Special Commission of Inquiry into Healthcare Funding

Statement of Sharon Smith

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1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary to give to the Special Commission of Inquiry into Healthcare Funding as a witness. This statement is true to the best of my knowledge and belief.

A. INTRODUCTION

2. My name is Sharon Smith. I am the Executive Director, System Information and Analytics (**SIA**) Branch at the NSW Ministry of Health (**MOH**). A copy of my curriculum vitae is exhibited to this statement (Exhibit 3 in NSW Health Tranche 4 Consolidated Exhibit List).

3. I am on the following committees and forums:

   a. National

      i. Health Data Collaborative (**HDC**)

      ii. Strategic Committee for National Health Information (**SCNHI**) – Chair

      iii. Clinical Quality Registries (**CQR**) Advisory Committee

      iv. National Health Data Hub (**NHDH**) Advisory Committee

      v. National Health Reform Data and Performance Working Group – Co-chair

      vi. Australian ICD 11 Taskforce

   b. NSW

      i. Health Information Performance Governance Committee (**HIPGC**) – Chair

      ii. Data Governance Steering Committee – Chair

      iii. Mental Health Living Longer (**MHLL**) Program – Chair

      iv. MOH ICT Governance Forum

      v. Patient Reported Measures (**PRM**) and Health Outcome and Patient Experience (**HOPE**) Steering Committee

      vi. Northern Sydney Local Health District Executive Steering Committee

      vii. Operational Data Store (**ODS**) Program Steering Committee

viii. Integrated Care and Population Health Governance Committee

ix. NSW Health Primary Health Network (**PHN**) Statewide Committee

x. Enterprise Data Warehouse for Analysis, Reporting and Decision Support (**EDWARD**) Business Implementation Steering Committee

xi. EDWARD Ministry of Health Transition Governance Committee – Chair

xii. Future Health Strategic Outcome 2 Steering Committee

xiii. Future Health Strategic Outcome 5 Steering Committee

xiv. State-wide Data Custodian For Data In Systems – Data Governance Reform Program

xv. Lumos Data Governance Committee

xvi. Highly Specialised Services Committee – Chair

xvii. Virtual Care Steering Committee

xviii. Virtual Care Measurement and Evaluation Committee – Chair

xix. Self-Reported Information (**SRI**) Steering Committee

xx. Steering Committee Meeting: MOH Dynamic Statewide Ambulance Matrix Build

xxi. Measurement and Intelligence Council

xxii. eApproval Steering Committee

xxiii. Urgent Care Services Governance Committee

xxiv. Health Data and Analytics Advisory Committee (**HDAAC**)

xxv. Single Digital Patient Record Steering Committee

xxvi. Collaborative Commissioning Steering Committee

xxvii. NHRA Scope of Services Committee

xxviii. EDWARD Business Implementation (**EBI**) Steering Committees for various Local Health Districts (**LHDs**): Central Coast LHD, Nepean Blue Mountains LHD, Northern Sydney LHD, Western Sydney LHD, Murrumbidgee LHD, Southern NSW Local Health District, Sydney LHD and Western NSW LHD.

xxix. Priority Reform 4 – Closing the Gap Band 2 Working Group

xxx. NSW Data Leadership Group

4. The SIA Branch manages the majority of important data collections held by NSW Health for the purposes of governance, performance, funding and managing the health system. It enables the MOH to be an effective health service purchaser and system manager through high quality data, analysis and performance reporting. The branch ensures that NSW Health meets its state and national reporting obligations and maintains high standards of public accountability and transparency in the health system. The staff in my team support key decision-makers within NSW Health by providing high quality, timely information on the performance, service utilisation, activity forecasting and modelling of health services.

5. In this role, I am responsible for oversight and management of 6 teams which fulfil the functions of the branch. These are:

   a. Information Management and Quality

   b. Performance Analysis and Reporting

   c. System Monitoring and Insights

   d. EDWARD Data Warehouse

   e. Information for Mental Health

   f. Service Utilisation and Activity Modelling

6. As Executive Director, I also receive recommendations on developments, enhancements and modifications to data products which will facilitate compliance with statutory data requirements, ongoing and improved data quality and supportive and efficient business processes from a range of working groups and committees, including the NSW Clinical Coding Leadership Group (**CCLG**), Non-Admitted Patient Data Working Group and the Health Information Performance Governance Committee (**HIPGC**). These working groups and committees support the development of data collection in NSW Health. There are other groups from which these groups take advice and recommendations such as those led by the Activity Based Management Team.

