Special Commission of Inquiry into Healthcare Funding

Statement of Deborah Willcox AM

Name:	Deborah Willcox AM
Professional address:	1 Reserve Road, St Leonards NSW 2065
Occupation:	Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health

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 (**Inquiry**) as a witness. The statement is true to the best of my knowledge and belief.

A. INTRODUCTION

2. My name is Deborah Willcox AM. I am the Deputy Secretary, Health System Strategy and Patient Experience of NSW Ministry of Health (**MOH**) appointed in September 2022.

3. Prior to my role as a Deputy Secretary, I held senior executive positions including Chief Executive, Northern Sydney Local Health District, Director of Operations, Sydney Local Health District, General Manager, Royal Prince Alfred Hospital, Director Customer Service and Corporate Governance, HealthShare NSW, and Director Executive and Ministerial Services, NSW Health. I have also held senior positions in NSW government including Chief of Staff to the Minister for Planning, Minister for Aboriginal Affairs, and Minister for Housing, and Policy Advisor to the Minister for Health and Minister for Aboriginal Affairs. I was a Registered Nurse for twelve years and was admitted as a legal practitioner in NSW in 2005.

4. I have previously sat on the Boards of the NORTH Foundation, the philanthropic partner of Northern Sydney Local Health District, and HealthShare NSW, and was a member of the former eHealth Executive Council, the, Australian Institute of Health Advisory Board Service Management, and the Kolling Institute Governance Committee.

5. A copy of my curriculum vitae is exhibited to this statement (Exhibit 10 in NSW Health Tranche 4 Consolidated Exhibit List).

B. SCOPE OF STATEMENT

6. This statement addresses Term of Reference B concerning NSW Health's governance including strategic and capital planning, but on direction from the Inquiry does not address workforce governance, which is to be dealt with at a future hearing. I understand other statements will address corporate, clinical and financial governance, and audit and risk management.

7. The governance and accountability structure of NSW Health derives from disparate sources: legislative, policy and historical custom and practice. Where I refer to source documents, the source document speaks for itself, but I describe my understanding of the effect of the source document. Where I refer to the manner in which things are done according to a historical custom or practice, I will endeavour to make that distinction clear.

C. BACKGROUND

8. The Health System Strategy and Patient Experience Division (**the Division)** is made up of six portfolio areas / branches:

    a. Government Relations

    b. Health and Social Policy

    c. Allied Health

    d. Mental Health

    e. Patient Experience

    f. Strategic Reform and Planning

9. This statement describes the Division's portfolio areas, key priorities, and the governance frameworks in place to support the achievement of these priorities with reference to the engagement and interface with other agencies and jurisdictions; complementary services delivered by service partners such as Non-Government Organisations (**NGOs**); and the role of the Division in areas such as service and capital planning. To provide an overarching perspective with respect to the planning process, reference is made to the Local Planning Documents described in the Corporate Governance and Accountability Compendium a copy of which is Exhibit A.12

SCI.0001.0008.0001 however the Division does not have responsibility for the development or implementation of these Local Planning Documents.

10. I am the Executive Sponsor of three critical programs of work for NSW Health:

    a. *Future Health: Guiding the next decade of healthcare in NSW 2022 – 2032*, (***Future Health***) a copy of which is Exhibit A.14 SCI.0001.0010.0001. Future Health is NSW Health's 10 year plan to deliver a sustainable health system that delivers on outcomes that matter most to patients and the community;

    b. the *Single Digital Patient Record* (**SDPR**) program, the rollout of which will be a major step in the digital transformation of healthcare across NSW, providing a highly secure, holistic, and integrated view of the care a patient receives across the NSW public health system;

    c. *Closing the Gap* (***CtG***), working in partnership with the Centre for Aboriginal Health, MOH and the NSW Coalition of Aboriginal Peak Organisations to embed responsibility for achieving health equity for Aboriginal people in NSW across all NSW Health entities.

11. I am the designated Deputy Secretary partner for the Bureau of Health Information (**BHI**) and for Health Infrastructure NSW (**HINSW**). I maintain a strong relationship with the respective Chief Executives of the BHI and HINSW and I support the BHI and HINSW with their negotiation process of the annual Performance Agreement/Statement of Service and associated Key Performance Indicators which is led by the System Sustainability and Performance Division of the MOH. I chair the bi-annual Performance Meetings with BHI and HINSW which include discussion of strategic initiatives in line with Future Health strategy priorities and relevant operational matters.

12. I am a member of a number of key committees and forums relevant to the governance of the NSW Health system; cross-agency and cross-jurisdictional priorities and issues; and relevant to my Division.

    a. I am a member of a number of committees and forums including:

        i. Senior Executive Forum (**SEF**)

        ii. Ministry Executive Meeting (**MEM**)

        iii. Health System Strategy Group

iv. Health System Advisory Group

v. Future Health Strategic Outcome 1: Elevating the Human Experience Steering Committee (Chair)

vi. Future Health Strategic Outcome 3: Population Health Steering Committee

vii. NSW Health Research and Innovation Strategy Steering Committee

viii. Capital Strategy Group (Chair)

ix. Regional Health Committee

x. Single Digital Patient Record Steering Committee (Chair)

xi. NSW Aboriginal Health Transformation Committee

xii. BHI Performance Review Meeting (Chair)

xiii. HINSW Performance Review Meeting (Chair).

13. There is a deliberate intent to have membership across MOH Divisions and where relevant, LHD's (**LHD's**), to ensure integration and support a wholistic approach to policy and planning development. Examples include:

a. New Technologies and Specialised Services Committee (Chair)

b. NGO Advisory Committee (Co-Chair)

c. Capital Strategy Group (Chair).

14. I also attend a wide range of cross agency committees and forums, relevant to the work across the Division. These groups drive cross agency collaboration and engagement, which is critical for policy and program development to meet the needs of priority cohorts and address intransigent issues, including closing the gap and the prevention of violence, abuse and neglect.

15. Given the role of the Division in leading engagement with other jurisdictions, including the Australian Government, I also attend a range of interjurisdictional committees and forums, relating to areas including cross border, aged care, primary care, mental health. disability and the implementation of the National Health Reform Agreement.

D. GOVERNMENT RELATIONS

16. The Government Relations Branch negotiates intergovernmental agreements, such as the National Health Reform Agreement (**NHRA**) including associated long-term reforms, Federal Financial Agreements and bilateral agreements with the Department of Health and Aged Care (the **Australian Government**), and cross-border agreements under clause A114 of the NHRA; coordinates and supports NSW participation at the Health Ministers' Meeting (**HMM**) and the Health Chief Executive Forum (**HCEF**); represents NSW on the Shareholder Committee of Healthdirect; and develops and implements policy to guide and monitor delivery of health services to victims/survivors of sexual assault, domestic and family violence, all forms of child abuse, and for children and young people with problematic or harmful sexual behaviours.

17. The Government Relations Branch (**GRB**) is made up of five units:

    a. Prevention and Response to Violence, Abuse and Neglect (**PARVAN**) who lead the Violence Abuse and Neglect Redesign Program to enhance the capacity of the public health system to provide 24-hour integrated psychosocial, medical and forensic responses to presentations of sexual assault and child physical abuse and neglect; support system reform through implementation of the *Integrated PARVAN Framework* and the *Integrated Trauma Informed Care Framework: My story, my health, my future*, copies of which is Exhibit 221 and Exhibit 222 respectively in NSW Health Tranche 4 Consolidated Exhibit List, and promotion of an integrated public health approach with close collaboration with interagency partners to improve safety, wellbeing, health and justice outcomes for the people of NSW; lead NSW Health policy and clinical reform on the recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse with a specific focus on integrated responses for adult survivors of child sexual abuse with complex needs; lead NSW Health responses for criminal child abuse through the Joint Child Protection Response Program and by providing statewide support to emergency department clinicians though the Child Abuse and Sexual Assault Clinical Advice Line facilitate collaboration with partner agencies and support primary care providers through the development of a Violent Abuse and Neglect referral pathway; lead the program of work under the National Partnership Agreement to End Violence Against Women and Children on behalf of NSW Health; and provide strategic advice and support to MOH on legislative reform and national and state priorities on violence abuse and neglect including, Closing the

