Time	Session	Presenter / Facilitator
09:30–10:00am (30 mins)	*Arrival*	
10:05–10:10am (5 mins)	*Opening and Acknowledgement of Country*	**Peter O'Halloran**
10:10–10:20am (10 mins)	*Opening Vision*	**Amanda Cattermole** Including overarching driver of consumer empowerment and central role of clinical governance
10:20-10:40am (20 mins)	*ACSQHC priorities for high-quality digitally enabled care*	**Gillian Giles, Executive Director Clinical Governance, ACSQHC**
10:40am–11:30am (50 mins)	*The role of clinical governance and consumer & clinician engagement*	**Sandra Cook to facilitate** Clinician & Consumer perspective (Dr Amandeep Hansra, Gillian Giles, Imelda Gilmore)
11:30am–12:00pm (30 mins)	*Share by Default*	**Alex Powell** This will be where is SBD going and the exemptions
12:00–12:40pm (40 mins)	*Lunch*	
12:40–1:10pm (30 mins)	*Standards*	**Ryan Mavin** Short ref. to MoF, where are we going and how it all ties together Key things available, rehash previous work
1:10–2:00pm (50 mins)	*Conformance*	**Sandra Cook** Conformance, the new approach
2:00-2:30pm (30 minutes)	*SBD + Standards + Conformance = Connected Care*	**Peter O'Halloran**
2:30–3:10pm (40 mins)	Customer Experience and Product update	**Ines Sostaric & Darian Eckersley** Design approach and HIPS HealthViewer The future approach to clinician viewing of My Health Record (i.e native integration/Smart on FHIR app & HIPS/NPP)
3:10-4:00pm	Q&A from audience and final wrap-up	**Peter O'Halloran to MC; Alex, Ryan, Sandra and Ines**

Connected Care Update

Information Session

Australian Government

Australian Digital Health Agency

Acknowledgement of Country.

The Australian Digital Health Agency acknowledges the Traditional Custodians of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to Elders past and present.

Scene Setting

Amanda Cattermole

> With the right short and long term policy settings, incentives and appropriate regulatory framework I believe Digital health represents the single greatest opportunity to transform health care in Australia.

The Hon Mark Butler MP
Minister for Health and Aged Care
Summit on Clinical Governance in Digital Health

Australian Government
Australian Digital Health Agency

Australian Commission on **Safety and Quality** in Health Care

National Model for Clinical Governance

Gillian Giles, Executive Director Clinical Governance

What keeps you awake at night?

> There is a lot of white noise in all that we do – we need to find our way to what matters.
>
> Board Chair,
> regional health service

> A catastrophic service delivery failure in an outpatient clinic which was not even on our risk radar
>
> Chief Executive,
> rural health service

