Final Report – Review of nKPI and OSR

Department of Health, Disability and Ageing

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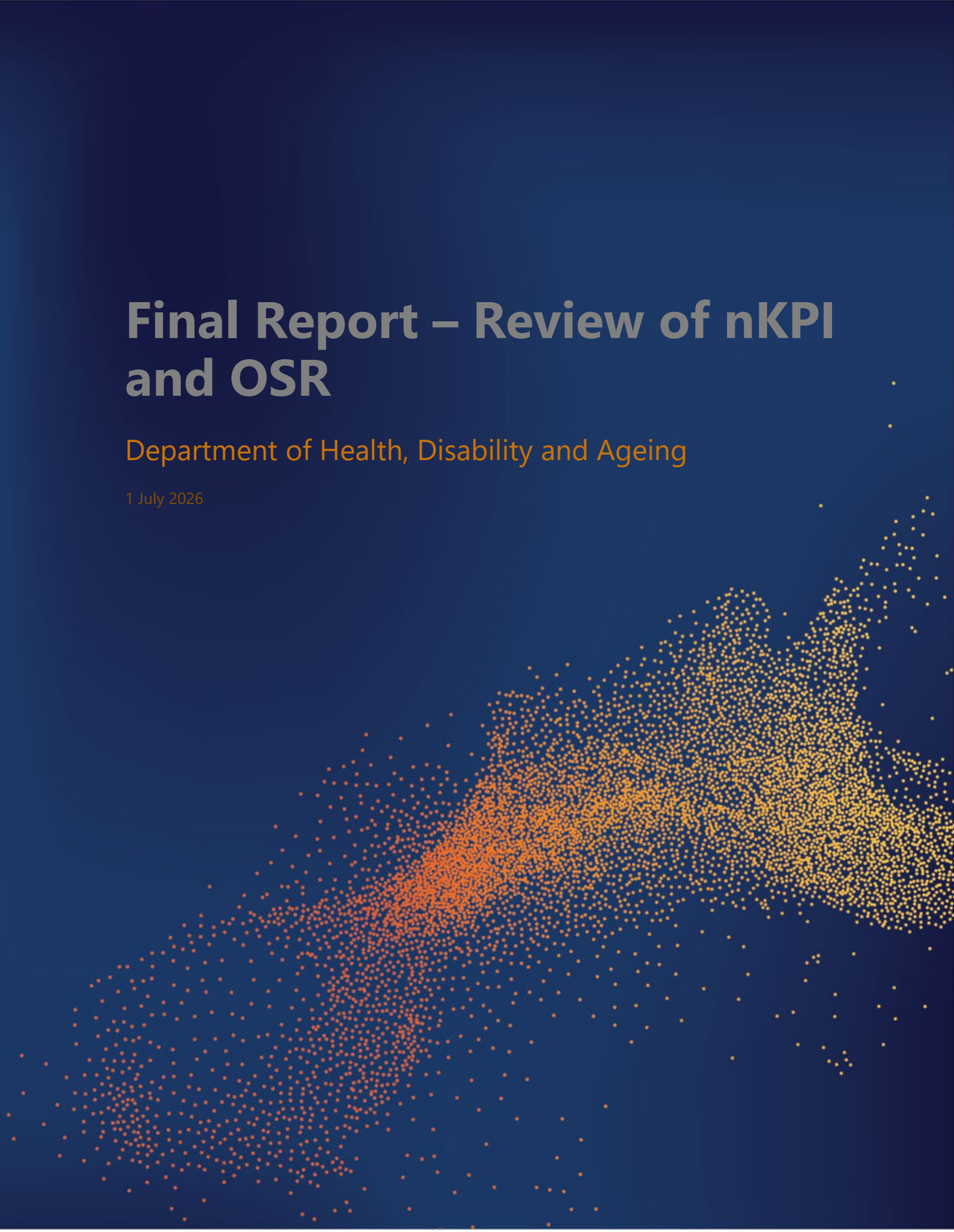

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Nous Group acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the Traditional Custodians of Country throughout Australia. We pay our respect to Elders past and present, who maintain their culture, Country and spiritual connection to the land, sea and community.

This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities.

Contents

1 Executive Summary

This report presents the final findings and recommendations of the review of the national Key Performance Indicators (nKPIs) and the Online Services Report (OSR), commissioned by the Department of Health, Disability and Ageing (the Department). The review examines the appropriateness, usefulness, efficiency and governance of the collections, the burden they place on First Nations Primary Health Care (PHC) services, and how they can be strengthened in the context of Indigenous Data Sovereignty principles[1], broader national digital health reform, and the Closing the Gap Priority Reforms, in particular Priority Reform 4 relating to shared access to data and information at a regional level.