7. I am the Data Custodian for a range of data assets held by NSW Health. It is my role to negotiate what the data which we hold is going to be used for and put conditions on its use when linking and sharing data with other parts of the MOH or health system or external organisations. This is pursuant to the *GL2019_002 NSW Health Data Governance Framework* (Exhibit 81 in NSW Health Tranche 4 Consolidated Exhibit List).

8. The data managed and held by the SIA Branch is utilised by downstream users for a myriad of purposes including health statistics, health system performance monitoring, activity-based management, national reporting, planning and the Bureau of Health Information. Patient-reported experience measures (**PREMs**) and patient-reported outcomes measures (**PROMs**) are not currently managed within this branch (save for PREMs related to mental health) and are managed by the Agency for Clinical Innovation (**ACI**) and Bureau of Health Information (**BHI**).

B. SYSTEM INFORMATION AND ANALYTICS BRANCH

Information Management and Quality

9. The function of the Information Management and Quality team (**IMQ)** is to manage data collections from LHDs and networks by reference to MOH standards and policies. IMQ

also monitors data as it is received to ensure it is being uploaded and that there are quality checks for the data in place.

10. IMQ is broadly responsible for working with relevant policy areas and business units in determining what data the MOH needs from LHDs and how it is going to be collected and submitted. In order to do so, IMQ defines the policy, business requirements and standards for the collection of data. This includes information such as:

    a. What data fields need to be supplied

    b. What values need to be supplied

    c. Interface specifications given to local IT developers to ensure data can be extracted from local systems

11. IMQ is responsible for putting the business requirements which inform Key Performance Indicators (KPIs) into data terms to ensure the correct data is being collected and that it is being measured correctly and consistently from month to month and place to place. These are summarised in the *KPI Data Dictionary*.

12. An example of a policy is the *KPI Data Supplement 2023-24,* which includes definitions to assist LHDs and other data users with the calculation and interpretation of KPIs referenced in the respective Service Agreements for 2023-24 (Exhibit 82 in NSW Health Tranche 4 Consolidated Exhibit List). The Service Agreement is a key component that provides a clear and transparent mechanism for assessing and improving performance. The Service Agreement only covers KPIs. The KPIs contained in this policy document have been defined specifically with the intent to meet the reporting requirements under the agreements to align with the MOH monthly health system performance monitoring reports.

13. Setting of business requirements and targets is largely done outside of this branch. KPIs each have business owners in other branches of the MOH who determine what performance they want to measure and what level of performance or target they want in respect of each KPI. Whether performance targets are being met is assessed in relation to 3 categories: performing, underperforming and not performing. For example, the KPI for transfer of care from the care of paramedics to an Emergency Department (**ED**) clinician is “owned” by System Management Branch. The KPI is for transfer of care to occur within 30 minutes and the target is for this to be achieved for 90% of patients per LHD. By reference to the KPI definitions, it is the role of IMQ to identify the data element in the relevant data collection information system which indicates that a patient has arrived at the ED or been transferred from the care of the ambulance to the ED, to determine how that time period is measured and to define what performing, underperforming and not performing means in this context.

14. IMQ produces a similar policy document for the reporting of Improvement Measures – the *Improvement Measures Data Supplement 2023_24* (Exhibit 83 in NSW Health Tranche 4 Consolidated Exhibit List). Whereas a KPI has a target and thresholds of performance, improvement measures simply reflect changes in particular areas over time and may have no particular target or threshold.

15. There are currently a range of disparate systems across NSW that provide data to the MOH. IMQ currently needs to have awareness of all of those systems to ensure requirements are met across the board. The Single Digital Patient Record (**SPDR**) will replace and consolidate a larger number of these systems. IMQ will work with the team

responsible for the SDPR in relation to ensuring the SDPR delivers on its mandatory reporting requirements, which are set by IMQ.