Gap, coercive control; domestic and sexual violence; child protection and wellbeing and diversion from the Out of Home Care system.

b. Program Delivery Office (**PDO**) who lead and deliver key inter-governmental reform projects and cross-portfolio program commitments in response to the Royal Commission into Institutional Responses to Child Sexual Abuse, including: reform to better identify, prevent and improve responses to children and young people with problematic or harmful sexual behaviours; the development of a multi-agency public health framework, *Children First 2022-2031* a copy of which is Exhibit 223 in NSW Health Tranche 4 Consolidated Exhibit List and supporting prevention action strategy, *Talking About It* a copy of which is Exhibit 224 in NSW Health Tranche 4 Consolidated Exhibit List; expanding the availability of New Street Services providing therapeutic services for children and young people aged 10 to 17 years who have engaged in harmful sexual behaviours towards others, and their families and caregivers and improving access for people with disability and Aboriginal people; and improving access to sexual assault services for people with disability and Aboriginal people.

c. **PDO** also provide strategic advice to MOH on the problematic and harmful sexual behaviours reform agenda under the National Strategy to Prevent and Respond to Child Sexual Abuse, working collaboratively across cluster agencies to inform policy positions and identify impacts to NSW, and have led the development of the *NSW Health Child Safe Action Plan 2023-2027* a copy of which is Exhibit 225 in NSW Health Tranche 4 Consolidated Exhibit List, and the implementation of Sexual Violence Response Program and Aboriginal Program streams funded under the National Partnership Agreement on Family, Domestic and Sexual Violence Responses.

d. Policy and Funding Reform (**PFR**) who provide strategic advice and lead on national health policy and funding reforms and manage NSW Health's relationship with several national bodies established under the NHRA, including: the Independent Health and Aged Care Pricing Authority (**IHACPA)**, the National Health Funding Body (**NHFB**).

e. PFR also negotiate and manage key intergovernmental agreements and initiatives, including: 2020-25 Addendum to the NHRA, cross border agreements and reconciliations under the NHRA, pharmaceutical and dental reform, agreements with other Commonwealth departments such as Department of Veterans Affairs

and Home Affairs, and support the negotiation and reconciliation of other time-limited and ad hoc agreements developed led by relevant subject matter experts across the Divisions in MOH. PFR also supports the NSW representative on the Shareholder Committee of Healthdirect Australia, currently the Executive Director, GRB.

f. Intergovernmental Liaison Team (**ILT**) who support the NSW Health Minister and Health Senior Executives to position NSW on priority issues health issues at the HMM and the HCEF. HMM acts to progress health issues of national importance which require cross-border collaboration and is made up of the health ministers of each state and territory government, along with the Australian Government Minister for Health and Aged Care. HCEF is an intergovernmental forum for joint decision-making and strategic policy discussions that helps to efficiently deliver health services in Australia. It is made up of the health department chief executive officer from each state and territory and the Australian Government.

g. National Health Secretariat (**NHS**), currently hosted by NSW and jointly funded by all Commonwealth, State and Territory Governments, provide strategic policy advice and secretariat support to the HMM and the HCEF Chairs and members.

18. The NHRA Project Team was established in early 2024 within Government Relations Branch for a time limited period of 5 months to coordinate negotiations with the Australian Government and other States and Territories on the next Addendum to the NHRA to run from 1 July 2025 to 30 June 2030.

E. HEALTH AND SOCIAL POLICY

19. The Health and Social Policy Branch (**HSPB**) works to improve the health and wellbeing of people, and partners with government and non-government agencies to develop equity focused policies and programs for the NSW Health system.

20. The HSPB is made up of four units:

<u>Aged Care Unit</u>

a. The Aged Care Unit (**ACU**) works to ensure older people are able to access the care that best meets their needs when they are no longer able to manage at home without assistance and improve the health outcomes for people receiving aged care through timely access and appropriate health care services. This includes

having program and policy responsibility for a range of Commonwealth funded aged care programs that NSW Health operates on behalf of the Commonwealth including Commonwealth Home Support Program, Aged Care Assessment Program, Regional Assessment Services, Australian National Aged Care Classification Program (**AN-ACC**), Transitional Aged Care Program (**TACP**) and state government residential aged care facilities.

b. The ACU works with the Australian Government on key aged care, primary care, acute and disability interface issues through the Intergovernmental Health and Aged Care Senior Officials Group (**SOG**), co-chaired by the Australian Government and South Australian Government. The Australian Government's responsibility for aged care includes consideration of the funding and policy settings that underpin the necessary support for aged care providers to deliver high quality care. This includes where there is an interface with the health services provided by State and Territory governments. The SOG was established by HCEF as a cross-jurisdictional, time limited group having oversight of recommendations arising from the Royal Commission into Aged Care Quality and Safety that require collaboration between the Australian Government and the state and territory governments. The SOG focuses on key issues relating to health and aged care interface, including both Royal Commission recommendations and broader emerging interface issues, to improve outcomes for older Australians.

c. The ACU also works with key partners to reduce hospital discharge delays of older people returning to residential aged care. Examples of other work being progressed by ACU include: the implementation of state-wide Patient Reported Outcome and Experience Measure for the TACP which provides short term care that aims to optimise the functioning and independence of older people after a hospital stay; providing support to LHD's for transition to the new NSW Health Single Aged Care Assessment model in readiness for the new service commencing from 1 July 2024; and supports the embedding of Policy Directive *PD2023_023 Identifying and responding to abuse of older people* a copy of which is Exhibit 226 in NSW Health Tranche 4 Consolidated Exhibit List across the NSW Health system.

Community Care and Priority Populations Unit

d. The Community Care and Priority Populations Unit (**CCPP**) covers a range of policy portfolios including priority populations, primary care, non-Government organisations, end of life and palliative care.

e. The CCPP Unit oversees implementation of the *NSW LGBTIQ+ Health Strategy 2022-2027* a copy of which is Exhibit 227 in NSW Health Tranche 4 Consolidated Exhibit List and supports the delivery of a health centre that provides health care, support and referral services to LGBTIQ+ people in NSW; works with LHD's to implement the statewide Specialist Trans and Gender Diverse Health Service for People Under 25; works to support multicultural and refugee health, including implementing the NSW Refugee Health Plan 2022-2027; oversees implementation of enhancement of women's health services; develops policy options and provides strategic advice on improving safe access to termination services; works to increase access to affordable fertility treatments under the NSW Affordable IVF Initiative, supports access to community-based reproductive health services; oversees implementation of the *End of life and Palliative Care Framework 2019-24;* works to deliver the World Class End of Life Care commitment to deliver service enhancements for end of life and palliative care; monitors and evaluates the enhancement to community care for people with movement disorders, including Parkinson's Disease; supports the implementation of the *NSW Health and NSW Primary Health Networks: Working together to deliver person-centred healthcare, the NSW Primary Health Network (PHN) - NSW Health Joint Statement* a copy of which is Exhibit A.50 SCI.0001.0045.0001 with NSW Primary Health Networks (**PHNs**) and other key health partners through the NSW Health Joint Statement Steering Committee and NGO Advisory Committee; and supports implementation of the *NSW Grants Administration Guide* a copy of which is Exhibit A.57 SCI.0001.0049.0001 across NSW Health.