The nKPIs and the OSR were established at different times and for distinct but complementary purposes within the First Nations PHC system. The nKPIs were developed in 2010 to support continuous quality improvement (CQI) in First Nations PHC services, by providing a nationally consistent, service-level view of key clinical activities and outcomes, alongside a secondary role in informing program monitoring and policy development. Since their introduction, the nKPIs have been refined through periodic review and stakeholder input, but their core design as a six-monthly, aggregated, CQI-oriented collection has remained unchanged.

The OSR has a longer history, originating in earlier service activity and organisational reporting collections from the late 1990s and later consolidated into a single annual report to support funding accountability, service profiling and system-level understanding of the First Nations PHC sector. The OSR was designed primarily as an administrative and organisational dataset, capturing workforce, activity and service context information to inform Indigenous Australians' Health Programme (IAHP) funding assurance, program management and national reporting. Over time, incremental changes to scope and reporting requirements have increased burden and reduced clarity of purpose, without diminishing the underlying value of the collection for its core roles, reinforcing the need to re-establish the OSR as a focused and proportionate collection aligned to its core funding and stewardship functions.

The review draws on an extensive evidence base, including a documentation and literature review, quantitative analysis of the collections and supporting systems, and comprehensive consultation with Aboriginal Community Controlled Health Organisations (ACCHOs), other First Nations PHC services, peak bodies, government agencies, data custodians and system partners. Findings reflect consistent themes across these sources and build on the Initial Findings and Recommendations through additional analysis, sector feedback and refinement of proposed reform pathways.

The role of the nKPI and OSR in the current data environment

The review finds that the nKPI and OSR collections continue to play an important and enduring role within the First Nations PHC data ecosystem. When assessed against their original and intended purposes, the collections together provide nationally consistent, service-level data that supports CQI, benchmarking and governance oversight through the nKPI, and funding accountability, program administration and sector-level profiling through the OSR. Compared with many other government reporting programs, they are relatively mature, reflecting sustained investment in indicator design, cross-vendor automation, validation processes, training and sector support.

At the same time, recognising the distinct ways in which different stakeholders use the data, the review confirms that both collections are best understood as partial and purpose-bound instruments rather than comprehensive or standalone measures of First Nations health or service performance. Structural features of the collections, including aggregation, reporting frequency, partial population coverage and reliance on Clinical Information Systems (CIS), inherently limit the extent to which all original objectives can be realised simultaneously. These constraints reflect deliberate design choices intended to balance value, feasibility and reporting burden, rather than shortcomings in implementation. This reflects a broader, systemic issue beyond the nKPI and OSR, where digital architectures fail to accommodate the holistic models of health held by First Nations peoples.

Importantly, some perceived limitations in how data is accessed and interpreted are not solely a function of these structural features but also relate to how data is currently presented to the sector and stakeholders. For example, the configuration of Qlik Sense (Qlik) dashboards provides a relatively flat and constrained view of the data. However, this reflects design choices in reporting and visualisation, rather than inherent limitations in the underlying data or its potential use. There is therefore scope to enhance how data is presented and interrogated over time, without requiring fundamental changes to the collections themselves.

[1] These principles apply to all data relating to First Nations people, regardless of whether it is generated within community-controlled or non-community-controlled service settings, with governance mechanisms adapted appropriately to each context.

In practice, these purpose boundaries are reflected in the different uses of the data. At the service level, nKPI data primarily supports high-level CQI, reflection, benchmarking and governance reporting, while OSR data is experienced largely as an administrative and funding-related reporting requirement. At the sector level, organisations such as the National Aboriginal Community Controlled Health Organisation (NACCHO) and some Affiliates use aggregate outputs to support advocacy, sector monitoring and system stewardship. Within government, use is concentrated in specific departmental and program areas for funding assurance, contract management and contribution to national reporting, including analysis undertaken by data custodians such as the Australian Institute of Health and Welfare (AIHW). Understanding these distinct use cases is critical to identifying where value is generated, where reporting burden is most acutely felt, and how reciprocity can be strengthened across the system.

A central finding is that clarity of purpose and use matters more than the volume of reporting itself. Where the intended purpose of a collection is clearly articulated, aligned to how data are used, and visibly linked to value for services and the sector, reporting effort is more readily understood and accepted. Conversely, lack of transparency about downstream use undermines trust and amplifies perceptions of burden.