16. An example of the role of policies, reporting and flow of data managed by IMQ is as follows:

    a. *PD2013_010 Non-Admitted Patient Activity Reporting Requirements* (Exhibit 84 in NSW Health Tranche 4 Consolidated Exhibit List) outlines the mandatory requirement to report a minimum data set describing each non-admitted patient service each month. This reporting requirement underpins activity based funding.

    b. Data submitted by each health service is classified before we receive it so IMQ has developed *GL2017_014 Non-admitted Patient Classification Principles* (Exhibit 85 in NSW Health Tranche 4 Consolidated Exhibit List) which outlines for determining what constitutes a non-admitted patient service and how to appropriately classify, or identify the service they have provided.

    c. Reporting requirements might slightly change on an annual basis, in which case an information bulletin is disseminated to provide updates on the requirements – see *IB2021_051 Non-Admitted Patient and Supplementary Services Data Collection: Core Minimum and Extended Data Set* (Exhibit 86 in NSW Health Tranche 4 Consolidated Exhibit List).

    d. Data sets are fed into the Non-admitted Patient National Best Endeavours Data Set (**NBEDS**) developed by the Australian Institute of Health and Welfare and the Independent Hospital and Aged Care Pricing Authority. Reporting requirements from the MoH to districts and networks are in accordance with these requirements – see *Non-Admitted Patient National Best Endeavours Data Set (**NBEDS**) 2022-23* (Exhibit 87 in NSW Health Tranche 4 Consolidated Exhibit List).

17. The *EDWARD Public Admitted Patient Care Data Stream Data Dictionary* (Exhibit 99 in NSW Health Tranche 4 Consolidated Exhibit List) is another example the data specification work of IMQ. It prescribes the concept definitions, standard classifications and codes that must be reported, category definitions, justification for inclusion, scope and related guidelines for reporting the EDWARD data. The target audience includes staff who configure source system builds, data suppliers, data custodians and data stewards and technical staff involved in developing and maintaining the EDWARD system.

Performance Analysis and Reporting

18. The Performance Analysis and Reporting team does routine weekly, monthly and quarterly reporting against KPIs based on the data which is collected and monitored. Regular reports include:

    a. Health System Performance Report – this is produced monthly for each LHD and Specialty Health Network (**SHN**) and measures each KPI against targets included in their Service Agreements, and is also produced monthly for NSW Health against the health strategic outcomes

    b. Weekly and Monthly reports to the Secretary and Executive of MOH

    c. Reporting on strategic priorities such as Future Health Strategy indicators, Aboriginal Health, Rural Health, and

d. Quarterly Board reports for each LHD for consideration at their Board meeting.

19. This team is also responsible for analysing data and providing responses to queries from various stakeholders including the Minister’s office, parliamentary Questions on Notice, LHDs, other parts of the MOH, media and responding to GIPA requests. This team is also responsible for compiling annual results and data for publication in the NSW Health Annual Report and for submission to the NSW Auditor General and NSW Health Care Complaints Annual Reports and the Australian Productivity Commission Report on Government Services.

20. This team also submits data to Commonwealth agencies for public hospital funding and public reporting purposes and to meet the requirements of the National Health Reform Agreement and the National Health Information Agreement . It is important to note that the same source information and data collected by MOH for the purposes of the service agreements is also submitted to the Commonwealth government. For example, data reflecting ED performance, elective surgery wait times or NWAU is utilised for both these purposes. Maintaining consistency and end to end traceability of the data is important to MOH.

21. A number of organisations within and outside the MOH use the data managed by my branch in order to do their work. For example:

    a. The MOH's System Performance Support and Systems Management Branches use the data to work with LHDs on improvement projects, particularly around patient flow and emergency department reform.

    b. The Activity Based Management Branch uses the data to work locally with districts to examine opportunities for cost savings and efficiencies.

    c. The ACI uses the data in clinical development work.

    d. The BHI uses data held by the MOH to create public reporting. BHI has access to our data warehouses but undertakes its own independent calculations based on its own measurements from the data we manage. This is because the role of BHI is to form an independent assessment. However, it relies upon our data and its quality to come to that view. Some measurement standards are different, and the point in time at which indicators are measured are different, so our analysis may result in slightly different results to BHI using the same data. The role of BHI is outward-facing compared with the role of my branch, which is primarily for internal governance purposes, improvement functions and national reporting. The MOH does not hold the data for the Patient Survey Program run by BHI; however, it supports the program by undertaking sampling activities to provide a list of the patients to be surveyed.

System Monitoring and Insights

22. The primary function of this team is to monitor performance in priority health reform areas and run the Lumos program. Linkage with the primary healthcare system and monitoring and evaluation of integrated care is fundamental to the work undertaken in this team.

