporates feedback from the sector and finalises the purchasing model to be applied for the purchasing process.

Purchasing Roadshows and Purchasing Discussions

34. The first stage of the annual purchasing process is the "Purchasing Roadshows," with each LHD and SHN which cover key elements of the Service Agreement including:

    a. Financial environment for NSW Health,

    b. Changes to the funding model,

    c. Updates to any strategic priorities,

    d. Changes to Key Performance Indicators,

    e. Impacts of additional new policy proposals that are known,

    f. Impacts of any hospital redevelopments in the LHD or SHN, and

    g. Specific issues the LHD / SHN would like to raise, to be worked through with the MOH.

35. For example, in 2024-25, value-based models of care derived from clinical data were extensively discussed, including the introduction of new targets for surgical and medical interventions. These targets aim to promote allocative efficiencies within the public system and improve outcomes for patients.

36. The Purchasing Roadshows are held early in the calendar year and each LHD and SHN are visited for detailed discussions on any changes to the purchasing model, the

financial environment and introduction of local purchasing requests for the following year.

37. This is followed up by the “Purchasing Discussions” which is at least one additional meeting between MOH and each LHD and SHN, generally between April and May each year. These meetings between MOH and each LHD and SHN are to negotiate activity targets and growth funding allocations for LHD / SHN specific factors. This includes AHO matters (where LHDs have this delegated responsibility). Actions from the Purchasing Roadshows are followed up and provide an indication of additional activity in the upcoming budget. All LHDs and SHNs can request additional meetings if required.

38. In recent years, lack of certainty of NSW Health’s budget, due to NSW Treasury releasing the state budget later or providing temporary funding, has meant that confirmation of activity has not been provided to LHDs and SHNs until June. This minimises their ability to plan resource and funding allocations for the following financial year and adds uncertainty for the ongoing funding of programs.

39. All LHDs and SHNs can submit funding requests for new services or expansion of existing services requiring funding beyond the base at any stage. As part of the purchasing process, submissions are assessed for viability in terms of alignment with strategic priorities and clinical best practice, evidence of benefits for patient, staff and system outcomes and consideration of offsets through Efficiency Improvement Plans.

40. Purchasing requests are reviewed by subject matter experts in the MOH’s policy areas as well as the MOH’s purchasing, finance and activity based management branches. These local requests are funded within the total growth funding envelope determined by the MOH’s FSAM Division.

41. While there are discussions locally with LHDs and SHNs, an important tenet of the current devolved governance structure is that there are local budgets for local decision making. MOH is responsible for allocating the available budget to LHDs and SHNs (based on the best available data and evidence), and it is up to LHDs and SHNs to prioritise which services are provided based on local need.

42. Throughout this process, the Key Performance Indicators (**KPIs**) are reviewed to ensure appropriateness and alignment with the strategic focus of NSW Health. This is done in conjunction with the policy owners within the branches in the MOH.

43. The proposed KPI allocations to LHDs and SHNs are provided to the Ministry Executive Meeting (**MEM**) for approval. Once approved, the KPIs are included in the Service Agreement where they are managed by the SMB under the *Performance Framework* throughout the relevant financial year.

(iii) Budgetary allocations for population, aging and equity

44. LHDs and SHNs are responsible for local decision making on service delivery to meet the needs of their community. In line with the existing devolved governance structure, funding for population, ageing, and equity is the principal source of funding for local initiatives at the discretion of the LHDs and SHNs.

45. In recent years, the MOH has been increasingly unable to provide additional funding to LHDs and SHNs for allocation at their discretion due to the reduction in the growth budget size. Since 2018-19, there has been a decreasing trend in the amount of available activity growth funding from $471 million to $290 million in 2024-25. It should be noted that of that $290 million, $198 million was received from NSW Treasury through **NPPs** and should be considered supplemental to the available budget given the amounts are generally tied to specific items (e.g. elective surgery recovery

46. Whilst the overall available growth budget has decreased, the percentage of this funding compared to the whole has also decreased, as new builds are prioritised given their imminent opening. Where they apply, funding available through the NPP forms part of the total available growth funding. The overall budget received from Government each year, and the year to year change in growth funding, is managed through the Deputy Secretary FSAM and CFO's portfolio.

47. There may be a perceived lack of transparency regarding the funding model due to the timing of information in recent years. Prior to 2020, information was provided to NSW Health regarding budget allocations that allowed for information to be disseminated to the system early in the purchasing process. Over the last few years, this information has become available after the purchasing process was complete. This limits the time available to have meaningful discussions about the allocation available within the year.

48. Where there is less funding available compared to our estimated growth, each LHD is given a proportional reduction. This reduction applies only to population and ageing allocations and does not apply to the equity allocation.

E. HEALTH OUTCOMES INCENTIVISED BY FUNDING MODELS

49. NSW Health uses a combination of targeted funding and purchasing adjustors aligned to strategic priorities and evidence to ensure NSW public health service purchasing is linked to outcomes for patients, carers, staff and the system.