Maternity, Child and Family Unit

f. The Maternity, Child and Family Unit (**MCF**) provides strategic reform and policy leadership that promotes optimal health and wellbeing outcomes for pregnant women, children and families in the first 2000 days of life. The MCF unit is responsible for leading the implementation of The *First 2000 Days Framework* a copy of which is Exhibit A.59 SCI.0001.0051.0001, supporting LHD's and key stakeholders to implement the *First 2000 Days Implementation Strategy 2020-25*

a copy of which is Exhibit A.60 SCI.0001.0052.0001 and implementation of *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW* a copy of which is Exhibit 228 in NSW Health Tranche 4 Consolidated Exhibit List which aims to strengthen maternity care services to ensure they are collaborative, equitable and woman-centred.

g. MCF also has responsibility for maternity and child and family health services for Aboriginal families. This includes the Aboriginal Maternal and Infant Health Service and Building Strong Foundations programs. MCF works closely with the Centre for Aboriginal Health and the Aboriginal Health and Medical Research Council of NSW on the implementation of relevant Closing the Gap initiatives.

h. MCF leads NSW Health's participation in the NSW Government *Brighter Beginnings, first 2000 days of life whole of government initiative.* This includes implementing the health and development checks in early childhood education program, targeting 4 year olds in NSW; expanding the Sustaining NSW Families clinical nurse home visiting program to eight new sites and piloting SNF lite for families who need support for a shorter period of time and SNF plus for more vulnerable families; making Pregnancy Family Conferencing available to more parents across NSW; developing the clinical interface of the Digital Baby Book; extending access to virtual residential parenting services and evaluating service delivery outcomes.

i. MCF is leading the implementation of *Pregnancy Connect* to build on improvements achieved through the Maternal Transfer Redesign Initiative. Pregnancy Connect aims to improve timely access to specialist consultation and the safe transfer of pregnant women who require higher levels of care with particular benefits for women and their families in regional and rural NSW.

j. MCF oversees the budget commitment to provide care and support for pregnant women suffering from hyperemesis gravidarum and supports the provision of Pasteurised Donor Human Milk (PDHM) Bank for vulnerable infants in Neonatal Intensive Care Units in NSW; and operationalise and implement the Maternity and Neonatal Governance Framework in collaboration with the Clinical Excellence Commission and the Agency for Clinical Innovation.

Disability, Youth and Paediatric Health Unit

k. The Disability, Youth and Paediatric Health (**DYPH**) Unit is leading the significant disability reform resulting from the NDIS Review and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. The reforms will impact on the services provided by and the way NSW Health delivers services for people with disability. The disability reform involves the development of a foundational support system to provide low to moderate intensity supports for people with disability requiring more support than mainstream services provide and that do not meet the eligibility criteria of the NDIS. DYPH supports the provision of safe and quality health care for the people with disability including the review and update of the NSW Health Policy Directive Responding to the Needs of People with Disability during Hospitalisation PD2017_001; and working towards the development of the next NSW Health Disability Inclusion Action Plan in line with the NSW Disability Inclusion Plan and the Australian Disability Strategy 2021-2031. DYPH also works with LHDs to oversight the delivery of Intellectual Disability Health Services with an evaluation of these state-wide services scheduled to commence in 2024. DYPH is responsible for the implementation of the Wellbeing Nurses (Wellbeing and Health In-reach Nurse (WHIN) Coordinator Program) to work in schools in vulnerable regions across NSW and the Out-of-Home Care Health Pathway Program to provide health assessment and planning for children and young people in statutory care. DYPH supports ongoing improvements in paediatric care; and supports NSW and interjurisdictional work on the expansion of the Newborn Bloodspot Screening program. DYPH supports the provision of safe and appropriate health care for young people, including currently developing a new NSW Health Strategy for Young People's Health and Wellbeing and building capacity and capability in the health workforce supporting young people. DYPH works closely with the Departments of Communities and Justice and Education to strengthen the approach to investment in human services investment.

21. The team within the HSPB working on Aged Care work collaboratively with the Government Relations Branch, as this part of the HSPB works with the Australian Government to ensure older people are able to access the care that best meets their needs when they are no longer able to manage at home without assistance, through NSW Health’s operation of a range of Australian Government funded aged care assessment and support services.

22. Similarly, the DYPH Unit within the HSPB work collaboratively with the Government Relations Branch concerning the National Disability Insurance Agency (**NDIA**).

F. ALLIED HEALTH

23. The Chief Allied Health Officer (**CAHO**) provides expert advice on strategic policy issues to me, the Secretary NSW Health, and the Minister for Health. The role of the CAHO is to provide system-wide leadership, advice and consultation on allied health services, with respect to strategy, governance, clinical and professional matters.

24. The CAHO works within the MOH and across LHD's and Speciality Health Networks (**SHN's**) to support the ongoing development of the allied health workforce and the delivery of effective evidence-based policies, programs and models of care to achieve the best possible outcomes for patients and the health system. The CAHO facilities interdisciplinary and interagency collaboration in allied health initiatives and works closely with the NSW Health Directors of Allied Health and NSW Health Allied Health Discipline Advisory Network to develop and strengthen the allied health workforce to implement models of care and system wide reforms to support patient outcomes and address system wide challenges.

25. The CAHO works closely with branches within the Division including HSPB, Government Relations Branch and Mental Health Branch in areas including the First 2000 Days, Brighter Beginnings, paediatrics, aged care, disability, the NDIS and maternity health. The CAHO also works across the MOH Divisions and Pillar Agencies to provide support, advice and to implement allied health programs and reforms. These include the Agency for Clinical Innovation, the Clinical Excellence Commission, the MOH's Workforce Planning and Talent Development Branch, the MOH's Workplace Relations Branch, eHealth NSW and the Regional Health Division.

26. The CAHO is responsible for developing and leading specific programs and reforms including: the Lymphoedema Prevention Program, Rural Allied Health Educator Program and Partnered Pharmacist Medication Charting. A key outcome for the CAHO is to continue to progress and expand allied health scope of practice to address patient and system needs.

27. The CAHO is a member of the National Allied Health Advisors and Chief Officers Committee (NAHAC) which consists of Chief Allied Health Officers from each jurisdiction and the Australian Government. This forum supports collaboration across jurisdiction

and provides advice and leadership on allied health matters on a national level, including on national reforms and programs.

G. MENTAL HEALTH

28. The Mental Health Branch **(MHB**) develops, manages and coordinates MOH policy, strategy and program funding relating to mental health and works to support people with severe and persistent mental illness and distress in community and inpatient settings. Areas of focus include:

    a. Suicide prevention including establishing a Suicide Prevention Act to enshrine a whole-of-government approach to suicide prevention in NSW; and continued roll out of the Towards Zero Suicides initiatives, including the Safe Haven initiative which provides a calm, culturally sensitive and non-clinical alternative to hospital emergency departments, for people experiencing distress or suicidal thoughts

    b. Implementation of the Bilateral Schedule to the National Mental Health and Suicide Prevention Agreement, which includes the rollout of seven co-funded initiatives over five years in partnership with the Commonwealth. Initiatives include universal aftercare for people who have attempted suicide, expanded headspace services, and new adult Head to Health Centres

    c. Supporting investment in mental health capital infrastructure and ensuring new mental health infrastructure delivered as part of the Statewide Mental Health Infrastructure Program is informed by codesign discussions with consumers, families, carers and staff

    d. Providing consumer-centric models of care through developing a model of care framework for non-acute (including sub-acute) units, with input from consumers who have had lived experience of care from relevant mental health services

    e. Overseeing policy settings in relation to the use of restrictive practices across NSW, with the goal of reducing the use of seclusion and restraint and improving safety for people accessing public health services, as well as staff

    f. Commissioning and oversight of Community Living Programs such as the Housing and Accommodation Support Initiative and Community Living Supports program, which help people with severe and persistent mental illness to live and recover in the community in the way that they want to. The Pathways to Community Living

Initiative has also been established to support the transition of long-stay mental health patients (12 months or more), and those at risk of long stays, into appropriate community-based living and services

g. Roll out of Safeguards Teams, a community-based service for children and adolescents (0-17 years) experiencing acute mental distress, and their support network

h. Implementing a range of initiatives to support older people with complex mental illness and older people experiencing suicidal distress, including the expansion of community mental health outreach to residential aged care and specialised mental health-aged care partnership models, and targeted older people's suicide prevention initiatives

i. Closing the Gap and supporting the implementation of Aboriginal Mental Health and Wellbeing Models of Care and Building on Aboriginal Communities Resilience initiatives to improve the cultural safety, effectiveness and quality of mental health services and care pathways for Aboriginal people and communities across NSW

j. Investment in the Rural Adversity Mental Health Program to strengthen regional, rural, and remote communities through mental health promotion, prevention and early intervention strategies that promote connectedness

k. Investment in Disaster Recovery Clinicians, which provide support to individuals and communities affected by bushfire, flooding, and other natural disasters

l. Supporting LHD's deliver the *Mental Health Line* - the key access point to public specialist mental health services.