Modelling and Collaborative Commissioning

23. This team is currently building capability around Dynamic Simulation Modelling. This is an emerging type of statistical modelling which allows us to look at the impact of policies and priorities in a safe way before implementing them. Dynamic Simulation Modelling

was built up over a number of years in house, initially with the assistance of Ernst & Young, for the purposes of Collaborative Commissioning. Its utility has since expanded to other parts of the MOH. For example, before introducing urgent care services, this modelling was used to identify locations in which we would be able to place urgent care services that would have the best benefit for the community and to understand the nature of the demand. The model is built with actual data and for each initiative we monitor the actual data against the model.

24. Each of the Collaborative Commissioning joint partnerships between the LHD and the Primary Health Network (**PHN**) identified a cohort of need that they wanted to build a service or pathway of services for. For example, in Murrumbidgee Local Health District the cohort of need was identified as consumers with Chronic Obstructive Pulmonary Disease and Chronic Heart Failure. The Dynamic Simulation Model was used with each partnership to identify the size of the opportunity and the kinds of outcomes they might expect, such as on emergency department presentations and hospitalisation. The model is now used in Collaborative Commissioning to monitor those outcomes and outputs for the identified cohort according to the initial targets set by the partnership.

25. There are always deficiencies in data inputs which we would like to include in our modelling but we do not have. We will seek to gain access to additional inputs over time.

26. The model is flexible which means we can add or remove the data being used in the model depending on its purpose. For example, modelling done for emergency department reform will require workforce data.

Lumos

27. I am the Executive Sponsor for the Lumos program, in which capacity I am responsible for the overall function and strategic direction of the program. The programs functions and data are contributed to by a range of stakeholders including the MOH.

28. Lumos is an ethically approved program that securely links encoded data from general practices to other health data in NSW, including hospital, ambulance, emergency department and mortality data. Lumos seeks to analyse entire patient journeys by bringing together de-identified data from patient records across all parts of the continuum of care. It is delivered through a partnership between NSW PHNs, general practices and the MOH and operates under strict data governance processes.

29. The program is the result of a four-year pilot project which commenced in 2016 and funded by a Commonwealth Health Innovation Fund (HIF) grant. The pilot demonstrated that it is possible to securely extract patient records from general practice systems and link them to data about patients in the public health system, in order to yield actionable insights for both primary care and acute care sectors. The *Lumos Monitoring and Evaluation Framework* describes the program aims, approach and data sources (Exhibit 88 in NSW Health Tranche 4 Consolidated Exhibit List). A scale-up phase followed the pilot, also funded by a Commonwealth HIF grant, in 2024 Lumos has transitioned to business as usual, funded by NSW Health. There are currently more than 700 participating GPs across all 10 NSW PHNs. There are more than 5 million patient journeys in the Lumos data set.

30. Given Australians overwhelmingly want their de-identified data to be used for authorised health purposes but hold substantial concerns about its protection and the impact of data breaches on their lives, the Lumos program has implemented robust data governance protocols. The *Lumos Data Governance Framework* ensures that data management across the Lumos program is aligned with the aims of Lumos, complies with the relevant

legal, ethical and policy requirements, builds social license and public trust, guides stakeholders in their decision-making and establishes responsibilities and accountabilities for relevant decision-makers (Exhibit 89 in NSW Health Tranche 4 Consolidated Exhibit List).

31. One of the challenges for NSW Health is that it is an interaction-based data system, which means that we only have visibility of services which we provide. This excludes data regarding people that did not utilise a service or people that may have needed care but did not seek it. Therefore, understanding the health outcomes or journeys of people that do not access our services or after they have accessed our services is limited using our usual administrative data sets. A key gap is what happens to patients in GP services that have not traditionally been visible to NSW Health. Lumos allows us to begin to see patient journeys outside the use of NSW Health services such as whether the patient went on to see their GP, whether they had health conditions that were diagnosed by their GP before they presented to hospital and their ongoing utilisation of health services.

32. Examples of the utilisation of Lumos data are described in the following factsheets:

    a. *Lumos Factsheet – Management of Diabetes in the Community Influences for Acute Care and Mortality* (Exhibit 90 in NSW Health Tranche 4 Consolidated Exhibit List).

    b. *Lumos Factsheet – General Practice Activity Can Affect Hospital Visits* (Exhibit 91 in NSW Health Tranche 4 Consolidated Exhibit List).

    c. *Lumos Factsheet – Health Care Usage for Older People* (Exhibit 92 in NSW Health Tranche 4 Consolidated Exhibit List).

    d. *Lumos Factsheet – Impact of Where People with Diabetes Live* (Exhibit 93 in NSW Health Tranche 4 Consolidated Exhibit List).

    e. *Lumos Factsheet – Care in General Practice Can Affect Hospital Visits* (Exhibit 94 in NSW Health Tranche 4 Consolidated Exhibit List).

    f. *Lumos Factsheet – Continuity of Care Benefits Patients and the System* (Exhibit 95 in NSW Health Tranche 4 Consolidated Exhibit List).