PAIN POINTS

Clinical governance is not universally understood

A compliance approach

Too many siloes

WHAT'S NEEDED

Practical guidance

Key areas of focus

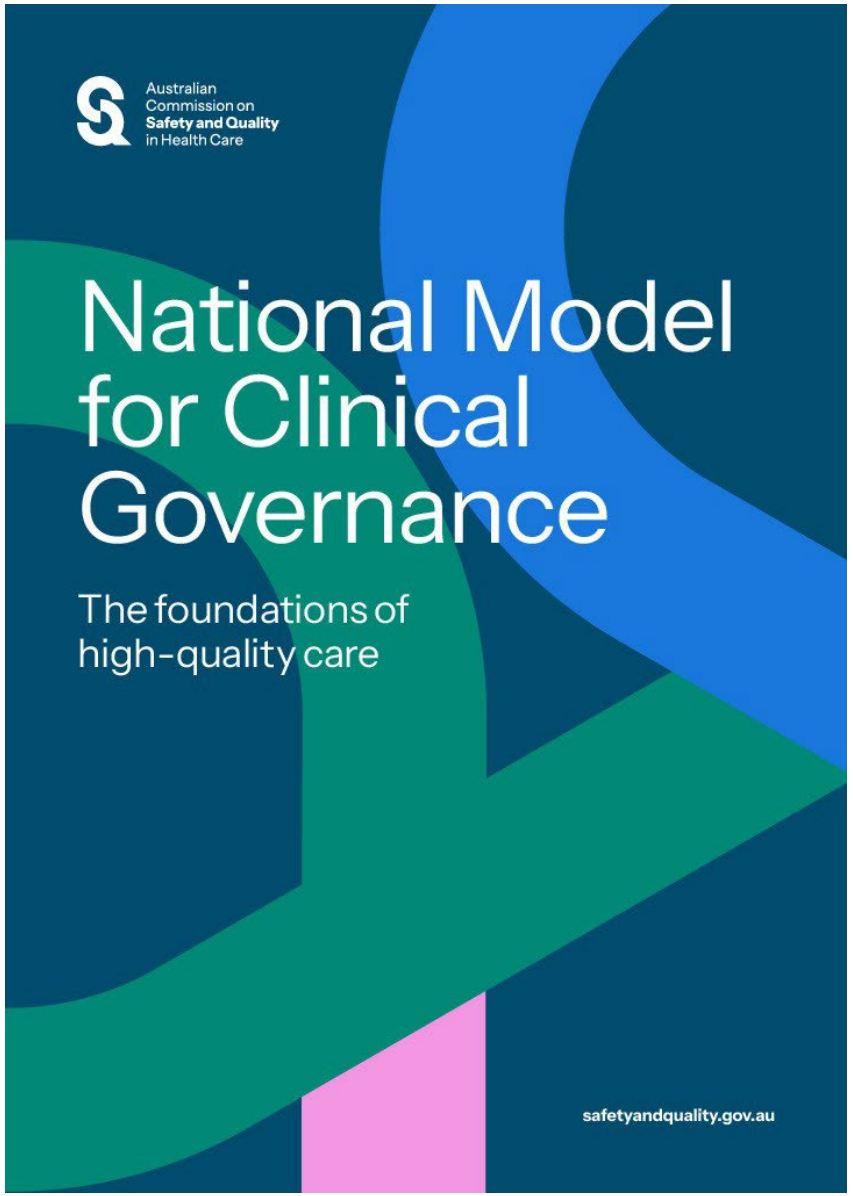
Contemporary thinking

Our response

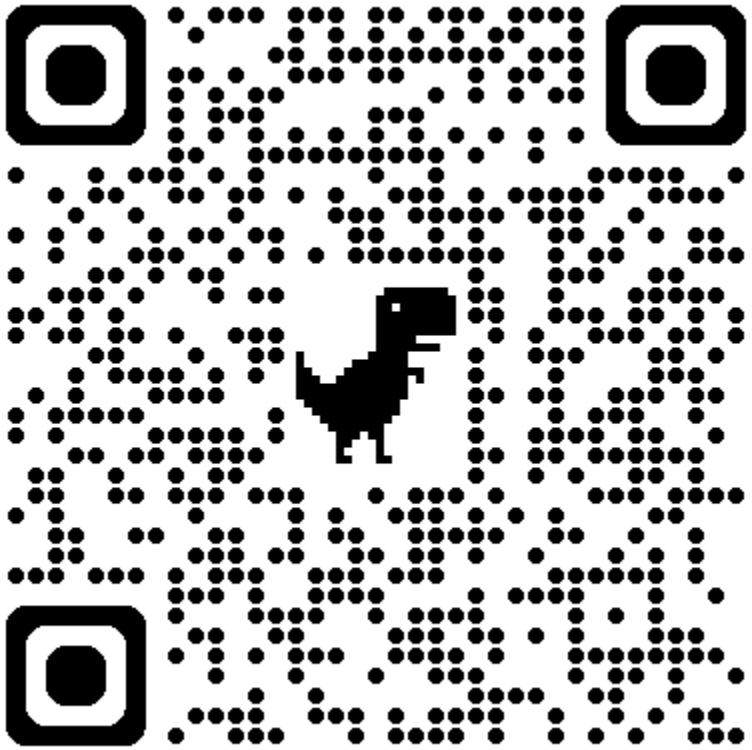
- ✓ A new national model
- ✓ Resource hub
- ✓ Re-shaping the Clinical Governance Standard

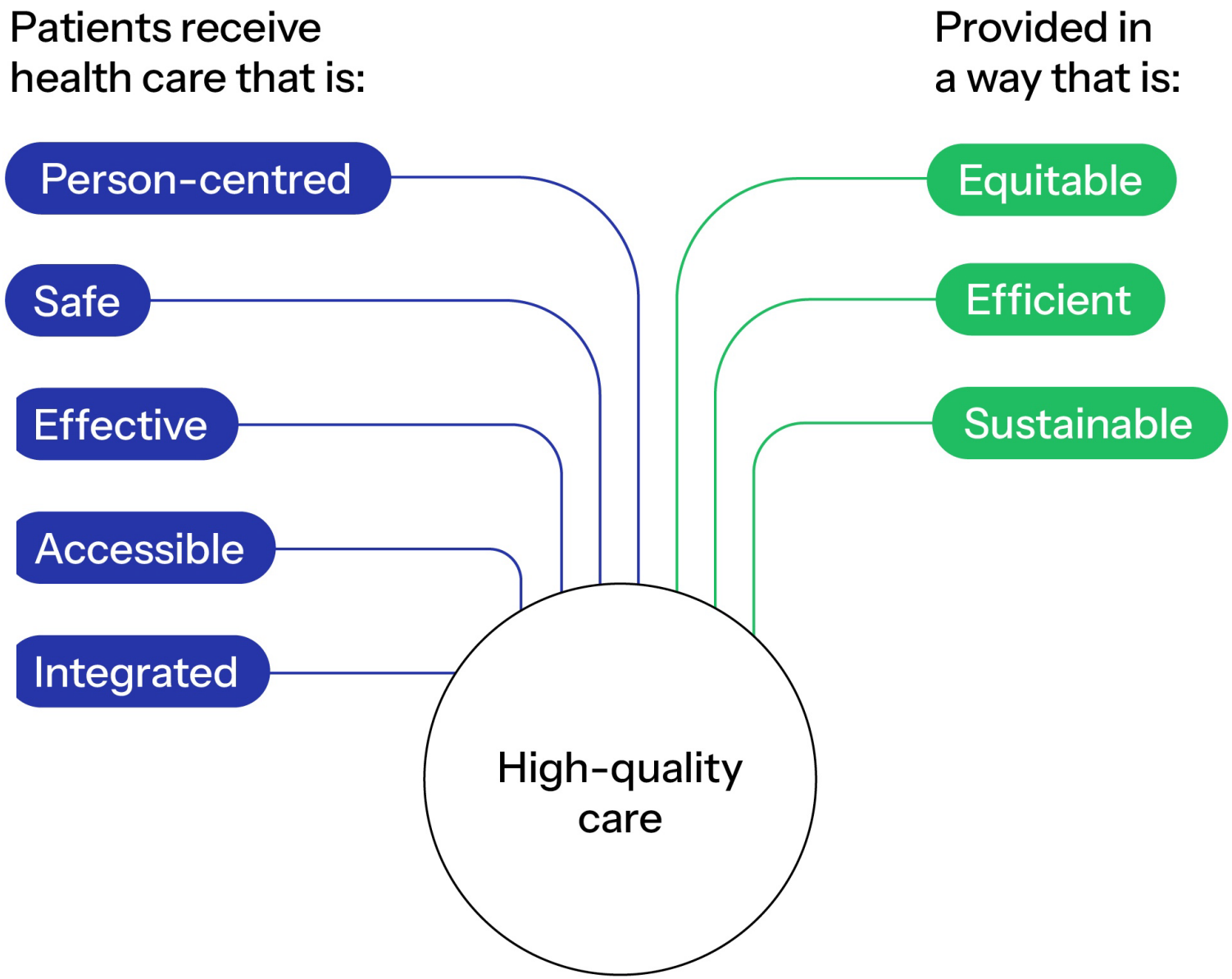
National Model for Clinical Governance

- Highlights the foundations of clinical governance – helps health services focus on high-quality care
- Principles-based so that health services can adapt to suit local needs
- Emphasises the role of boards and leadership teams in strengthening clinical governance



The purpose — **providing high-quality care**





Make it meaningful –
a definition that puts the patient first

> Clinical governance is central to providing the best possible outcomes for patients

- It is the **combination of organisational culture, systems and structures** that enables everyone in a health service to deliver care that is consistently high quality and improving.
- Effective clinical governance means that **boards, executives, clinical leaders and the workforce are clearly accountable** to patients and the community for providing high-quality care.

Organisational culture, systems and structures — **the six foundations of clinical governance**

Zooming in on data

> We’re drowning in data – our last set of board papers included a 120-page report on data

Board Chair,
Regional health service

Foundation 6: Using data for better care

! Warning signs

- A compliance mindset leads to excessive data collection (‘drowning in data’).
- There is a high reporting burden.
- Data reports are high on detail and lack insights, key messages, and visualisations.
- Focus is on positive data rather than pursuing data that reveals inconvenient truths, missing opportunities for improvement.
- Security controls do not keep pace with increasing volume and sources of data, resulting in data breaches.