29. MHB works in partnership with LHD's and SHN's including the Justice Health and Forensic Mental Health Network (**JHFMHN**). JHFMHN is responsible for providing healthcare services to people involved with the criminal justice and forensic mental health systems in NSW. Together, MHB and JHFMHN are working to develop a Forensic Mental Health Strategic Plan and a new Forensic Mental Health Services Policy to support the delivery of integrated, comprehensive care for forensic patients and ensure

that there are appropriate standards for forensic mental health services and general mental health services that provide care and treatment to forensic patients.

30. The NSW Chief Psychiatrist provides high level advice to me, the Executive Director, Mental Health, the Secretary NSW Health, and the Minister for Health, on the mental health needs of the NSW population, professional leadership to NSW mental health clinicians across all areas, and clinical input to policy development and implementation to improve the mental health status of target groups.

31. A Parliamentary Inquiry is underway into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales. Findings are expected to be handed down by mid 2024. NSW Health provided a submission to the Inquiry, a copy of which is Exhibit 229 in NSW Health Tranche 4 Consolidated Exhibit List.

H. PATIENT EXPERIENCE

32. The Patient Experience team provides statewide guidance on improving the patient experience.

33. Led by the Chief Experience Officer, the Experience team is responsible for developing and managing programs designed to elevate the experiences of our patients, carers, families, staff and volunteers, leading to better outcomes and wellbeing for all. The team is responsible for NSW Health's first statewide strategy for improving experience *Elevating the Human Experience – Summary guide to action for patient, family, carer and caregiver experiences,* a copy of which is at Exhibit 230 in NSW Health Tranche 4 Consolidated Exhibit List, which sets a strategy for partnering with consumers, carers, communities and the workforce to improve patient experience through more human-centred healthcare. Areas of focus include:

    a. Improving the experience of patients, families and carers waiting in Emergency Departments

    b. Developing contemporary guidance on visitation in NSW Health hospitals using a co-design approach with consumers, carers, families and staff

    c. Implementing and evaluating the impact of *All of US: A guide to engaging consumers, carers and communities* across NSW Health

d. Implementing and evaluating the impact of the NSW Health Guideline: *GL2023_016 Consumer, carer and community member remuneration* (Exhibit 231 in NSW Health Tranche 4 Consolidated Exhibit List)

e. Designing and implementing strategies and programs to ensure that kindness and compassion is experienced by all people who come in contact with the NSW Health system including through Schwartz Rounds; Gathering of Kindness and Compassion Labs

f. Establishing a statewide Health Literacy Hub for NSW.

34. To elevate and strengthen the voice and influence of consumers, carers, and communities in strategic health decision making, the MOH will establish a Consumer, Carer, and Community Advisory Council (**CCCAC**) reporting to the Secretary NSW Health. It is intended the CCCAC will work in partnership with the Health System Advisory Council (**HSAC**) to enhance input and build on existing positive relationships with consumers, carers and communities and peak consumer, carer and community bodies. A dedicated working group will be established to monitor and evaluate the effectiveness of the proposed approach. The CCCAC is projected to commence a 12-month trial with the first meeting expected in July 2024. The working group will produce an evaluation report with recommendations at the end of this period.

I. STRATEGIC REFORM AND PLANNING

35. The Strategic Reform and Planning Branch (**SRPB**) supports and enables strategic reform and planning for the NSW Health system by leading the overarching projects and processes to achieve shared outcomes across NSW Health. SRPB works with LHD's and other partners to improve the quality of service planning and capital investment proposals.

36. SRPB's key functions include:

a. leading and supporting the process of service and capital planning and the capital investment program

b. facilitating specialty services and new technology planning and evaluation

c. providing tools to guide the system in strategic analysis and evaluation

d. developing strategic policies that support improved outcomes for patients, families, carers, staff, and the system

e. supporting the NSW Health system to be a leader in the delivery of value based health care.

37. SRPB is made up of six units:

Service and Capital Planning Unit

a. The Service and Capital Planning Unit (**SCPU**) supports infrastructure and service planning aligned to the health needs of the population, connected with other services and partners. SCPU lead the annual review of Health Entities' Capital Investment Proposals to inform NSW Health's 10 Year Capital Investment Strategic Plan, manage the Aboriginal Health Minor Works Program and Rural Health Minor Works Program, and lead on the implementation of the 20-Year Health Infrastructure Strategy.

Strategic Analysis and Investment Unit

b. The Strategic Analysis and Investment Unit (**SAIU**) develop and maintain analytical tools which provide service planners with data to inform planning and investment decisions. SAIU supports LHD's and SHNs to undertake Preliminary Cost Benefit Analysis and early options analysis submissions as part of the Capital Investment Proposal process, review clinical service plans to validate the activity modelling which supports the clinical service plan, and support a NSW Health service planning community of practice.

Specialty Services and Technology Evaluation Unit

c. The Specialty Services and Technology Evaluation Unit (**SSTEU**) engages with LHD's, SHNs and Pillar Agencies in the identification of new health technologies and emerging clinical evidence. SSTEU supports the alignment of health technology assessment and funding nationally and evaluates trials or pilots of new health technologies and treatment advances in NSW. SSTEU provides oversight for the implementation of the NSW Health Genomics Strategy and also oversight of supra-LHD services and the NSW Nationally Funded Centres, and maintains and updates the NSW Health Guide to Role Delineation of Clinical Services.

d. Governance and oversight of supra-LHD services occurs through the New Technology and Specialised Services Committee. This includes monitoring implementation and outcomes and providing advice to inform service level agreements. The Committee has representation from across the MOH and the Agency for Clinical Innovation, the Cancer Institute NSW and the Clinical Excellence Commission. Supra-LHD services are listed separately in LHD Service Agreements and in some cases are funded through separate arrangements such as block funding.

e. SSTEU works closely with the MOH's System Purchasing Branch and other MOH branches, and pillar organisations, to determine advice relating to changes and enhancements to supra-LHD services. Location of supra-LHD services is determined through an open expression of interest process. The requirements for each service are determined by the New Technology and Specialised Services Committee and, depending on the type of service, may include requirements for clinical specialties, access to critical care services at a certain role delineation level, and equipment and infrastructure. LHD's and Specialty Health Networks are invited to submit expressions of interest to host new supra-LHD services and must demonstrate they meet the requirements and agree to comply with all monitoring and evaluation activities set by the New Technology and Specialised Services Committee.

Economics and Evaluation Unit

f. The Economics and Evaluation Unit (**EEU**) focuses on monitoring and evaluation plans and evaluation of the impact of Value Based Healthcare initiatives across the four dimensions of value. The EEU has a lead role in responding to NSW Government evaluation requirements and embedding a systematic approach to measuring clinician experiences of delivering care.

Strategy and System Priorities Unit

g. The Strategy and System Priorities Unit (**SSPU**) supports the delivery of the outcomes of Future Health. Priorities include Future Health implementation planning and support, embedding structural and cultural change to support the system deliver better value as part of business as usual, and statewide strategy for the collection and use of self-reported information.

Strategic Change and Policy Reform Unit

h. The Strategic Change and Policy Reform Unit (**SCPRU**) works to drive value based health care through supporting value based healthcare capability across the system, and supports reform policy in areas like Social Impact Investment.

Planning strategies and policies

38. A range of planning and policy documents govern the operation of the NSW public health system, individual health agencies, and guide the work of the SRPB. Some are created and overseen by the Division, while some are the responsibility of other divisions but operate across divisions.

39. The SRBP collaborates with other divisions and branches of MOH and NSW Health pillars, agencies and organisations to coordinate the strategic implementation of Future Health and the NSW Health 20-Year Health Infrastructure Strategy.

40. Planning tools and guidelines are available to support local health district and speciality health network service and capital planning. Under the *Health Services Act 1997*, one of the Board's functions is ensuring that strategic plans to guide the delivery of services are developed for the Local Health District or Specialty Health Networks, and the Board is responsible for approving those plans. LHD's and specialty health networks, oversighted by their Board, have responsibility to undertake the following planning activities:

a. investigate and assess the health needs in their area;

b. any planning considered necessary at the local level to respond to particular health issues, emergencies or service needs;

c. develop plans to improve health outcomes in response to national, state and local health priority areas;

d. plan the future development of health services and consult and plan jointly with MOH and such other organisations as it considers appropriate;

e. undertake detailed service planning and workforce planning to ensure a sound foundation for investment decisions, both capital and recurrent;

f. support, encourage and facilitate the organisation of community involvement in the planning of services; and

g. develop and maintain reliable information systems to support services planning and delivery, and the monitoring and evaluation of performance and health outcomes.