Findings on the nKPI collection

The nKPI collection is most effective as a high-level CQI, benchmarking and governance tool. This aligns directly with the original intent of the nKPIs to support service-level continuous quality improvement, reflection and oversight. Its six-monthly, aggregated design supports reflection on trends over time and peer comparison and is particularly useful for board reporting and high-level oversight. However, the same design features limit its usefulness for day-to-day clinical improvement, targeted follow-up or real-time decision-making. This reflects the way the collection has evolved in practice rather than a deliberate exclusion of real-time CQI in its original intent. At the time of its establishment, the nKPIs were expected to support CQI within services; however, over time, the emergence of more advanced CIS tools and internal analytics has enabled services to undertake timelier, patient-level CQI through other means. In practice, PHC services rely on their own CIS-based tools and internal analytics for operational CQI, with nKPIs providing a complementary rather than primary evidence source.

The review finds that the current nKPI set broadly aligns with many core clinical priorities relevant to IAHP-funded PHC services, but does not reflect the full scope of holistic, culturally grounded PHC service delivery. Significant gaps remain in areas such as social and emotional wellbeing and mental health, where there is strong sector interest but no agreed, low-burden approach to standardised collection. These gaps highlight the limits of the nKPI as a bounded CQI and governance dataset, rather than a comprehensive representation of all PHC activity. At the same time, not all existing indicators provide commensurate value, and some require refinement to improve relevance, interpretability and alignment with holistic, culturally grounded clinical practices of IAHP-funded PHC services.

The review concludes that, in the short to medium term, reform should focus on strengthening the clarity, value and usability of the existing nKPI collection, rather than expanding its scope. This reflects the broader, longer-term direction of health data reform, which points toward greater use of interoperable, unit-level data within CISs as part of national digital health reform, rather than incremental enhancement of existing aggregated reporting collections.

In this context, references to unit-level data relate to changes in data structure and reporting architecture, not the introduction of whole-of-system person-level data linkage or expanded surveillance of individuals. This includes clearer articulation of what the nKPIs are and are not intended to be used for; targeted refinement of indicators; optionality where indicators are not relevant to all services; and exploration of approaches that better support CQI without increasing compliance burden.

In this context, the value of significant investment in further expanding or materially redesigning the current nKPI approach is limited. Instead, the emphasis is on practical, proportionate improvements that address current pain points, minimise additional burden on PHC services, and are achievable without significant investment in time or resourcing, while progressing longer-term reform in parallel. A future transition to unit-level data has the potential to address many current limitations in the longer term.

Findings on the OSR collection

The OSR remains a critical funding and accountability dataset, particularly for workforce, service activity and organisational context. This is consistent with the original purpose of the OSR as an administrative and organisational collection designed to support IAHP funding assurance, service profiling and system stewardship, rather than service-level CQI. Government stakeholders rely on OSR data to support IAHP funding assurance and program management, and system-level analysis by data custodians such as the AIHW depend heavily on OSR workforce information.

In this role, the OSR also supports national reporting on the size, distribution and scope of the ACCHOs sector and provides baseline organisational information that assists services and funders to understand sector capacity and sustainability.

However, the OSR is widely experienced by services as higher-burden and comparatively low-value in its current form. Manual reporting requirements, particularly workforce and vacancy reporting, are the primary drivers of burden, and several measures do not consistently reflect contemporary PHC service models, including multidisciplinary, outreach-based and culturally grounded care. These issues undermine the OSR's effectiveness in fulfilling its core purposes, both for funding assurance and for sector-level reporting, as inconsistency and reporting burden reduce confidence in the data and limit its usability. This burden is compounded by limited shared understanding of how OSR data is used for its core funding and stewardship purposes. There is also limited shared understanding of how specific OSR measures are used in policy decisions, which weakens confidence in the collection and contributes to perceptions of non-reciprocal reporting.

The review finds limited appetite for expanding the scope of the OSR. Instead, the priority is purposeful simplification in line with the OSR's core role in funding assurance and system-level understanding.

The primary value of the OSR for funding assurance lies in a small set of core measures, particularly client numbers, episodes of care and clinic location, which are used by the Australian Government as inputs to understand service scale, reach and distribution. These data support high-level funding assurance and system oversight rather than detailed analysis of service delivery models.

For the OSR's other core purposes, including supporting organisations to understand their own scale and profile, and enabling national reporting on the size and scope of the ACCHOs sector, the focus is on making data easier to collect/report and more consistent, rather than more detailed. Accordingly, reform should prioritise removing low-value or redundant items, reducing unnecessary granularity, clarifying definitions, and improving alignment between reporting effort and actual use. Where OSR data is relied on for funding or system oversight, clearer communication and feedback loops are essential to improve transparency and trust.