★ Good practice points

- The board and executive systematically use data to determine whether the organisation is providing all the dimensions of high-quality care.
- The board and executive are accountable for the governance, quality and appropriateness of data generated by digital systems to support high-quality care, and relevant data are provided to clinicians for improving quality of care.
- The organisation develops the capability of all parts of the organisations to use data to improve care.

National Model for Clinical Governance

The foundations of clinical governance for public and private acute health services.

Read more →

Practical guide and tools

How to implement the National Model for Clinical Governance in your health service.

Read more →

Clinical Governance Standard

The clinical governance requirements in the NSQHS Standards.

Read more →

Stories of success

What good looks like in public and private acute health services.

Read more →

Insights

Expert viewpoints on why clinical governance matters.

Read more →

Resource hub

Curated clinical governance resources from across Australia.

Read more →

Back to top

www.safetyandquality.gov.au/clinical-topics/clinical-governance

The national model and the NSQHS Standards

The Clinical Governance Standard in the NSQHS Standards 3rd edition:

- Aligns with the six foundations
- Board to ward connection
- A focus on outcomes

Overview of the standards

NSQHS Standards – the next Clinical Governance Standard

Clinical Governance

Outlines **the responsibilities of the board and leadership team** for the organisational culture, systems and structures required to deliver consistently high-quality care

1. Leading systems and organisational culture
2. Partnering with patients, carers and consumers
3. Building a healthy workforce culture
4. Enabling high-quality and integrated clinical practice
5. Managing and reducing risk
6. Using data for better care

The opportunity for driving connected care

- The third edition of NSQHS Standards:
  - reinforce national efforts for connected systems to **enhance quality and safety.**
  - set clear, nationally consistent **interoperability requirements** for health services.
  - establish clear signals to software vendors, align health service investment with **national digital health infrastructure**, and complement the National Healthcare Interoperability Plan 2023-2028.
  - are a **strong national lever** for driving connected care and reducing fragmentation across health sectors.

Leading systems and organisational culture – Requirement 1.04

Standard 1: Clinical Governance

Purpose	Requirement	
The board, executive and leaders are **accountable for digitally enabled care**	1.04	The board, executive and leaders have organisational systems to: a. ensure **oversight of digitally enabled care**, **privacy and security**, **health information** and **digital tools and technologies** used for clinical support and decision-making b. ensure the responsible use and maintenance of an information security management system for health information, including compliance with security and privacy jurisdiction requirements c. detect, respond to and report on information **security risks and incidents** d. integrate digital tools and technologies **downtime and cybersecurity** planning and preparedness into governance systems e. maximise digital capabilities through the procurement, risk assessment, implementation, use, maintenance and replacement of all digital tools and technologies f. cultivate **partnerships with the workforce, consumers and community** in the design, implementation and governance of digitally enabled care g. uplift **digital health literacy** across the workforce with a focus on improving quality of care

Using data for better care – Requirement 1.30

Standard 1: Clinical Governance

Purpose	Requirement	
Digital systems are optimised to improve continuity of care and integration	1.30	The executive and leaders have organisational digital data systems that: a. use **national clinical terminologies** and **specifications** b. use **interoperable data formats for seamless information extraction** and **exchange** c. monitor system performance to optimise the accuracy, completeness and quality of the data d. support continuity of care and informed decision-making

Healthcare record systems – Requirement 3.04

Standard 3: Safe Clinical Systems

Purpose	Requirement	
Accurate, integrated patient information is available to reduce risk and **improve continuity of care**	3.04	The health service has healthcare record systems that: a. use **national healthcare identifiers** that are verified against the **National Healthcare Identifiers Service** b. are interoperable with: i. **National Digital Health Infrastructure** (such as My Health Record) to support access, sharing and exchange of health information in accordance with **national legislative and policy requirements** ii. diagnostic testing reporting systems iii. Point of Care Testing devices to capture findings c. are able to share and exchange information in alignment with **national requirements, specifications and infrastructure** d. have alert systems that minimise alert fatigue, support decision-making and highlight patient risks to the clinical and non-clinical workforce e. are accessible to clinicians at the point of care f. contain accurate, integrated, comprehensive and up-to-date patient care information that can be used by the workforce to provide high-quality care, support continuity of care and improve patient experiences and outcomes

Embed digitally enabled care in clinical governance

Clinical Governance

Strengthen virtual care quality

Standards and Accreditation

Advance connected care through standardised data

Partnerships and Collaboration

Lead system-wide quality improvement in digitally enabled care

National Guidance

Australian Commission on **Safety and Quality** in Health Care

Priorities for high-quality digitally enabled care

The Commission sets and stewards best practice for digital health to support high-quality care. Digital health enables better care when it is safe, integrated and trusted.

Digitally enabled care is the appropriate application and integration of digital health tools and technologies in clinical settings to deliver, coordinate or enhance patient care.

Our four priorities		How we deliver change
Embed digitally enabled care in clinical governance		
RISK	Digitally enabled care is treated as an IT initiative, outside of clinical governance.	Clinical governance
FOCUS	Integrate the principles in the National Model for Clinical Governance across digitally enabled care.	
OUTCOME	Robust clinical governance underpins digitally enabled care, and digital health tools and technologies.	
Strengthen virtual care quality		
RISK	Virtual care lacks nationally consistent standards that drive high-quality care.	Standards and accreditation
FOCUS	Set and steward nationally consistent standards for virtual care.	
OUTCOME	National leadership of continuous improvement in virtual care quality.	
Advance connected care through standardised data		
RISK	Unstructured, siloed data widens communication gaps, which fragments care and risks patient harm.	Partnerships and collaboration
FOCUS	Work with partners so data is easily created, collected and used to drive action across the care continuum.	
OUTCOME	High-quality standardised data enhances coordinated decision making and continuity of patient care.	
Lead system-wide quality improvement in digitally enabled care		
RISK	Rapid digital innovation outpaces credible guidance and creates risks.	National guidance
FOCUS	Provide proactive national guidance to enable consistent practice.	
OUTCOME	The Commission leads quality improvement in digitally enabled care.	

Foundational principles

These principles underpin all four priorities and guide how the Commission works.

Build capability

Supporting sectors, services and communities, particularly rural and remote regions, to build enduring digital capability that strengthens the quality of care.

Support equity and access

Enabling equity and access through culturally safe design for First Nations people, and supports for diverse communities.

Strengthen trust

Strengthening clinician and consumer trust in digitally enabled care through governance, evidence, and shared design.