33. Participating general practices and PHNs receive reports on a regular basis that compares their practice with other practices in the PHN and across NSW - see, by way of example, *Lumos – General Practice Report October 2020* (Exhibit 96 in NSW Health Tranche 4 Consolidated Exhibit List).

34. NSW Health also publishes a Lumos Evaluation Report annually. By way of example, *Lumos Evaluation Report 1* of December 2021 is Exhibit 97 in NSW Health Tranche 4 Consolidated Exhibit List.

35. The data obtained by the Lumos program is not just utilised within NSW Health. The Secure Analytics Primary Health Environment (**SAPHE**), which went live in 2021, is custom-built by the Lumos program for PHN, LHD and MOH stakeholders and is the first time a linked data asset containing NSW Health data has been made accessible to PHN partners. Authorised users can analyse de-identified data in that environment. Since going live, around 100 analysts have been granted access to the SAPHE after applying through a rigorous application process. User feedback on the SAPHE was gathered during the most recent Lumos evaluation and is informing planned improvements.

36. There are a nevertheless a number of limitations to the Lumos program. First, it requires participation by GPs. The first few years of the program involved recruitment of participating GPs. There are no incentives to participate in the program other than the provision of practice-specific reports after each linkage. We now have approximately 700 participating practices and are confident that the patient cohort is representative of the NSW population through comparisons of key demographic information with census data. So much was confirmed in a published study, *Lumos: A Statewide Linkage Programme in Australia Integrating General Practice Data to Guide System Redesign* (Exhibit 220 in NSW Health Tranche 4 Consolidated Exhibit List). Information is provided to interested GPs and a consent form is provided to the practice in the *Lumos – Information for General Practitioners* and *Lumos Consent Form* (Exhibit 98 in NSW Health Tranche 4 Consolidated Exhibit List).

37. Secondly, not every GP uses an electronic practice management software which enables us to extract data from it. Thirdly, privacy legislation can be an impediment to data collection. Sharing information such as discharge summaries or referral forms for primary use is permitted but there are limitations on using data for secondary purposes such as management of the health service or research if consent is not obtained from each individual patient. The public benefit of such uses must be weighed up against the protection of individuals' privacy. In the case of the Lumos program, this determination has been made under the *Health Records Information and Privacy Act 2002* by an appropriately authorised ethics committee.

Current Developments

38. There are significant benefits to patient experience, health outcomes and the utilisation of the health system if there is integration with primary care and GPs are actively engaged in a patient's journey at the time of their hospital discharge. If there is greater visibility of data between the Commonwealth and state systems and with primary care we can better assess the impacts of health service delivery and improve patient health outcomes.

39. There are a number of other initiatives taking place both nationally and in NSW that involve linked data sets to take us further in the direction of integrated data in order to assess health outcomes. For example the Digital NSW initiative, the Better Outcomes Lab incorporates data sets across health, education and the Department of Communities and Justice, which allows us to look specifically at the health of vulnerable populations. The Person Level Integrated Data Asset is a national asset that pulls together information from the Census, Australian Taxation Office, Department of Immigration, health, education and social security. We submit data to the Commonwealth for this purpose. Initiatives such as these help us to understand more broadly the needs of our community. However, they are relatively new and difficult to get off the ground.

40. NSW has been tasked by the Health Ministers Meeting to lead a national project to link primary and acute care data similarly to the Lumos program. We are working on a design program over the next 18 months to design the project across all jurisdictions.

41. There were significant disruptions to data collection during Covid-19. The ability to look at trends, particularly long-term trends for chronic disease, was impacted due to service disruption. There was modelling done pre-Covid on what the health system might look like now that we are in the process of revisiting in order to reset baselines. My branch was responsible for leading the development of guidance on dealing with limitations and disruptions in the data. An example of this is a guide for analysts on how to use different techniques to continue evaluating some of their work programs whilst overcoming some limitations in the data.

EDWARD Data Warehouse Team

42. EDWARD stands for Enterprise Data Warehouse for Analysis, Reporting and Decision Support. EDWARD was designed to progressively replace the Health Information Exchange (**HIE**) as NSW Health’s strategic data source for performance monitoring, health service purchasing and funding, health service planning and disease surveillance. It is a single state-wide data warehouse that receives data directly from IT systems in LHDs.