41. LHD's and specialty health networks, oversighted by their Board, have responsibility for developing the following organisational plans:

a. Strategic Plan;

b. Health Care Services Plan;

c. Corporate Governance Plan;

d. Annual Asset Strategic Plan; and

e. Operations/Business plans at all management levels of the local health district or specialty health network.

Local Health District or Speciality Health Network Health Care Services Plan (LHD/SHN HCSP)

42. Each Local Health District or Specialty Health Network will undertake a full range of strategic and operation planning. As part of this process, the LHD/SHN HCSP will be the most comprehensive plan, providing the service direction and detail of priorities for a local health district or specialty health network over a five-to-ten year horizon, with specific focus on those issues which affect the health of the catchment population and the delivery of services.

43. The information and analysis provided by the LHD/SHN HCSP is particularly important in local strategic planning and priority setting for appropriate capacity to respond to demand. The value and quality of a HCSP will depend on the quality of a number of separate, but inter-dependent foundation planning processes, which focus more specifically on areas such as health improvement, clinical services, clinical and non-clinical support services, assets, resource implications and sustainability (workforce, financial, environmental).

44. The HCSP should consider the provision of safe and efficient health care within the available recurrent budget, efficient and effective networking of services including opportunities to link with other services and providers, and the best approach to service delivery. This is the planning mechanism where value for money opportunities are

investigated by the local health district or specialty health network and may include partnering with other service providers, public or private, not-for-profit and / or other non-government organisations.

Local Health District or Speciality Health Network Specific Service Plans

45. Service planning processes are generally non-linear, iterative, and mutually dependent, with several activities proceeding concurrently. LHDs and SHNs will have their own processes and governance for service planning.

46. Service plans describe how a service, or services, will need to be delivered in the future to reflect the changing health needs of the community and ways of providing care. They provide clear direction for the provision of health services to achieve measurable health improvements and outcomes and are undertaken within a broader framework of system-wide goals, objectives and priorities.

47. The form, scope and content of service plans are influenced by the nature of service under consideration and the objectives of the particular planning exercise. However, they have the common elements of exploring and documenting the problem/opportunity, policy and planning context, objectives and priorities, service development options, intended outcomes/benefits, measures that can be used for evaluation, stakeholder consultations, capability/capacity to deliver the services proposed, resources required and sustainability.

48. Service plans may focus on services provided in a particular facility; a particular type of service, such as community health care; a particular category of services, such as maternity; a particular population group, such as Aboriginal people or those with chronic illness; or a particular health issue, such as drug and alcohol use.

49. In some cases, such plans may be required as part of agreements with the Commonwealth and other State Government agencies. Local clinicians, clinical networks and NSW Health entities, such as the Agency for Clinical Innovation; Clinical Excellence Commission; Health Education and Training Institute; Cancer Institute NSW; NSW Ambulance; NSW Health Pathology; eHealth NSW; HealthShare NSW; and relevant departments in the MOH will also provide valuable reference points for the development of these plans. LHD's and Specialty Health Networks will determine the stakeholders that need to be engaged for each plan.

50. Health improvement is an integral aim of service planning, and all service plans should address, among other things, desired health outcomes and how these will be measured for the specified service. Service plans should also take into account evidence of effectiveness of interventions and lessons learnt from similar initiatives. The timetable for producing specific service plans will vary and may be influenced by the local priorities, requirements of central agencies, the framework provided by relevant statewide policy or planning documents, and/or targets negotiated in annual Service Agreements.

51. The *Guide to Service Plans informing Local Health District / Speciality Health Network Capital Planning* articulates the key considerations and content requirements of Service Plans submitted to MOH for review and endorsement. MOH is required to review and endorse Service Plans underpinning approved capital projects or programs valued at $10 million and above. The Guide aims to promote a collaborative and consistent approach to the development of the Service Plan, a copy of which is exhibited to this statement (Exhibit 128 in NSW Health Tranche 4 Consolidated Exhibit List).

52. Examples of other guidelines and frameworks to assist LHD/SHN service planners are exhibited to this statement as follows:

    a. *GL2022_012 New Health Technologies and Specialised Services,* a copy of which is exhibited to this statement (Exhibit 13 in NSW Health Tranche 4 Consolidated Exhibit List),

    b. *NSW Health Service Planning Tool,* a copy of which is exhibited to this statement (Exhibit 130 in NSW Health Tranche 4 Consolidated Exhibit List),

    c. *Guide to the Role Delineation of Clinical Services,* a copy of which is exhibited to this statement (Exhibit 193 in NSW Health Tranche 4 Consolidated Exhibit List).

J. CAPITAL PLANNING

20-Year Health Infrastructure Strategy

53. The *20-Year Health Infrastructure Strategy* is the first look at what the future of the health system should be that shifts the focus of care to earlier support and intervention and ensures accessible, convenient services to respond to the growing and ageing population and rising rates of chronic disease. It sets out an alternative response to planning for future capacity and involvement with an emphasis on:

a. A future infrastructure network that encompasses the full spectrum of care from a patient's home to their local centre and their hospital.

b. A culture of innovation where learnings are dispersed quickly across the State.

c. A new budget and investment framework that supports flexibility and network sharing, and agile ways of managing growth.

d. A places framework that articulates the hierarchy and different role of health and education precincts across NSW and identifies our global and national centres of excellence and research.

54. This includes a future portfolio that provides care in a wider range of settings and facilities, including alternate non-acute, community or in-home settings, wider application of virtual and telehealth services and consistent investment in life-cycle and preventative maintenance to maintain and extend asset life. The Strategy aligns with the *NSW Government Investment and Prioritisation Framework*, a copy of which is exhibited to this statement *(*Exhibit 141 in NSW Health Tranche 4 Consolidated Exhibit List).

55. The Strategy was endorsed by the NSW Government in April 2020. The *20-Year Health Infrastructure Strategy Implementation Plan 2021-2024* outlines a three-year work programme for the NSW Ministry of Health to assist Health Entities to help the system transition and deliver on the objectives of the Strategy, a copy of which is exhibited to this statement.

Capital Investment Strategic Plan

56. The *Capital Investment Strategic Plan* has a ten-year horizon and outlines the aggregation of NSW Health's capital projects based on needs and priorities, including estimated total costs and cash flow for the annual budget process (Year 1) and forward estimates period (Years 2-4). Future priority projects that are likely for inclusion in the outer years (Years 5-10) are also identified. Capital projects approved for inclusion in the Forward Capital Investment Strategic Plan are prioritised in the context of competing State-wide investment needs and the constraints of funding allocations made available to NSW Health through the annual Budget process.

57. Planning and delivery of approved capital projects/programs valued at $10 million and above is to be undertaken in accordance with *the NSW Health Facility Planning Process* (GL2021_018) a copy of which is exhibited to this statement (Exhibit 142 in NSW Health

Tranche 4 Consolidated Exhibit List), *NSW Health State-wide Investment and Prioritisation Framework, a* copy of which is exhibited to this statement (Exhibit 141 in NSW Health Tranche 4 Consolidated Exhibit List), and other relevant government policy directives.

NSW Health Facility Planning Process (GL2021_018)

58. The NSW Health Facility Planning Process (**FPP**) provides a framework for prioritising, planning, delivering and evaluating capital infrastructure across the NSW public health system. LHDs/SNs are required to use the FPP for capital investment projects valued at $10 million and above. The stages in the FPP includes five interconnected stages aligned with the lifecycle. Patient, carer, family and staff outcomes and experiences of receiving and providing care in the public health system are at the centre of the process. Each stage is focused on ensuring the capital assets that are delivered are fit for purpose, future focused, and enable high quality and safe care with defined key outputs. The five stages are:

    a. Stage 0: Principles, Planning and Prioritisation - to identify proposals aligned with local service needs, system-wide objectives and Government policy using a collaborative approach. Key output: Potential investment proposals

    b. Stage 1: Services and Facilities Needs Analysis - to robustly analyse a spectrum of options to maximise benefits and improve. Key output: Investment decision document

    c. Stage 2: Project Definition - To develop an evidence base that proves the preferred option best meets the service need and maximises benefits at optimal cost. Key output: Final business case

    d. Stage 3: Implementation - To develop an approach to market and delivery scope that will realise the intended benefits of the project. Key output: Tender documents and delivery

    e. Stage 4: Evaluation - To understand how well the intended benefits and outcomes have been realised and what can be learned from the project or program. Key output: Evaluation report and next steps for lessons learned.