04/2026

For more information visit: safetyandquality/digital-health

Scan for more information

Australian Commission on **Safety and Quality** in Health Care

Have your say on the initial draft NSQHS Standards:

Thank you

T. +61 2 9126 3600

Level 5, 255 Elizabeth St

Sydney NSW 2000 Australia

safetyandquality.gov.au

Panel - The role of clinical governance and consumer & clinician engagement

Sandra Cook
Branch Manager
Connected Care
Australian Digital Health Agency

Dr Amandeep Hansra
Chief Medical Advisor
Australian Digital Health Agency

Gillian Giles
Executive Director,
Clinical Governance
Australian Commission on Safety and Quality

Imelda Gilmore
Consumer Advocate &
Digital Health Advisor
Australian Digital Health Agency

Share by Default

Alex Powell

Australian Government
Australian Digital Health Agency

My Health Record

Better and Faster Access

Timely health information in the hands of Australians and their care teams supports safer, more connected care.

These changes help consumers and healthcare professionals to act quickly, make informed decisions, and ultimately improve health outcomes.

Australian Government
Australian Digital Health Agency

Better Access

Sharing information to My Health Record by default

- ✓ **A powerful legislative lever**
  to substantially improve the completeness and utility of My Health Record

- ✓ **Initially applies to pathology and diagnostic imaging reports**
  legislation and rules outline which health information needs to be shared to My Health Record by default, and by whom.

- ✓ **Impacted providers must share to My Health Record by default**
  unless an **exception** applies or an **extension** of time to comply has been granted.

Supporting a better-connected health system

Less reliance on consumers re-telling their story

Reduce duplicate testing

Consumers in control of their health information

Enable information sharing to coordinate care

Support better informed, safer clinical decisions

Increased evidence-base for treatments and interventions

Privacy and access controls

A person can choose to restrict access to specific documents in their record

A person can restrict access to their entire record using a Record Access Code

A person can choose to receive an SMS or email alert when certain activity occurs (such as access by a new healthcare organisation)

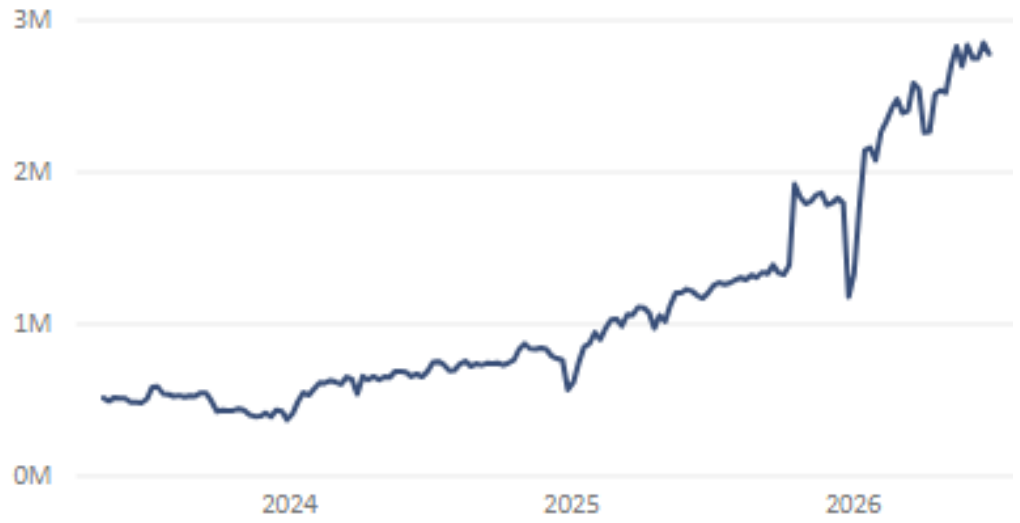
A person can choose to remove documents from their record at any time

All instances of access to My Health Record are monitored and logged

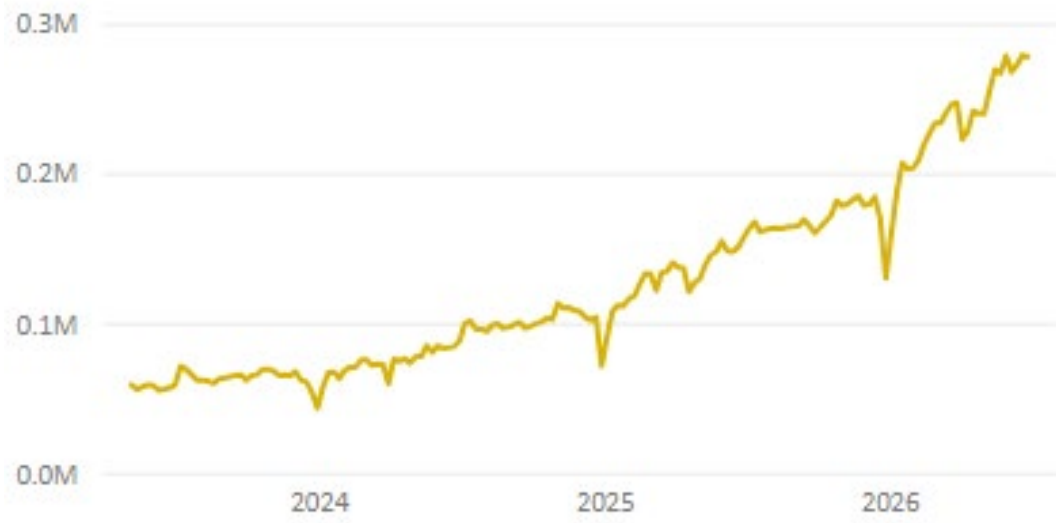
Healthcare providers can't see any restricted information in a person's record unless the person gives the healthcare organisation access

Weekly views by consumers

Pathology and diagnostic imaging reports



Pathology



Diagnostic Imaging

Data as at June 2026 – depicting the increase since Share by Default reforms were announced in May 2023

Weekly uploads

Pathology and diagnostic imaging reports

Pathology

Diagnostic Imaging

Data as at June 2026 – depicting the increase since Share by Default reforms were announced in May 2023

Clinical governance

Person-centred and clinically-led

The Share by Default reforms have been directly informed by clinical and consumer advice - through public consultation and a dedicated committee of healthcare and consumer representatives.

Ongoing advice is provided through the National Clinical Governance Committee for Digital Health and expert advisory groups.

This helps ensure the reforms are:

- ✓ person-centred
- ✓ clinically informed
- ✓ focused on clinical safety
- ✓ mindful of implementation considerations
- ✓ directed toward realising the benefits of connected care.

Exceptions

Consumer does not have a My Health Record

(Has opted out or is not eligible (e.g. tourist))

Consumer or representative says **'Do not upload'** to My Health Record'

Healthcare provider reasonably believes uploading the information would pose a **serious threat to** the consumer's **health, safety or wellbeing**

Circumstances beyond the reasonable control of the healthcare provider **prevent the upload**

(e.g. significant technical issue)

Evidence of exceptions must be documented and retained for at least 2 years.