Infrastructure, governance and future directions

Both collections are underpinned by shared digital infrastructure, including the Health Data Portal and associated analytics tools. While automation and direct load deliver clear benefits, services continue to experience challenges with usability, access management, validation processes and data preparation, particularly in high-turnover, low-capacity organisational settings. These issues compound reporting burden and limit the value returned through dashboards and reporting tools.

The review situates these findings within a broader and rapidly evolving digital health landscape. National reforms are increasingly oriented toward interoperable, unit-level data architectures, linkage across care settings and reuse of data for multiple purposes, consistent with Closing the Gap Priority Reform 4. Interoperable, unit-level data architectures relate to how clinical data are structured, extracted and reused to reduce duplication and reporting burden. Data linkage across care settings and the reuse of data for multiple purposes raise additional questions about consent, linkage, access and downstream use. Progress toward this future state will be incremental and will depend in part on technical advancements beyond the sector, including CIS vendor development, broader standards adoption, and national certification frameworks.

Beyond Priority Reform 4, these directions also have important implications across the full set of Priority Reforms under Closing the Gap. Priority Reform 1, which focuses on formal partnerships and shared decision-making, highlights the need for stronger co-design and joint governance of data systems with Aboriginal community-controlled organisations, ensuring that decisions about data collection, use and reform are made in genuine partnership. Priority Reform 2, which centres on strengthening the community-controlled sector, reinforces the importance of reducing unnecessary administrative burden on ACCHOs, building sector capability in data and digital systems, and aligning data collection and governance with community-controlled models of care. Priority Reform 3, which seeks to transform government organisations, underscores the need for government to improve transparency, consistency and accountability in how data is collected, used and shared, including clearer articulation of purpose and stronger feedback loops to services.

While this overall direction offers substantial long-term benefits, First Nations PHC services consistently emphasised the need for caution, strong Indigenous-led governance, and demonstrable reciprocity, particularly in relation to any reforms that extend beyond service-level reporting toward cross-system data linkage. This includes ensuring that future governance arrangements apply consistently to all data relating to First Nations people across the health system, including data generated in mainstream service settings, not only within community-controlled organisations.

In this context, the future direction points toward shared data infrastructure with First Nations-led governance, building on existing platforms such as the Health Data Portal (HDP). The HDP provides an established, sector-wide foundation, with existing functionality, service familiarity and support structures that could be progressively strengthened and adapted over time, rather than replaced. Evolving toward shared infrastructure of this kind would support more coordinated reporting, improved data access, and greater sector influence over how data is governed, used and returned, consistent with Indigenous Data Sovereignty principles and the objectives of the Closing the Gap Priority Reforms. Any future data model must also ensure that data flows back to services in a form that supports direct clinical follow-up and meaningful CQI, not only upward to system users.

Over the longer term, a mature and well-governed data environment of this kind has the potential to significantly reduce, or potentially eliminate, the need for periodic compliance-based reporting by PHC services. However, trust, consent and control are foundational requirements, not secondary considerations, for any future data reform.

Overall implications and reform pathway

Given that the nKPI and OSR collections will remain the primary national service-level datasets in the near term, the review concludes that reform efforts should prioritise clarity, proportionality and trust, rather than expansion of scope. This includes:

- reaffirming and clearly communicating the purpose, use and limits of each collection
- reducing reporting burden by removing or simplifying low-value requirements
- strengthening feedback loops so services can see how their data is used and reciprocity so services can gain more benefit from the collected data
- embedding Indigenous Data Sovereignty more deeply in governance and decision-making.

At the same time, reforms should be deliberately sequenced to avoid over-investment in legacy approaches and to remain compatible with longer-term system transformation. The recommendations in this report are therefore framed across three horizons: immediate improvements to current collections; foundational changes that enable more substantial reform; and transition steps that prepare the system for a future data environment that better supports self-determination, service-level improvement and integrated, whole-of-system insight.

This policy requires government agencies to develop a strategic approach to AI adoption, embed responsible-AI processes across their operations, and implement risk-based oversight throughout the AI lifecycle, including pathways for reporting and responding to AI incidents. These guardrails reinforce that AI may only be introduced where strong governance, adequate protections, and proportionate risk-mitigation measures are in place, ensuring that efficiency gains do not come at the cost of safety, ethics, or public trust.

AI in the health sector is evolving rapidly and recommendations quickly become outdated.