59. The Service Plan describes how a service, or services, will need to be delivered in the future to reflect the changing health needs of the community and ways of providing care.

Where there is a need for a capital response the subsequent capital planning process will translate the service requirements in the Service Plan into the infrastructure response.

Business Case

60. When undertaking a new infrastructure project, HINSW and the Local Health District or Speciality Health Network work together to submit a Final Business Case to the MOH for review and approval. Examples of Final Business cases for the following projects are exhibited to this statement:

    a. New Maitland Hospital Development (Exhibit 143 NSW Health Tranche 4 Consolidated Exhibit List)

    b. Shoalhaven Hospital Redevelopment (Exhibit 144 NSW Health Tranche 4 Consolidated Exhibit List)

    c. Tumut Hospital Redevelopment (Exhibit 145 NSW Health Tranche 4 Consolidated Exhibit List)

61. This process involves preparing a number of documents prior to Business Case submission, often in collaboration with external consultants and architects. These include:

    a. Investment Logic Map

    b. Investment Decision Document

    c. Services Plan – see *The Children's Hospital at Westmead Clinical Services Plan 2018 – 2031* as an example, a copy of which is exhibited to this statement (Exhibit 146 NSW Health Tranche 4 Consolidated Exhibit List)

    d. Change Management Plan

    e. Financial Impact Statement

    f. Project Procurement Strategy

    g. Cost Plan

    h. Cost Benefit Analysis (guided by the Health Infrastructure CBA Toolkit)

i. Risk Management Plan

j. Benefits Realisation Plan

k. Value Management Report

l. ICT Strategy

m. Functional Design Brief

n. Workforce Plan

o. Project Governance Arrangements

p. Communications Strategy, and

q. Aboriginal Health Impact Statement.

NSW Health Capital Strategy Group and Capital Program

62. I chair the Capital Strategy Group (**CSG**) which oversees and advises on strategic directions, policy and governance for the planning and management of the NSW Health capital program as well as the implementation of the *20-Year Health Infrastructure Strategy*. The CSG was established in 2013 in response to the Strategic Gateway Review of the 2013-14 Asset Strategy. The draft CSG *Terms of Reference*, a copy of which is exhibited to this statement (Exhibit 136 in NSW Health Tranche 4 Consolidated Exhibit List) provide that the CSG is responsible for considering and making determinations on matters including:

a. Contingency funds (sums allocated within a cost plan to cover the cost of unplanned activities or risks necessary to deliver project outcomes)

b. Asset sales

c. Capital build delivery

d. Policy

e. Evaluation, and

f. Sustainability.

63. The CSG is also responsible for approving the *NSW Health Capital Contingency Management Framework* which promotes consistent, effective cost control processes across projects and NSW Health's capital program, a copy of which is exhibited to this statement (Exhibit 137 in NSW Health Tranche 4 Consolidated Exhibit List).

64. A governance review of the recurrent affordability of capital projects was completed by Deloitte in November 2021, a copy of which is exhibited to this statement (Exhibit 138 in NSW Health Tranche 4 Consolidated Exhibit List). A performance audit was undertaken by the Auditor-General in 2020, a copy of which is exhibited to this statement (Exhibit 139 in NSW Health Tranche 4 Consolidated Exhibit List).

65. A governance review of the CSG was performed by MOH Internal Audit in 2023. A preliminary briefing was provided to the CSG. The CSG agreed that work should commence on a number of the observations made noting that a final paper is due to be finalised in May 2024. The review identified opportunities to strengthen governance and transparency of decision-making through enhanced financial and robust risk reporting and an increased strategic focus. Opportunities identified included consideration of risk tolerance levels for the CSG with respect to project decision-making; incorporation of project evaluation and lessons learned into CSG discussions; and consideration of environmental sustainability and sustainability with respect to the broader health system.

66. As a requirement of NSW Treasury, any NSW Health projects valued at more than $250,000 are to be included on the capital program. This includes projects supported under the Locally Funded Initiatives (**LFI**) Program. LFIs are Local Health District or Health Service funded capital projects of $250,000 - $10 million to support local service delivery priorities such as equipment upgrades, minor refurbishments and ICT projects. They are funded by the Local Health District or Health Service own sources of funds. LFI Requests are submitted to the MOH for approval.

Recurrent Affordability Working Group

67. The 2024 Recurrent Affordability Working Group will review the existing processes, roles, and responsibilities within the MOH regarding the recurrent cost impacts of infrastructure projects. It will help address some of the issues identified in relation to the affordability of capital projects by ensuring that actions are assigned to the relevant areas of the MOH to improve oversight and responsibility. The Working Group is chaired by the SCPU and members include representatives from Divisions across the MOH including Finance, Workforce, System Information and Analytics, System Purchasing, and SAIU.

68. The draft Recurrent Affordability Working Group *Terms of Reference* describe the functions of the Working Group which include:

    a. Review of existing processes and responsibilities regarding the recurrent affordability of capital projects before a FIS is developed

    b. Identification of potential guidance that could be provided to LHD's/Specialty Health Networks to improve recurrent affordability as part of early planning of capital projects

    c. Identification of additional actions, assurance points or responsibilities that could be introduced to improve oversight and accountability after a Financial Impact Statement has been endorsed

    d. Development of a roadmap to address identified issues, with assigned responsibilities, for consideration by the CSG.

K. GOVERNANCE OF THIRD PARTIES GRANTS

Community Managed Organisations (CMOs)

69. CMOs are principally managed by community or consumer groups and operate mainly in the mental health area, such as the Mental Health Coordinating Council, BEING – Mental Health Consumers, and Mental Health Carers NSW.

Non-Government Organisations (NGOs)

70. I Co-Chair the NGO Advisory Committee (**NGOAC**) with the Chief Executive Officer, Network of Alcohol and other Drugs Agencies.

71. The NGOAC acts as a senior advisory forum about the joint service delivery and partnership between NSW Health and the NGO sector, provides strategic advice on the delivery of services to people with complex needs from the NGO perspective, and acts as a mechanism to engage with the NGO sector on the design and implementation of health priorities and policies. The NGOAC is a forum for identifying opportunities to develop better service partnership linkages between the public sector and NGOs to improve the health of people in NSW. In particular, how partnerships and performance can be maximised to effectively reach the clients and communities NGOs' serve. Membership includes Peak Agencies such as the Aboriginal Health and Medical Research Council of NSW, community organisations, the Physical Disability Council of

NSW, and the Mental Health Coordinating Council, and representatives across the MOH and LHD's.

72. I recently initiated a project revisiting the role of the NGOAC to identify current strengths and opportunities for improvement. Key themes included the importance of sharing information in a proactive way, early consultation and collaboration, and need to recognise and value the knowledge and expertise of all members of the NGOAC.

73. The Division is responsible for the administration of grants to NGOs delivery services that align to the Division's portfolio. Grant funding for NGOs also occurs across other portfolios in the MOH. Responsibility for the administration of these grants is with the relevant branch and Division or LHD/SHN.

74. NSW Health allocates grant funding to NGOs to deliver community-based services supporting health and wellbeing, particularly for vulnerable populations. Aboriginal health, aged care, children, youth and families, chronic care and disability, community transport, drug and alcohol, mental health, palliative care, population health and women's health are among the services for which NSW Health provides funding.

75. NSW Health is required to comply with the *NSW Grants Administration Guide* and *PD2019_013 Administration of NSW Health Grant Funding for Non-Government Organisations Policy*, copies of which are Exhibit A.57 SCI.0001.0049.0001 and Exhibit A.58 SCI.0001.0050.0001 respectively). The *Policy* contains sample grant agreement and conditions at the end of the document.

76. NSW Health grants can be divided into three categories: Ministerially approved grants under the NGO Grants Program, Ad Hoc Grants, and Program Grants.