Other exemptions

Non-mandatory tests

Sharing is not mandatory for:

- Workplace drug or alcohol tests
- Court-ordered tests
- Law-enforcement testing
- Organ or tissue donation compatibility tests
- Research or clinical-trial pathology reports

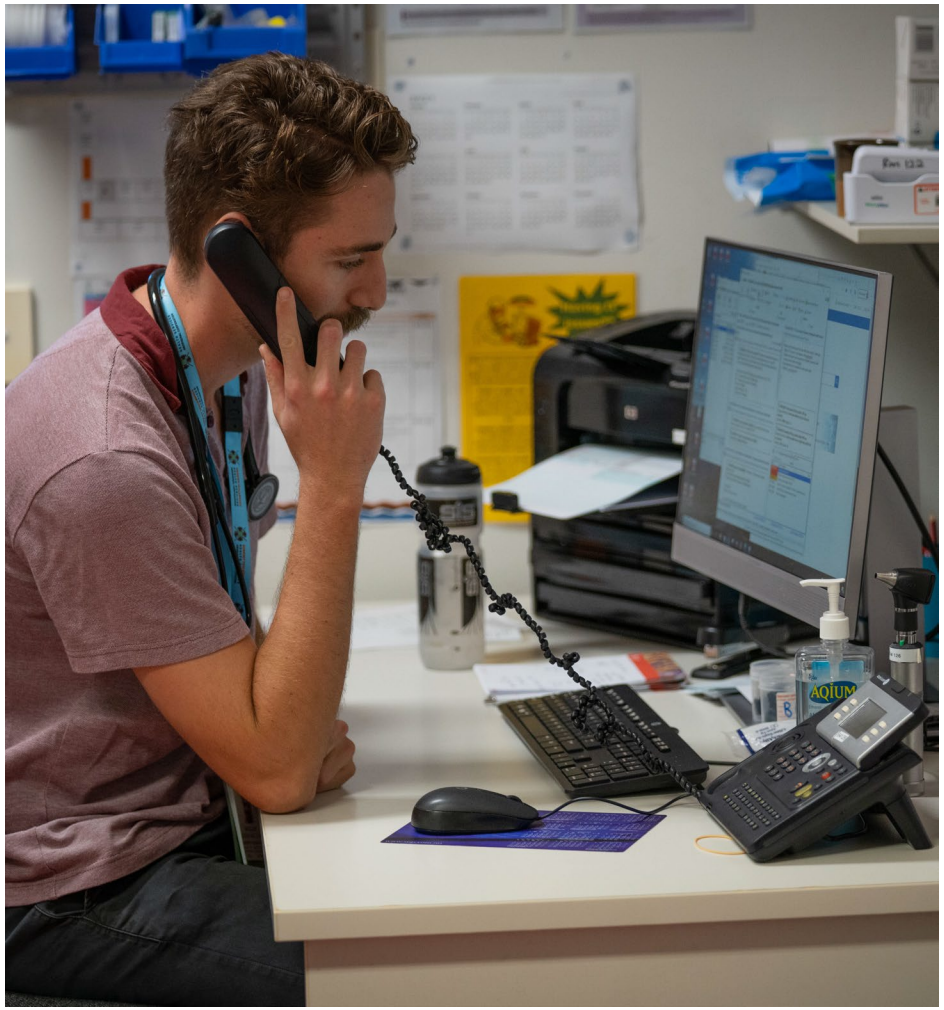
Detail and definitions: My Health Records Regulation 2026, section 12.

Privacy-laws

Consent may be required before sharing:

- HIV (ACT, NSW, QLD)
- Notifiable conditions (ACT, QLD)
- Contagious conditions (QLD)
- Environmental health events (QLD)
- Perinatal history (QLD)

If consent has **not** been obtained in accordance with the state or territory law, the upload requirement does not apply. However, reports can be uploaded if consent is given.



Extensions

Seeking additional time to comply

Need more time to start uploading?

If there is a genuine reason you cannot start by the required date, apply for an extension.

- Assessed case by case
- Length based on evidence
- Obligations resume when it ends
- Further extension can be requested

Scan for guidance

> As a first step to strengthen safety in digital medicines and telehealth, the Australian Government will implement requirements to ensure all medicines-related information from online prescribers is made available to consumers and their healthcare providers through My Health Record.
>
> **- The Hon Mark Butler MP – 28 January 2026**
> Minister for Health and Ageing
> Minister for Disability and the National Disability Insurance Scheme

What's next?

Share by Default for Medicines

- **Online prescribing will be brought into Share by Default.**
- Medicines information shared to My Health Record
- Clinical context included with prescribing information
- Designed to reduce medication errors and patient harm
- Consultation feedback will shape the final requirements

Target: rules developed by December 2026

Subject to consultation and Government decisions. Consultation page

Future opportunities

Share by Default may expand to more types of health information over time.

Budget-funded focus areas:

- **Medicines information** — online prescribing first
- **Chronic Condition Management Plans**
- **GP letters** — to specialists and allied health providers

Subject to consultation and Government decisions.

We will resume at 12:40

Australian Government
Australian Digital Health Agency

Standards

Ryan Mavin

National Framework for Digital Health Standards

Coordinated approach strengthening adoption and implementation of digital health standards

Scan to read

Australian Government
Australian Digital Health Agency

No single standard is enough

- **Interoperability depends on a coordinated standards ecosystem.**
  - **Coordinate** — multiple complementary standards together
  - **Govern** — implementation consistently at national scale
  - **Connect** — clinical and operational needs across the system

The framework brings the pieces together so standards can scale safely.

National Framework for Digital Health Standards

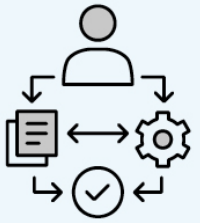
Leading a nationally coordinated approach to digital health standards