New AI models, and tools are released frequently, meaning any assessment risks becoming outdated quickly. The observations detailed in this report should treated as indicative of current capability and direction, rather than fixed predictions about future solutions.

Across the Digital Health landscape, vendors are exploring and implementing AI integrated workflows and are operating in a market where AI integration is increasingly expected. However, vendors and CISs are not at a consistent stage of technical readiness, with some platforms introducing AI enabled features, while others are more constrained by legacy architecture. Systems with more mature, cloud-based infrastructure and structured data models are generally better positioned to integrate AI, while those reliant on older or on-premises architecture face greater barriers to scalable implementation.

At the same time, vendors such as Microsoft are expanding natural language querying and exploratory data analysis functions in their tools such as CoPilot. While promising, their use in health contexts requires careful attention to privacy, security, and clinical governance.

The Department has also indicated an intention to shift toward a Google enterprise data and analytics platform. Vertex AI, which is Google Cloud's unified AI development platform, could be a viable foundation for supporting analysis of health service data. It provides access to Google's AI models (including Gemini) and third-party models, as well as tooling for secure deployment, integration, and managed operation. Vertex AI offers the technical "hooks" needed to connect AI capabilities into existing systems; for example, Qlik may be able to integrate LLM based batch processing or interactive dashboard insights via Vertex AI connectors. However, further investigation is needed to validate this use case and assess its feasibility.

AI enabled analytical support is a rapidly evolving space within the Digital Health environment, with many emerging tools. The sector's requirements are ultimately a simple, reliable interface that genuinely supports analysis and insight generation. Vertex AI is likely to be just one of several platforms capable of delivering this function.

2 Recommendations

2.1 Overview of recommendations

The recommendations in this review are designed to deliver a set of benefits that matter most to PHC services, the Department and other government stakeholders, and to the long-term utility and feasibility of data collection and reporting in the sector.

Collectively, they aim to improve clarity of purpose, increase the relevance and usefulness of collections for CQI, strategy and policy planning, funding assurance, and further reduce reporting burden. They also seek to strengthen and embed principles of Indigenous-led governance, ensuring data is governed, interpreted and used in culturally appropriate ways.

These improvements will see immediate action taken to improve the collections as they are, while building readiness for future reform and enhancing trust, governance, data quality and infrastructure in the First Nations PHC sector, necessary to support a transition to more integrated health data systems as the digital health environment evolves.

Given the complexity of reform in the digital health and data landscape, clear and deliberate implementation planning for all recommendations outlined in this report is critical. Importantly, effective implementation will enable the optimisation of the collections in the short term, while preparing for long-term reform.

The recommendations of the review address opportunities to improve the collections to increase their usefulness and clarity and further minimise reporting burden. These collections sit within a rapidly evolving digital health environment, where longer-term reforms may fundamentally change how primary care data is collected and used.

This review recognises that whilst there is a clear direction towards integrated unit-level data and standardised interoperable systems, there is a degree of uncertainty, and the future state is not yet fully defined. With this in mind, this review's recommendations and their implementation can be considered in three frames: how to deliver short-term improvements; how to establish foundations that align with this more substantive reform; and how to actively prepare for the transition to a future state.

- **Short-term improvements are actions that deliver immediate value and can be implemented largely within the Department's existing authority, systems and governance**. These actions focus on improving clarity of purpose, refining the scope and content of the collections to further minimise reporting burden, making necessary technical or definitional fixes, and addressing any other immediate concerns held by the sector. They are largely within the Department's control and do not depend on broader digital health reform, system-wide change, or highly complex multi-stakeholder engagement. Together these actions provide a practical step forward to improve the collections and demonstrate responsiveness to the sector.
- **Foundations for substantive reform are actions that represent more significant change – providing substantial value over the longer-term but involving greater implementation complexity.** These actions are intended to improve the value and usefulness of the collections – to both the government and PHC services – while laying the groundwork for more substantive but critically important changes, such as governance reform. They are more complex to implement, requiring multi-stakeholder input, co-design and agreement, or technical complexity, and are less directly within the Department's sole control. Taken together, these foundational actions create the conditions for sustained and substantial improvement of the collections, ensuring they are well-placed to function in a future state of digital health collection.
- **Transition steps that focus on the actions required to actively prepare for the future digital health data landscape**. These actions are forward-looking and exploratory, aimed at clarifying future options, testing assumptions, and identifying the conditions required for more fundamental reform to occur safely and credibly. They require detailed consideration of policy, governance, data architecture and sequencing, alongside sustained and meaningful consultation with the sector to build trust, shared understanding and readiness. Collectively, these transition steps provide a disciplined pathway for managing uncertainty, ensuring that future reform is evidence-led, Indigenous-governed, and progressed at a pace that maintains sector confidence while avoiding premature or misaligned system change.