50. The purchasing model uses adjustors to incentivise models of care that will improve outcomes for patients. For example:

    a. The stroke purchasing adjustor was developed in consultation with clinicians and the Agency for Clinical Innovation (ACI) to ensure stroke patients had access to appropriate and best practice care. LHDs receive block funding when stroke patients are transferred to a stroke centre providing a full multidisciplinary service in line with the ACI model of care,

    b. Where a hospital has a higher rate of readmissions than expected (based on patient characteristics), ABF is reduced a small amount to encourage allocative efficiencies such as improved discharge practice or community based programs to keep people well at home. IHACPA uses a similar approach when calculating NWAU allocations for each state and territory, and this is a way of flowing the IHACPA approach to NSW hospitals.

51. The 2024-25 Budget provided $480.7 million over four years for an Emergency Department (**ED**) Relief Package. The funded initiatives will connect more people across NSW with high quality, accessible and timely care, by expanding alternatives to the emergency department, and by improving the flow of patients through the system. [SCI.0011.0545.0001]

52. A component of the ED Relief Package was $31.4 million over four years to enhance the Hospital in the Home (**HITH**) program by increasing the use of virtual care.

53. The HITH key performance indicators will be revised for 2025-26 to reflect HITH activity and the use of virtual care. The health outcome being more patients are able to be cared for safely in the comfort of their own home rather than in a physical hospital bed.

F. NSW PERFORMANCE

54. The System Management Branch (**SMB**) has the lead role in monitoring the performance of LHDs, SHNs and NSW Ambulance against the requirements of the annual Service Agreements. Performance of support organisations (Pillar and statewide shared service organisations) is managed through a partner relationship between a

nominated Deputy Secretary and the Chief Executive of the support organisation against the requirements of Performance Agreements or Statements of Service. Performance of AHOs is managed by the respective LHD in which they sit, other than St Vincent's Health Network which is managed by MOH in the same manner as a LHD or SHN.

55. The *Performance Framework* (**SCI.0001.0007.0001**) incorporates the strategic priorities for the NSW Health system which flow from Commonwealth/State agreements, including implementation of the National Health Reform Agreement. [Exh A.11]

56. The *Performance Framework* includes the performance expected of LHDs, SHNs, NSW Ambulance and statewide shared service organisations to achieve the required levels of health improvement, service delivery and financial performance.

57. The *Performance Framework* requires that each health service is to have in place an effective internal performance framework that extends to facility and clinical network/stream levels for monitoring performance and identifying and managing emerging performance issues.

58. Regular communication on performance for LHDs and SHNs includes quarterly Performance Meetings between MOH and health service executives in accordance with the *Performance Framework* and provision of monthly Health System Performance Reports produced by MOH which outlines performance against KPIs. MOH assigns a performance level, which requires a corresponding response, as set out in the below table:

Performance level	**Description**	**Response**
0	Nil performance concerns	Participation in recovery activities designated by Ministry branches responsible for underperforming KPIs. More serious performance issues will result in broader and more intensive programs, including monthly recovery meetings with the Ministry for under-performing KPIs, reviewing
1	Under review	
2	Under performing	

		implementation of a comprehensive recovery strategy.
3	Serious under-performance risk	Monthly recovery meetings with the Ministry, reviewing implementation of a comprehensive recovery strategy. The Ministry may appoint a representative to assist the Board to effectively oversee necessary performance improvements, including attending Board meetings for that purpose.
4	Health service challenged and failing	Action determined by the nature of the performance issues. They may include commissioning an independent review, requiring the Board to demonstrate the Chief Executive is able to achieve turnaround in a reasonable time, and the Minister determining to change membership of the Board.

59. SMB monitors LHDs and SHNs for achievement of agreed KPIs and deliverables under the *Performance Framework.* MOH and LHDs/SHNs communicate regularly about performance, including through Quarterly Performance Meetings between MOH and the LHD/SHN executives and monthly Health System Performance Reports produced by the SIA Branch which provides detail on performance against KPIs. Where under performance is identified, MOH and the LHDs/SHNs work collaboratively to remediate the issue in accordance with the requirements of the *Performance Framework*.

60. The most recent published data on the IHACPA National Benchmarking Portal (shown below) indicates that NSW is one of the most efficient jurisdictions in terms of cost per NWAU, at $5,905. This is in comparison to the national average of $6,416.

61. In 2022-23, the Australian Institute of Health and Welfare reported that NSW had the highest proportion of emergency department presentations seen on time and the lowest proportion admitted to hospital of all jurisdictions.

62. NSW had the second-highest proportion of elective surgeries completed within clinically recommended timeframes at 77.3%, just behind Queensland with 77.7%. NSW was the highest-performing jurisdiction for category 2 (semi-urgent) patients treated within clinically recommended timeframes.