Enduring governance model

Strengthening evidence and benefits

Training, education and workforce

Communication, collaboration, engagement



Implementation support

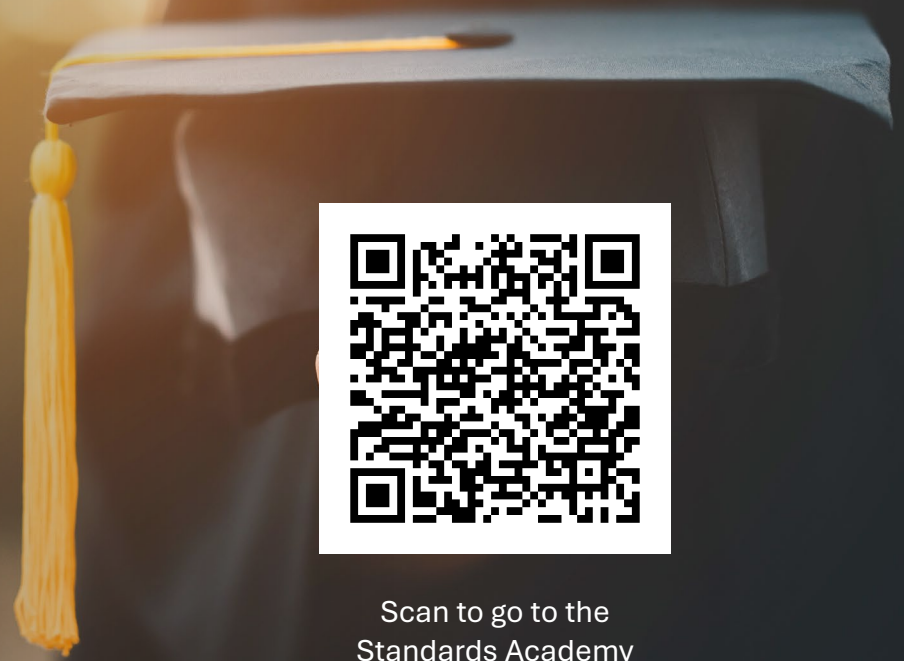
Key areas for supporting adoption and implementation of digital health standards

Standards Academy

Supporting capability building for digital transformation

- Role based short courses
- Self paced & instructor lead
- Access subject matter experts
- No cost to you (Agency funded)

We can FHIR up your workforce!



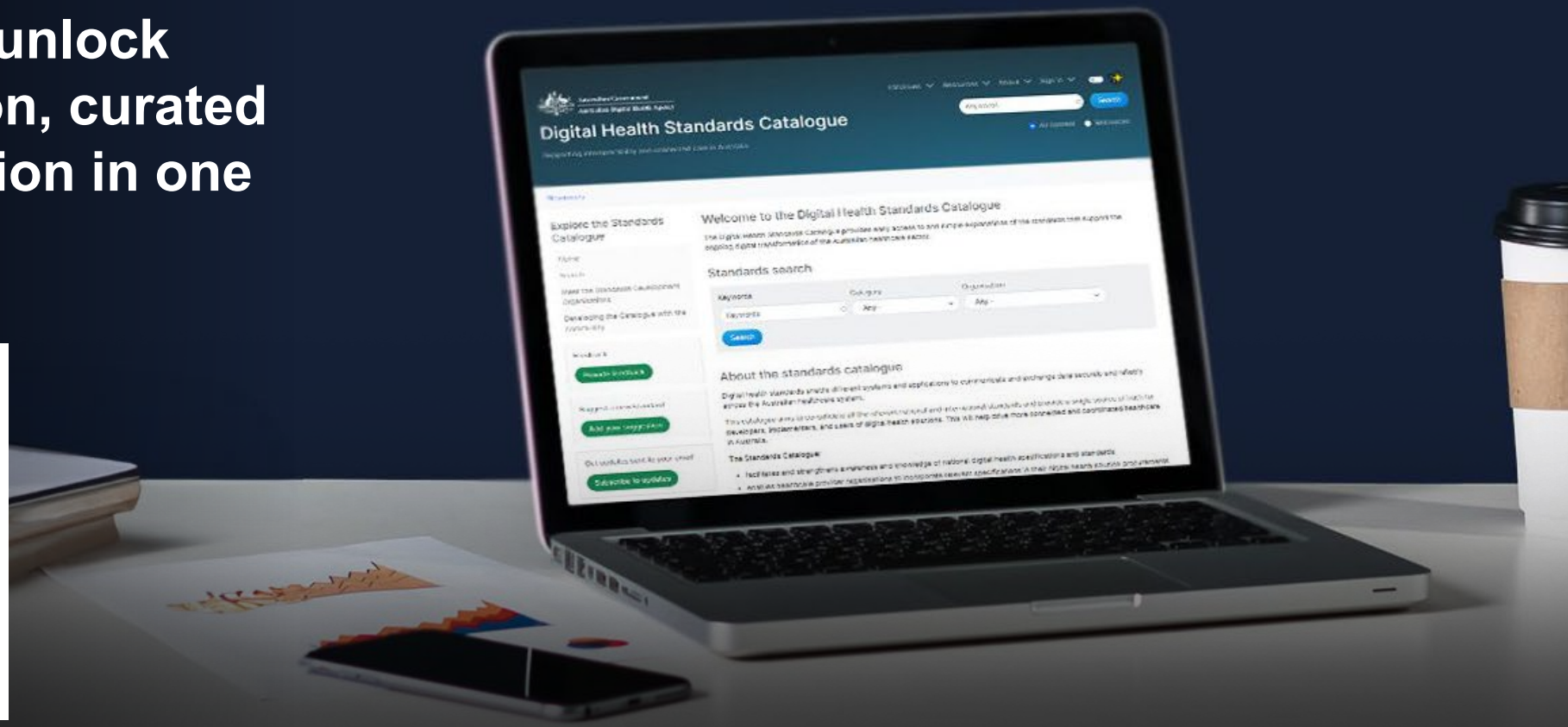
Scan to go to the Standards Academy webpage