Table 1 | Future Landscape

Future Landscape			
	#	Recommendation	Benefit
Transition steps	1	**Confirm the future vision for the collections in line with broader digital health data reform and develop a transition strategy in partnership with PHC services, NACCHO and state-based affiliates.**	Provides clarity on the position of the collections within broader digital health data reform – ensuring that all stakeholders are aligned on this vision – and strengthens readiness for future reform by embedding detail on sequencing, dependencies and decision-points into a transition strategy, enabling proportionate investment and reducing the risk of misaligned or premature change as the broader digital health environment evolves.
	1.1	**Prepare for effective use of FHIR and structured clinical terminology that will underpin the future reporting environment, ensuring infrastructure and processes are ready to transition.**	Improves interoperability, data quality and future readiness by aligning collections with national and international data standards, reducing fragmentation across systems and supporting more efficient data reuse as the digital health environment evolves.
	1.2	**Commit to transitioning toward shared data infrastructure that allows genuine sector control, underpinned by strong First Nations-led governance**	Strengthens trust, self-determination and long-term sustainability by signalling a clear commitment to First Nations control over data infrastructure, supporting alignment with IDS&G principles and providing a foundation for future reform.
	1.3	**Identify and establish the infrastructure required to support the future state data environment, including a sector-controlled platform capable of storing de-identified record-level data, linking across the broader health system, supporting automated low-burden reporting to funders, and returning rich, contextually relevant insights to services.**	Builds readiness for a future digital health data environment by defining the infrastructure needed to support secure data linkage, low-burden reporting and meaningful return of value to services, while ensuring future systems are Indigenous-governed, scalable and aligned with broader health system reform.

Table 2 | Recommendations – nKPIs

National Key Performance Indicators (nKPIs)			
	#	Recommendation	Benefit
Short-medium term improvements	2	**A. Confirm and clearly communicate the intended purpose of the nKPI policy and strategic planning.** **B. Strengthen support for PHC services to interpret and use nKPI data for CQI.**	Clarifying and communicating the purpose of the nKPI and strengthening support for PHC services to interpret and apply their data will primarily benefit PHC services by making clear how their data may be used to enable CQI and inform strategy and policy planning. This will strengthen trust, reduce perceptions of one-way reporting, and support more disciplined data stewardship.
	4	**Remove nKPI indicator PI14 (immunized against influenza).**	Reduces reporting burden by removing an indicator with limited CQI value and known data capture limitations, while improving the overall relevance and focus of the nKPI indicator set.
	5	**Make PI01 (birthweight recorded), PI02 (birthweight result) and PI13 (first antenatal visit) opt-in for PHC services that do not deliver maternal and child health services.**	Improves proportionality by removing mandatory reporting for services that do not deliver maternal and child health care, while retaining relevant indicators where services are positioned to collect and use them.

	#	Recommendation	Benefit
	6	**Refine PI09, PI10, PI12, PI25 and PI26 to ensure they best align with contemporary clinical guidance, service delivery models, and data feasibility.**	Improves indicator relevance, data quality and interpretability by aligning specifications with contemporary clinical practice and service delivery models, strengthening the usefulness of the nKPI for CQI and system-level analysis.
	7	**Expand PI07 to include all Chronic Disease Management Plans.**	Provides a more accurate and balanced view of chronic disease management activity across services, improving system-level insight while maintaining low reporting burden through use of existing, routinely captured data. Clear definition of the eligible cohort and consistent condition coding will support meaningful interpretation and comparability across services.
	8	**Disaggregate the smoking indicator to separately identify vaping/e-cigarette use.**	Improves the contemporary relevance of the nKPI by capturing emerging risk behaviours, supporting service-level prevention and planning while maintaining alignment with the existing indicator framework.
	10	**Explore the feasibility and value of introducing optional indicators to the nKPI collection to support local CQI priorities and program delivery.**	Optional indicators could expand the medium-term usefulness of the nKPI by enabling services to report on dimensions aligned to local priorities or program requirements and consolidate overlapping reporting obligations across programs.
Foundations for substantive reform	3	**Enhance support for day-to-day CQI without increasing compliance burden by introducing a two-speed nKPI model, including a more frequent, unvalidated CQI feed for service-level improvement with minimal central validation and no qualitative inputs.**	Improves the practical usefulness of the nKPI for service-led CQI by enabling more timely feedback while preserving the integrity, trust and benchmarking role of the validated six-monthly submission and avoiding an expansion of compliance reporting.
	9	**Explore, at an appropriate future point, options for capturing a mental health and/or SEWB indicator aligned to sector-led development of clinically coded SEWB concepts.**	Acknowledges a recognised data gap while avoiding premature indicator development, ensuring any future mental health or SEWB indicator is only considered once culturally appropriate, clinically meaningful and sector-supported approaches are available. Aligning with sector-led SEWB clinical coding initiatives reduces risk of harm, improves cultural safety, and supports development of an indicator that is feasible, comparable, and beneficial for CQI in the longer term.
	11	**Explore opportunities to host a centralised reporting portal for funders of First Nations PHC organisations, through both centralised infrastructure and alignment of overlapping data collections.**	Reduces duplication and fragmentation across reporting requirements by creating a pathway toward more coordinated reporting to multiple funders, lowering administrative burden for services while improving consistency and efficiency in how information is submitted and reused.