43. EDWARD is more than simply a server; it structures the data for easier consumption and adds value add elements such as the calculation for National Weighted Activity Units (**NWAUs**).

44. The team is responsible for the design, build, testing of EDWARD in close collaboration with the business requirements and enterprise strategic direction. This team is responsible for enacting the transition from HIE to EDWARD. It is responsible for transition, planning engagement with LHDs, engagement with vendors and engagement with eHealth as part of this process.

45. NSW Health is almost at the end of its transition to EDWARD. Once the transition is complete, this team will be responsible for the warehouse's maintenance and further development as a business asset for NSW Health. Future development will include the addition on new data sets identified by business owners.

Information for Mental Health Team

46. The Information for Mental Health Team (**InforMH**) manages data development, collection and reporting requirements for mental health and suicide. The NSW mental health system includes a range of hospital, community, residential and NGO services, and has several additional data collection and reporting requirements.

47. InforMH maintains specialist data collections for community mental health (**CHAMB**), mental health outcome measures (**MHOAT**), community residential services and seclusion and restraint in NSW hospitals and emergency departments.

48. InforMH also manages the collection and dissemination of data from the Your Experience of Services (**YES**) survey and the Carer’s Experience of Service (**CES**) survey. The YES survey is a nationally developed measure that asks consumers about their experience of mental health services. YES data are used in NSW service agreements, regular reporting to LHDs, and annual public reporting. InforMH also manages YES collection and reporting on behalf of NSW NGO mental health services, and a pilot of implementation of YES in NSW Drug and Alcohol services.

49. InforMH manages development and submission of data for national mental health-related collections. These include national minimum datasets for Community Mental Health, Residential Mental Health, mental health outcome measures (**The National Outcomes and Casemix Collection**), restrictive practices (**SECREST Dataset**) and experience of care.

50. InforMH also runs the NSW Suicide Monitoring System (**SuMS**). This is a joint initiative of the Department of Communities and Justice and the MOH. SuMS Uses Police and Coronial data to provide and early measure of suicide deaths in NSW, and meets NSW commitments to national efforts to establish suicide registers in each state. SuMS provides monthly public reports about the incidence of suicide and trends across NSW,

and a range of detailed reports for LHDs and partner organisations to support suicide planning and responses.

51. One of the unique functions of INFORMH is to directly interface with clinicians in districts and networks. This includes clinical benchmarking workshops where mental health data is presented to districts and networks and the local health services are talked through what the data shows and opportunities for improvement and exemplars are provided. It also includes regular briefings of LHDs and policy-makers on suicide and self-harm data and trends.

52. InforMH manages clinical measurement and documentation issues for NSW mental health services, including managing design of mental health aspects of NSW electronic medical records.

53. InforMH conducts policy-relevant analyses and research on mental health and suicide data, and uses data to support LHDs in planning and monitoring improvement efforts. This includes the NSW *Mental Health Living Longer* project which use slinked NSW Health data to understand and reduce premature mortality in NSW mental health service users .

Service Utilisation and Activity Modelling Team

54. This is a small team whose role is to model utilisation of the health system based on demographic factors such as population growth and the ageing population. This determines how much activity the MOH should purchase from districts and networks in the coming year based on allocations from NSW Treasury. This data contributes to future planning.

55. The team also undertakes development of purchasing adjustors and the methodology related to the equity adjustor. All of this is used to calculate district and network activity targets and projections.

56. There are 6 strategic outcome areas based on the *Future Health: Strategic Framework 2022 – 2032* developed by NSW Health. These are:

    a. Patients and carers have positive experiences and outcomes that matter

    b. Safe care is delivered across all settings

    c. People are healthy and well

    d. Our staff are engaged and well supported

    e. Research and innovation, and digital advances inform service delivery

    f. The health system is managed sustainably

57. Each of the strategic outcome areas has a Steering Committee which meets at least quarterly. They receive reports on the KPIs and measures which relate to the relevant outcome. The SIA Branch puts together these reports or dashboards and facilitates conversation with the Steering Committees about whether the system is on track to achieve its objectives and outcomes. This is a similar process to reporting back to districts on their KPI performance but may also include inputting data received from other sources which the branch does not itself hold, such as workforce data, and putting it together into the reporting.

Sharon Smith

Sharon Smith

Witness: [insert name of witness]

09/4/2024

Date

09/04/2024

Date