www.digitalhealth.gov.au/digital-health-standards/standards-academy

Australian Government
Australian Digital Health Agency

Standards Catalogue

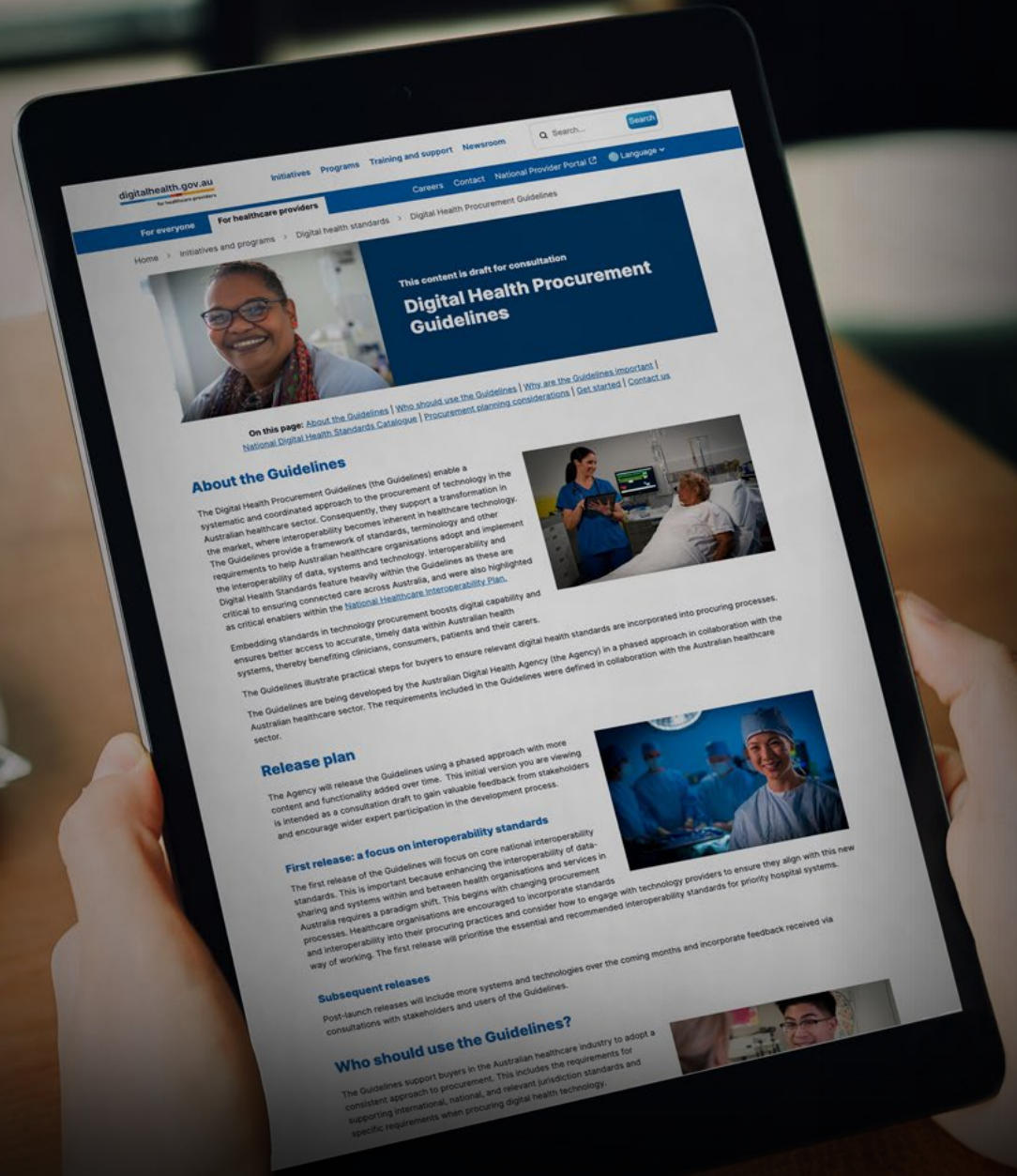
Details you need to unlock digital transformation, curated for Australian adoption in one place.



Australian Government
Australian Digital Health Agency

Procurement Guidelines

A consistent approach to purchasing healthcare technology in Australia



Australian Government
Australian Digital Health Agency

National Clinical Terminology Service

Tools + services supporting our health & care community's use of clinical terminologies

- SNOMED CT including AMT
- LOINC
- RCPA Standardised Pathology Informatics in Australia
- Maps between SNOMED and ICD-10 and more

SNOMED CT EXPO 2026

OCTOBER 21-23 | SYDNEY

Building Reliable Interoperability for Digital Global Empowerment

Join representatives from across the Australian and International health and care ecosystem to help advance the use of terminology and standards that underpin an interoperable, connected care system.

Registrations now open: https://www.snomed.org/snomedct-expo

Use code EARLYAU for discounted registration until 31st August

Australian Government
Australian Digital Health Agency

Modernisation of National Solutions

Standards shaping our FHIR enabled future

Mandating standards

My Health Record Act Interoperability Standards defined by Agency

- SNOMED CT AU (incl. AMT) is already mandated
- AU Core and AU CDI are now mandated for all FHIR connections

The foundations for consistent connection of care

Australian Government
Australian Digital Health Agency

Conformance

Sandra Cook

Australian Government
Australian Digital Health Agency

Reducing the complexity of connecting to Australia's digital health ecosystem

What we're doing

1 Enterprise approach

Recognise larger enterprise solutions while continuing to meet conformance requirements.

2 Reform-aligned standards

Align with Share by Default, Healthcare Identifiers legislative reforms, FHIR transition and sunsetting of legacy profiles.

3 Reusable assessment

Use automation and modular capability blocks to assess conformance requirements once and reused across products.

Outcome: simpler governance, lower clinical safety risk and more consistent digital health implementations.

Enterprise Conformance

Australian Government
Australian Digital Health Agency

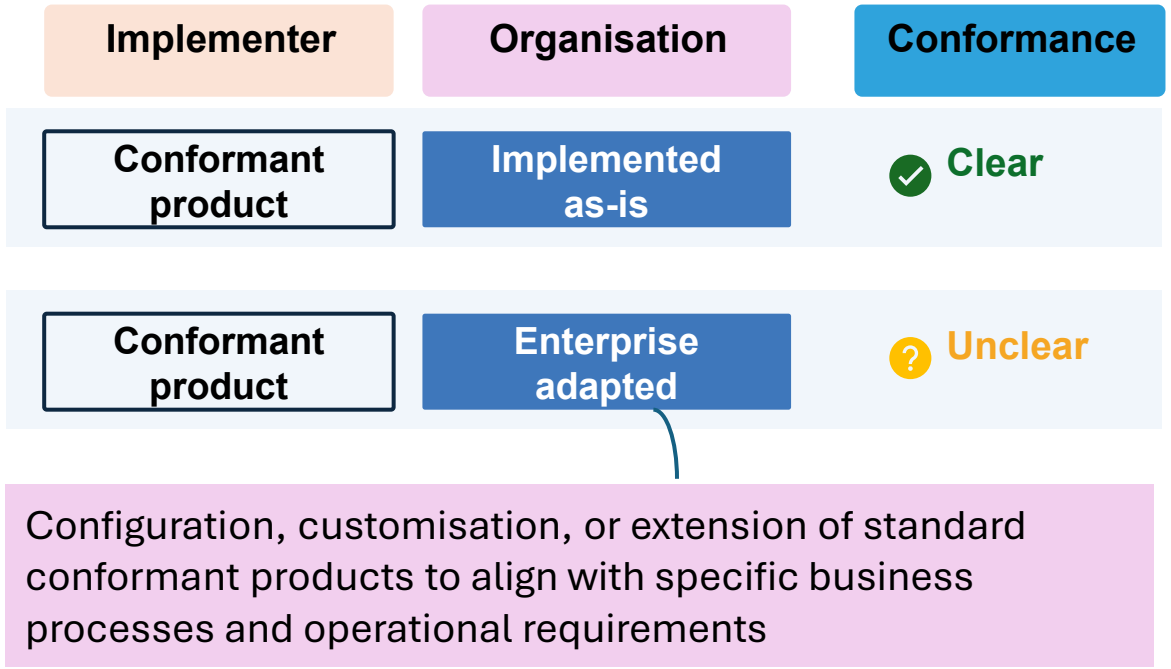
Enterprise Conformance

Challenge

Product-by-product assurance does not flex well for enterprise environments.