Ministerially Approved Grants

77. Each financial year, Agencies are allocated a certain amount of money for distribution to NGOs under the NGO Grants Program. The Minister for Health's approval is required to give, renew or vary grants under this program as such these grants are sometimes called Ministerially Approved Grants (**MAGs**). MAGs are only available to NGOs. MAGs can be administered by: the Local Health District in which the grant activity will take place or the NGO operates from; and the MOH, usually if the grant is to a peak NGO or an NGO that provides input to inform state-wide policy or delivers a grant activity of special interest to the MOH. Some LHD's may also be responsible for administering MAGs for statewide activities.

78. MAGs are provided to NGOs for the provision of community services to the NSW population with an emphasis on reaching vulnerable and marginalised communities. These grants are administered by LHD's, specialty health networks and MOH branches. The assessment process takes the following criteria into consideration:

    a. alignment with NSW Health priorities.

    b. NGO's performance in the current grant period, including achievement of outcomes.

    c. continued community need and demand for grant activities.

    d. NGO's capacity to continue delivering grant activities.

    e. determining whether changes are required to grant activities and performance indicators if an extension to the MAG is approved.

79. Each year, the grant manager from either the Local Health District, Speciality Health Network, or MOH branch work with the NGO to review their expiring MAG before making recommendations about its future arrangements. This includes assessing the NGO's performance against the performance indicators outlined in their current funding agreement.

80. As part of the process, grant managers provide recommendations for future funding for each MAG to the Minister for Health. These recommendations are informed by individual assessments for each MAG. This process is compliant with the requirements under the NSW Grants Administration Guide. The provision of grant funding is subject to Ministerial approval.

81. As the funding allocated to Agencies is subject to maintenance of funding to NSW Health as part of the State Budget appropriation, at any point Agencies can only guarantee one year of funding to grantees. However, it is possible to establish triennial funding arrangements. This means that the base grant awarded to the grantee for the first financial year can be provided for two further financial years (subject to funds being available) without the requirement for a new application. After three years the grantee will need to apply to renew the grant.

Ad Hoc Grants

82. Ad Hoc Grants are one-off grants. Ad Hoc Grants may only be issued if the Agency is satisfied that: the grant is in accordance with the mission of the NSW health system; the person, organisation or group is reputable, accountable and able to provide the service being funded; there is no conflict of interest; and the funds required are available.

83. They are different from MAGs in that they: are not paid from the pool of funding for the NGO Grants Program; are not limited to NGOs, but can be given to any person/organisation external to the NSW public sector health system; and do not require ministerial approval (but will be approved in accordance with normal expenditure delegations).

84. Ad Hoc Grants of $10,000 or more require prior advice to the Minister for Health. Like MAGs, Ad Hoc Grants may be given in response to a request for funding. Alternatively, they may be given at the initiation of the Agency, in which case, they could be given to targeted organisations or following an open, competitive application process.

Program Grants

85. Program Grants are generally for state-wide, whole-of-Health programs. Like Ad Hoc Grants, they are different from MAGs in that they: are not paid from the pool of funding for the NGO Grants Program; are not limited to NGOs and can be given to other government departments and organisations; do not require ministerial approval (but will be approved in accordance with normal expenditure delegations); and can be subject to a contested procurement process.

86. Like MAGs and Ad Hoc Grants, Program Grants may be given following a request for funding. Alternatively, they may be given at the initiation of the Agency, in which case, they could be given to targeted organisations or following an open, competitive application process.

Grant administration

87. Throughout each stage of grants administration, a grant administrator must comply with the NSW Grants Administration Guide and must also: carefully design and plan the grant opportunity and activity; work collaboratively with the grantee; focus on outcomes; seek value for money; take measures that are proportionate to risk; establish a governance framework and be accountable; and act fairly and transparently.

88. Grant funding agreements include a range of service deliverables, anticipated outcomes and outputs, milestones, and performance measures which are monitored on a regular basis.

89. Grants administration includes each step taken or process involved in issuing a grant. It includes designing the grant, selecting a grantee, drafting a grant agreement, monitoring performance, review and evaluation.

90. *PD2019_013 Administration of NSW Health Grant Funding for Non-Government Organisations* provides guidance on grant administration for NSW Health entities. The policy is intended to provide an overview and does not address every issue that must be considered. This is particularly so for complex or high-value grants where further legal or financial advice or guidance from the relevant branch should be sought. The policy is currently being reviewed and updated to bring it in line with the *NSW Grants Administration Guide* which was updated in March 2024.

Discretionary funding/decisions

91. A *Premier's Discretionary Fund* (**the Fund**) exists with funding provided at the discretion of the Premier. The Fund grants support to community-based projects which are identified by the Premier through ongoing community engagement.

92. The *NSW Grants Administration Guide* requires the disclosure and publishing of grants administration or transparency and public accountability. Information including the exercise of Ministerial discretion in making grant decisions that vary from the recommendation of officials, including the reasons for any such decision must be published in the NSW Government Grants and Funding Finder website.

L. ROLE AS EXECUTIVE SPONSOR

93. SDPR Program

    a. I am the Executive Sponsor of the SDPR Program. I Chair the SDPR Program Steering Committee and with the support of the Committee, I am accountable for the governance of the program so that it is delivered within the approved scope, schedule and budget. The SDPR High Level Governance Model demonstrates the integration of the Committee within NSW Health and strategic governance through the eHealth Advisory Board, Health System Advisory Council, Senior Executive Forum, and Health System Consumer COuncil. The SDPR Steering Committee

Terms of Reference details the purpose, membership, decision making rights, and responsibilities of the members including providing leadership and direction, providing program governance and maximising program benefits.

b. The SDPR Program envisages a digitally enabled health system that supports patient safety and quality of care by improving clinician access and the experience of using electronic medical records.

c. The strategic objective of the SDPR Program is to deliver a state-wide single digital patient record that will provide a holistic view of a patient's medical record at the point of care. This will ultimately enable greater collaboration and coordination of services across the NSW health system.

94. Closing the Gap

a. I am the Executive Sponsor for NSW Health's CtG Initiatives. NSW Health CtG Initiatives include the 5 Priority reforms and 4 health-led Socio-Economic targets. I work with the Centre for Aboriginal Health (CAH) within the MOH as the coordinating group for these initiatives.

b. The NSW Government and NSW Coalition of Aboriginal Peak Organisations (**NSW CAPO**), as representatives of Aboriginal communities, have agreed to joint governance arrangements to develop, implement and monitor NSW's plan for CtG. These joint governance arrangements make up the NSW Partnership for CtG. Currently, the NSW governance structure for CtG has three-tiers: the NSW Joint Council (**NSWJC**), the NSW Partnership Working Group (**NSWPWG**) and the NSW Officer Level Working Groups (**OLWG**).

c. I represent NSW Health as a member of the NSWPWG. The NSWPWG is made up of NSW Government senior executives across relevant departments, NSW CAPO members, and representatives from the National Indigenous Australians Agency, Local Government NSW, and the NSW Coalition of Aboriginal Regional Alliances. The NSWPWG supports the NSWJC and is responsible for monitoring performance and delivery.

d. The NSW governance structure for CtG is under review. The proposed restructure streamlines the existing three-tiered governance structure into a two-tiered structure. This would dissolve the NSW PWG and OLWGs and repositions Deputy

Secretaries and NSW CAPO members as co-chairs of ‘Sector Committees' reporting to the NSWJC.

e. The restructure aims to effectively leverage key decision-makers to drive change in-line with the Priority Reforms and enhance shared accountability and responsibility between NSW CAPO and NSW Government.