G. EFFICIENCY IMPROVEMENT PLAN PROCESS

63. The role of the Efficiency Improvement Support Team (**EIST**) is to support and advise LHDs and SHNs.

64. The EIST is the administrator of the *Efficiency Improvement Plan program* which is a Treasury obligation introduced in 2012 and a requirement of the NSW Health *Conditions of Subsidy* for all health entities to provide the MOH (via the EIST) with efficiency improvement plans (**EIPs**) which address efficiency dividends, and any underlying deficits carried forward from the previous financial year.

65. The EIST works with LHDs and SHNs to:

    a. Provide expertise in financially sustainable health service delivery,

    b. Provide benchmarking data and formal on-site expense efficiency reviews at the request of the Chief Executive or direction of the Chief Financial Officer or Secretary. Benchmarking involves examining staffing levels, use of premium labour, agency costs, acute activity levels, length of stay for comparable

treatments, occasions of additional nurse or security for one-on-one care (called 'specials') being provided, or spend on pharmaceuticals/prostheses between peer LHDs or facilities,

c. Identify and develop efficiency initiatives and financial recovery strategies,

d. Share, scale and enhance LHD and SHN initiatives that successfully reduce inefficiency throughout NSW Health. Examples of these initiatives include reducing premium labour costs through targeted recruitment, reduction in inappropriate diagnostic orders, realignment of IT licencing to reduce expenses and other expense reduction programs.

66. A key component of NSW Health achieving financial sustainability is through the delivery of a robust savings and efficiency program. A mandatory requirement of the *NSW Financial Requirements and Health Conditions of Subsidy* is for all health entities to provide the MOH with EIPs. EIPs, first introduced in 2012, address efficiency dividends, as determined by MOH or the health entity, and any underlying deficits carried forward from the previous financial year. [MOH.0010.0732.0001]

67. EIPs are detailed project plans capturing key information including: the efficiency strategy objective, target savings to be achieved, initiative sponsor, benefits, implementation milestones, issues and risks and detailed budget and financial information supporting the strategy. The detailed budget and financial information required includes:

a. Analysis of data supporting the EIP i.e. baseline used for comparison, Full-Time Equivalent (**FTE**) growth data or growth in premium labour costs and any strategy assumptions,

b. Cost centres and accounts impacted by the EIP used for monitoring benefits, including General Ledger reports, and

c. Any cost off-sets to ensure net benefits is measured.

68. EIPs are broadly categorised into Expense, Revenue, and Productivity:

a. Expense EIPs which capture efficiencies in employee related expenses, goods and services, reducing premium labour or overtime, and the renegotiation of contract prices,

b. Revenue EIPs which capture efficiencies aimed at increasing own source revenue such as patient fees, Medicare billings, prosthesis and pharmaceutical rebates, rental income, and

c. Productivity EIPs which capture improved activity and reductions in length of stay.

69. The EIP process is as follows:

a. An outline of the EIP process is provided in the MOH Purchasing Roadshows held with health entity Chief Executives (**CE**) and Directors of Finance (**DoF**) prior to the development of the next financial year's Service Agreement,

b. In April, all health entities are required to submit to MOH a preliminary efficiency plan and target for the following financial year. This plan is reviewed by MOH and discussed with the health entity DoF. Where there is insufficient EIPs to meet underlying deficits, health entities are requested to identify further EIPs, and

c. Once the preliminary assessment is accepted, health entities commence submitting individual EIPs to MOH. MOH review these EIPs and either request further validating information to ensure benefits can be measured and realised or accept and upload the EIP into the MOH electronic reporting system, KEY.

70. EIP performance is monitored and reported upon as follows:

a. At the end of each month, health entities are required to update the benefits of their EIPs directly into KEY,

b. A report on each health entity's EIP performance is provided to the health entity's CE and DoF each month,

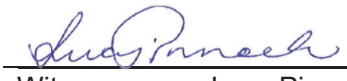
c. The overall NSW Health EIP Program is formally reported on at the monthly Health System Performance Monitor meeting,

d. EIP performance is also part of the formal performance meetings held between the health entity and MOH, and

e. Bi-monthly meetings are held with MoH and DoFs where EIP performance, EIP issues and risks, and the sharing of EIPs that are working in other health entities occurs.

71. NSW Health has emerged from providing a nation-leading response during the COVID pandemic to an unprecedented situation where nearly all health services, faces cost pressures to deliver services within the funding provided. NSW Health currently faces significant budgetary challenges as well as workforce shortages. Despite these challenges, NSW Health is continuing to deliver excellent patient care and outcomes which often are above that delivered by other jurisdictions. The EIP program and delivery of efficiencies is a key approach to reducing wastage and cost inefficiencies in the system and to demonstrate sound management and use of public monies.

Matthew Daly



Witness name: Lucy Pinnock

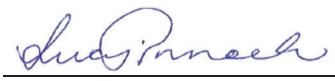
14-11-2024

Date

14-11-2024

Date

Joseph Portelli



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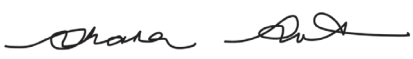

Sharon Smith

Witness name: Lucy Pinnock

14/11/2024

Date

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Date