Table 3 | Recommendations – OSR

	Online Services Report		
	#	Recommendation	Benefit
Short-term improvements	12	**Confirm the intended purpose of the OSR as aiding assurance and allocation of funding and strategic planning and explain how the collection is used to achieve these purposes.**	Clarifies how OSR data is used by the Department and where its use is limited, strengthening trust among PHC services, reducing perceptions of one-way reporting, and supporting more consistent and disciplined stewardship of the collection without increasing reporting burden.
	13	**Refine OSR workforce reporting to improve clarity, consistency and fitness for purpose.**	Reduces manual reconciliation and improves comparability by aligning workforce categories with common PHC workforce descriptors, supported by clearer mapping guidance, while maintaining appropriate granularity for system-level workforce analysis.
	14	**Assess options to improve the usefulness of OSR vacancy measures.**	Improves the interpretability and usefulness of vacancy data by better reflecting sustained workforce pressure over time, supporting more accurate system-level understanding without increasing reporting complexity for services.
	15	**Explore options to better reflect differences in service intensity, while maintaining the current underlying data inputs.**	Improves transparency and confidence in how OSR activity data is interpreted by making differences in service intensity more visible from data already collected. This responds to a widely held sector concern that comprehensive, multidisciplinary care is understated, without introducing new reporting requirements or increasing burden on services.

Table 4 | Recommendations – Data Platforms and Infrastructure

	Data Platforms and Infrastructure		
	#	Recommendation	Benefit
Short-term improvements	16	**Continue existing data quality support and invest in a sector-wide data literacy uplift across First Nations PHC services.**	Improves data quality and consistency at the point of care by building workforce data capability and strengthening CIS-specific data capture practices, reducing downstream reporting effort and increasing confidence in reported results across both current and future data environments.
	18	**Reduce barriers to data engagement by simplifying data analytics and visualisation tools, exploring accessible alternatives, and AI-guided analytics.**	Improves accessibility and practical use of existing reporting outputs by making dashboards easier to navigate and interpret, supporting more consistent engagement across services with varying data capability while strengthening the value returned from existing data collections. Identifies opportunities to improve accessibility and interpretability of data outputs for services with varying data capability, while enabling cautious, governed exploration of new analytical approaches that may reduce reliance on specialist expertise over time.

	Data Platforms and Infrastructure		
	#	Recommendation	Benefit
Foundations for substantive reform	17	**Explore a pathway to enable automated extraction of OSR workforce data through standardisation of definitions and engagement with HR system vendors.**	Builds sustainable data capability closer to services by providing shared, trusted support for data quality, interpretation and use, reducing reliance on individual service capacity while improving consistency and confidence across the network.
	19	**Adopt AI across the data pipeline commencing with established frameworks and progressing to pilot projects.**	Achieves the benefits of AI in a way that is safe, consistent and trusted, reducing administrative and reporting burden and improving data quality without increasing surveillance or altering accountability settings. By establishing clear frameworks and testing priority use cases through pilots, the Department and services can build confidence, manage risk and generate evidence on where AI delivers genuine value before scaling adoption across the system.