95. **Future Health**

a. I am the Executive Sponsor of Future Health which provides the strategic framework and priorities for how we deliver our services from 2022 to 2032.

b. The *Future Health* plan is made up of a *Report* (Exhibit X, SCI.0001.0010.0001) and *Strategic Framework* (Exhibit X, SCI.0001.0011.0001), and is NSW Health’s roadmap for delivering health services over the coming decade. *The Strategic Framework* outlines 6 strategic outcomes with corresponding key objectives:

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

ii. Safe care is delivered across all settings

iii. People are healthy and well

iv. Our staff are engaged and well supported

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

vi. The health system is managed sustainability.

c. The Future Health plan builds on the foundations of the previous NSW State Health Plan and continues work done in areas such as value-based healthcare, the integration of care and improving the patient experience.

d. The governance of Future Health cascades from the Health System Strategy Group to the five Future Health Steering Committees which serve as the peak governance bodies for each Strategic Outcome. Strategic Outcome 6 does not have a Steering Committee but operates as a collection of peak committees given the diverse nature of the Strategic Outcome. Each Strategic Outcome has a Deputy Secretary level Executive Sponsor who is also the Chair of the Committee.

e. The Steering Committees oversee and are accountable for the execution of the Future Health action plans to achieve the measure of success for the strategic outcome. They monitor this progress through a combination of agenda items, action reporting, and measurement dashboards.

f. In addition to the Steering Committees, there are two advisory councils: the Measurement and Intelligence Council and the Health System Advisory Council. The Measurement and Intelligence Council provides recommendations of appropriate measures within and across all strategic outcomes to track and monitor progress towards the Future Health strategy. The Health System Advisory Council is consulted as required as the peak clinician body of NSW Health. Consumer voices are captured through Strategic Outcome 1 Steering Committee and through routine processes.

M. OPPORTUNITIES

96. **Commonwealth and State Governments developing a framework to strengthen the interface between primary care and LHDs**.

a. This would require commitment from both Commonwealth and State Governments. The aim of a recommendation in this area is to identify actions that remove the structural and policy barriers that impact on continuity of care for patients moving between primary care and the acute hospitals. Barriers could be addressed through:

i. **The integration of patient medical records across Commonwealth and State health services**. Described above, NSW Health is embarking on the rollout of the SDPR Program. The program will be a major step in the digital transformation of healthcare across NSW, providing a highly secure, holistic, and integrated view of the care a patient receives across the NSW public health system. A limiting factor to improving patient flow, continuity of care, and seamless transition between primary care providers and LHD's, is that real time patient records are unable to be shared with General Practitioners. NSW Health has access to *HealtheNet,* a secure, statewide clinical portal which provides clinicians with immediate access to an aggregated view of patient and clinical information from NSW Health clinical systems and My Health Record, however information is static. Through the SDPR Program, there is opportunity for integration between primary care and LHD's which

would allow timely access to up-to-date comprehensive medical, pathology, and patient administration records in a single system. Resourcing the development of supporting legislation and consent models to ensure information can be shared across care settings while maintaining patient and clinician privacy is essential to address the regulatory and legal implications arising from such a program.

ii. **The role of Primary Health Networks (PHNs).** To support an integrated care system, the role of PHNs is critical. General practice engagement with PHNs is not uniform and PHNs have limited levers to mobilise and engage general practice to participate in new models of care or new workforce models. Commonwealth support for this component is required.

iii. **Flexible funding models.** To enable integrated care and joint planning, flexible funding models need to be considered. One example is the enabling of health providers other than General Practitioners to deliver care under the Medicare Benefits Scheme.

97. **Preventative Health and First 2000 Days - Embedding the First 2000 Days Framework (the Framework).**

a. Prioritisation of investment in initiatives that fall under this Framework is recommended.

b. The first 2000 days of a child's life is a critical time for physical, cognitive, social and emotional health with a flow on impact throughout their life. Successful implementation of the Framework will improve health and development outcomes for all children, avoiding mental ill health and chronic disease into adulthood.

c. Evidence indicates that the right actions will lead to a significant and positive impact on the long-term health outcomes and wellbeing of children, families and the NSW community. It is critical given the evidence available that prioritisation of this level of prevention is strengthened and resourced. If we do not act to mitigate the risk of disease and change the trajectory of a child's life, the demand on the health system will become increasingly unsustainable.

d. Opportunities that fall within the scope of the Framework include a range of activities that strengthen work already underway, and new initiatives to extend the support available to children and their families to improve outcomes. Whilst some

would be delivered through NSW Health others would best be delivered through partnerships with other government and non government service providers, and with parents and carers.

e. Examples of high priority opportunities to improve outcomes for all children include:

   i. Strengthen the services available to offer interventions and supports for children identified with developmental needs

   ii. Better harness existing and new technology to offer effective care closer to, or within, the home – including through offering virtual care where it can deliver comparable outcomes to traditional care delivery

   iii. Further enhance access to, and uptake of, child health and development checks in early childhood to support early intervention and minimise long term avoidable adverse outcomes

   iv. Strengthen the partnership with primary care through building the capacity of the workforce and through improving models of care for families. This may include expanding the successful shared care approaches that see women cared for through pregnancy by their general practitioner and public maternity team, to extend the program into the care families are offered throughout early childhood.

f. For children and families who need targeted support, opportunities include:

   i. Increase the availability of targeted intensive services to continue support to families who participate in pregnancy family conferencing, after the birth of their baby. Pregnancy family conferencing works in pregnancy to support families at risk of their child being removed at birth due to child protection concerns.

   ii. Increase accessibility of developmental diagnostic assessment services, and multidisciplinary care teams and supports for children.

   iii. Build the capacity of community and general paediatrics through greater access to supervision from paediatric psychiatry to enable better support for children and families with neurodiversity and behavioural needs.

iv. Using the emerging evidence on successful hub-based models of care to improve service collaboration, accessibility and wrap around delivery to families, with a particular focus on the needs of Aboriginal and multicultural communities. This would include strengthening partnerships with non-government and Aboriginal Community Controlled services in delivery of hubs.

v. Further develop models of care informed by evidence to improve outcomes for children and families in remote NSW, and those dealing with complex challenges that can impact on their children's health and development such as domestic and family violence, mental health and drug and alcohol dependence.

vi. Expand proven models of care for Aboriginal families including Aboriginal Maternal and Infant Health and Building Strong Foundations child and family health services for Aboriginal families.

98. **Clinical Service Planning - Strengthen the service and capital planning process to achieve Future Health Key Objective 2.5: Align service planning and infrastructure around future care needs.**

a. Service and capital planning processes in NSW are robust and have undergone substantial reform and strengthening through the implementation of the 20 Year Health Infrastructure Strategy referred to in paragraph 47 above. However, realisation of the benefit of these reforms in rebalancing the investment portfolio between acute hospital capacity and other care settings is slow due to the long lead times involved in the service and capital planning cycle. In the interim, the Recurrent Affordability Working Group referred to in paragraph XX is seeking to address the most pressing affordability concerns.

b. Building on the progress to date, there is opportunity to influence service planning at an earlier stage to prioritise contemporary models of care that both shape a future facing health system and have regard to the growing challenges in recurrent financial affordability at the point of commissioning major capital developments, and the environmental sustainability of the health system.

c. Clinical Service Planning data is largely based on historical patterns of service delivery, reflecting past models of care, funding models, supply constraints and environmental footprint. Projecting this forward to inform future infrastructure

investment reinforces current models of care and will not deliver infrastructure aligned to future care needs or a sustainable health system as described in *Future Health*. Historically, service plans have not adequately considered the impact on recurrent cost, workforce or sustainability factors *prior* to progression to an investment proposal.

d. Addressing these factors is complex and requires coordinated effort and consultation across NSW Health and the community more broadly.

e. Linking to Future Health Strategic Outcome 2.2 *Deliver more services in the home, community and virtual settings*, NSW Health has embarked on consultation to develop clearer guidance at the pre-planning phase about service profiles in areas such as demand management, out of hospital care (including in community settings), and virtual care to align with future care needs and a sustainable system as described in Future Health.

f. Prior to any investment or funding decision, the requirement for Service Plans to address recurrent funding, workforce and environmental factors in more detail is already signalled in the Guide to Service Plans informing LHD/SN capital planning. This guidance can be strengthened, and along with the guidance on service profiles aligned to meet future care needs sustainably, will further enhance existing reforms designed to deliver on the Future Health vision.

g. Aligned to Future Health Strategic Outcome 5.3 *Enabled targeted evidence-based healthcare through precision medicine* and Future Health Strategic Outcome 5.4 *Accelerate digital investments in systems, infrastructure, security and intelligence*, digital health transformation and personalised medicine will also have an impact on how patients want to receive their care and subsequently on the built environment from which care is delivered.

h. Changing how our hospitals are designed and organised to deliver care will require broad consultation and discussion with consumers, clinicians, the community, and the broader health system.

Deborah Willcox AM	Witness: Lavena Ramdutt
9 April 2024	9 April 2024
Date	Date