Table 5 | Recommendations – Governance

	Governance		
	#	Recommendation	Benefit
Short-term improvements	20	**The HS DAG and the Department should clearly articulate their respective mandates and decision-making authority, including which decisions rest with the Department and which are the responsibility of the HS DAG, as they relate to the collections.**	Clearly articulating the respective mandates and decision-making authority of the HS DAG and the Department will reduce ambiguity, enable more timely and defensible decisions, and strengthen confidence that changes to the collections are governed through transparent and appropriate processes.
	21	**Adopt a staged and continuous governance approach, with formal reviews triggered by system milestones rather than a fixed review cycle and priorities identified jointly between the HS DAG and the Department.**	Given the pace and uncertainty of change in the First Nations PHC data environment, reliance on infrequent, large-scale reviews is increasingly misaligned with the operating context. Instead, the Department and HS DAG should prioritise structured, ongoing engagement with PHC services through a standing advisory mechanism, supported by regular checkpoints on emerging issues, burden, data quality and governance. Comprehensive reviews should be reserved for key system transition points and triggered by material change rather than a fixed cycle.
	22	**Strengthen the connection between nKPI/OSR governance and broader digital health reform by embedding digital health expertise within governance arrangements.**	As the nKPI and OSR increasingly intersect with national digital health reform, governance arrangements must retain a clear line of sight to the broader digital health agenda. Incorporating digital health expertise into, or alongside, HS DAG governance would support alignment with system-wide reform, help anticipate interoperability implications, and reduce the risk of collections evolving in isolation. This capability should complement, not displace, Indigenous-led governance and sector priorities.

Data Platforms and Infrastructure			
	#	Recommendation	Benefit
Foundations for substantive reform	23	**The HS DAG establish a standing mechanism for First Nations PHC services to participate in and inform the group.**	Strengthens Indigenous-led governance by embedding lived service experience directly into HS DAG deliberations, improving the relevance, legitimacy and trustworthiness of decisions affecting the nKPI and OSR while supporting more reciprocal and transparent engagement with the sector.
	24	**Embed future evolution of the nKPI and OSR collections within whole-of-system First Nations data and digital health reform, supported by strengthened Indigenous-led governance and cross-portfolio coordination.**	Strengthening Indigenous-led governance and establishing standing mechanisms for First Nations PHC services to inform advisory bodies, including the HS DAG, would provide a structured avenue for systematic sector input into both collection-specific and broader system-level data reform.

2.2 Planning considerations

Barriers to implementation

Systemic barriers will limit the extent to which recommendations deliver their intended benefits. Some barriers sit outside the Department's direct control and may constrain impact even where recommendations are implemented as planned. The considerations below should be kept in mind when assessing progress and evaluating outcomes.

1. **Low data literacy will continue to constrain service's ability to use the systems available to them.** Consultations identified low data literacy as a major barrier to services data capability. The recommended simplifications will make submission steps and outputs easier to work with, but they will not remove this barrier on their own. Services will need external support to build confidence and capability before these systems are routinely and effectively used.
2. **Limited infrastructure and connectivity may continue to limit access to reporting systems and reduce the benefits of reform.** Unreliable internet and ageing hardware can slow or prevent access to the HDP, dashboards, and cloud-based CIS functions. This increases the time and effort needed to submit reports, even when the reporting requirements are simplified. It also reduces routine use of dashboards and feedback products, which limits the recommendations' intended benefits for CQI and decision-making. These constraints often sit outside the Department's direct control and may persist unless addressed through broader infrastructure and service-level investment.
3. **The Department has limited control over CIS design and functionality, which constrains how far recommendations can improve consistency and comparability across services.** This limits the ability to align CIS fields, workflows and reporting outputs with the way First Nations PHC services deliver care. The Department cannot mandate a single CIS and cannot require vendors to implement specific changes within their products. The Department can only use external incentives, and these are often weak because First Nations PHC services represent a small share of the overall CIS market.
4. **High workforce turnover in PHC organisations means services lose reporting knowledge as staff leave and new staff start.** This reduces the impact of improved guidance because capability does not stay in place long enough to deliver consistent benefits. Services must continuously onboard new staff to local reporting processes and data practices. This responsibility sits with services rather than the Department.
5. **Competing priorities and time pressure can push reporting and data-use activities behind immediate service delivery needs**. Staff focus on meeting deadlines rather than improving data quality or using results for CQI. This reduces the practical impact of the recommendations, even where systems and guidance are improved. It also increases the risk that reporting becomes a compliance task rather than a useful input to service planning. Training of new and existing staff is often deprioritised in favour of focusing on immediate patient care.

6. **Inherent suspicion about government motives may reduce willingness to engage with the transition strategy and any future data reforms**. Many First Nations communities have experienced data being misused and commitments not being met.

   Weak feedback loops and limited reciprocity reinforce a view that reporting is one-way and low value. This makes services cautious about adopting new data approaches, even when they are well designed. Without clear First Nations-led governance that applies Indigenous Data Sovereignty principles in practice, a radical future model is unlikely to gain buy-in.