- Limited flexibility in conformance requirements can discourage adoption.
- Equivalent or stronger enterprise controls may not be recognised
- Support enterprise organisations with multiple products and business systems

Current state



Consultation Overview

To validate support for the proposed Enterprise Conformance Approach and its core design elements.

JULY 2026
External consultation*

Department of Health, Disability & Ageing, Services Australia, MSIA, jurisdictions, private hospitals, software implementers, pathology and diagnostic imaging organisations.

* **40+ representatives** attended these external consultation sessions in addition to key Agency stakeholders

Stakeholders strong support for the **Alternative Conformance Assessment Pathway**, with suggested considerations for implementation

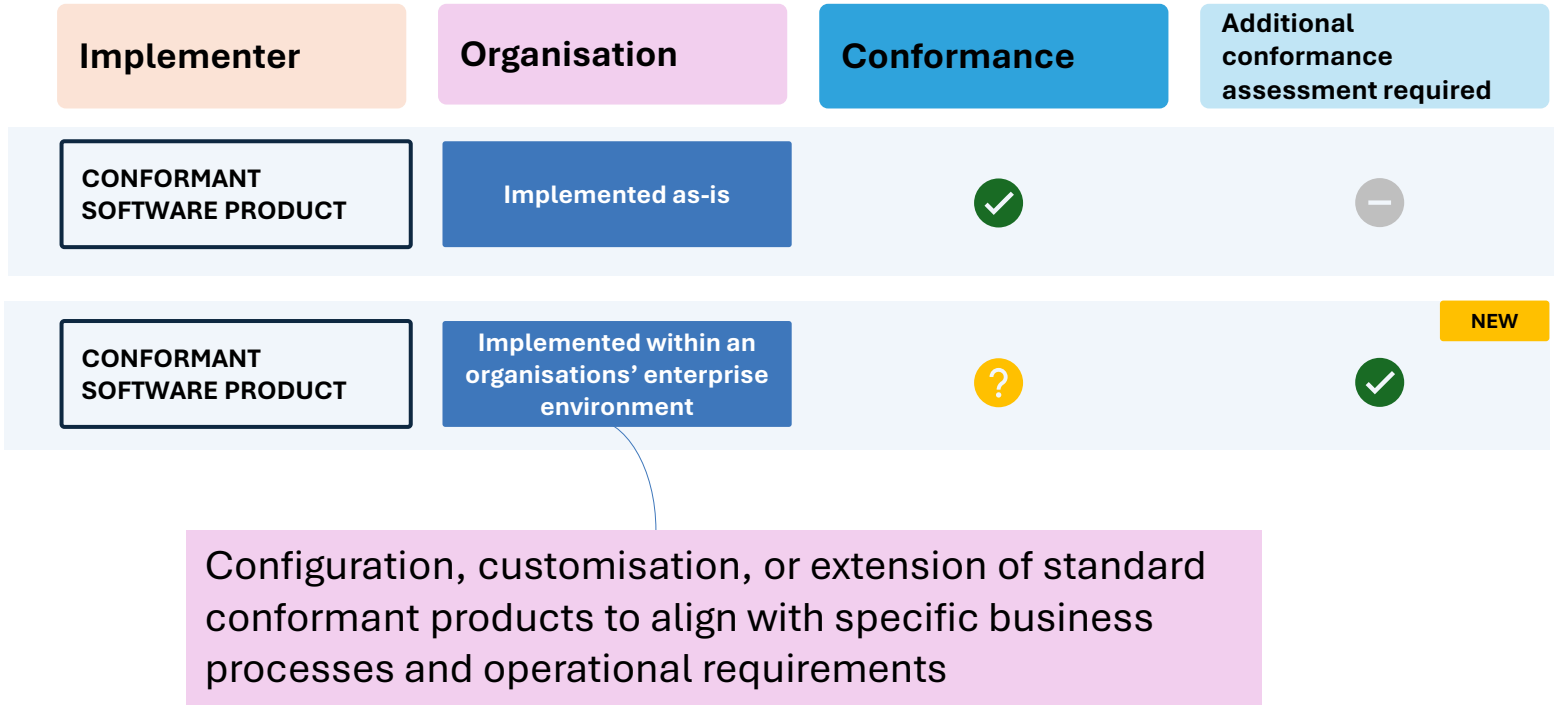
- Risk and assurance outcomes should drive conformance assessment
- Enterprise ecosystems should be recognised
- Existing evidence should be leveraged

Considerations

- Clear evidence criteria
- Defined accountability
- Strong governance
- Legal and policy alignment
- Sustainable conformance assessment capability

Alternative Conformance Assessment Pathway

Future state



Key Principles

Risk-based conformance assessment

Focuses on whether the underlying risk associated with the conformance requirement is effectively managed and assurance outcomes are maintained.

Recognition of enterprise controls

Allows enterprise capabilities and enterprise level controls to be considered where appropriate.

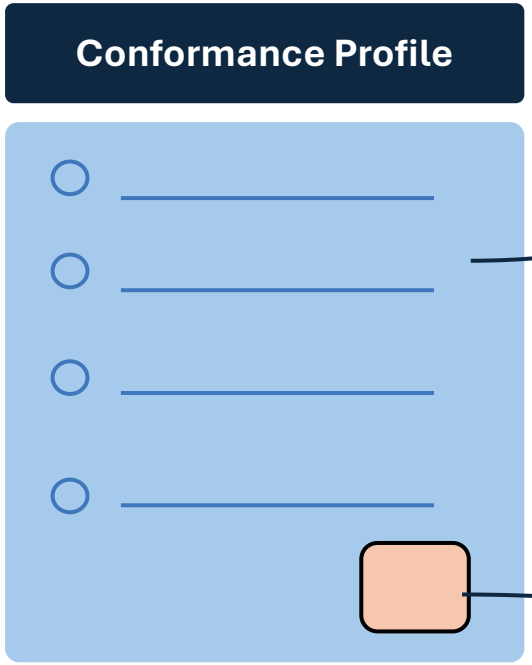
Targeted flexibility

Applies only to a subset of conformance requirements within a Conformance Profile.

Shared assurance model

Implementers and organisations contribute evidence to enable enterprise level controls.

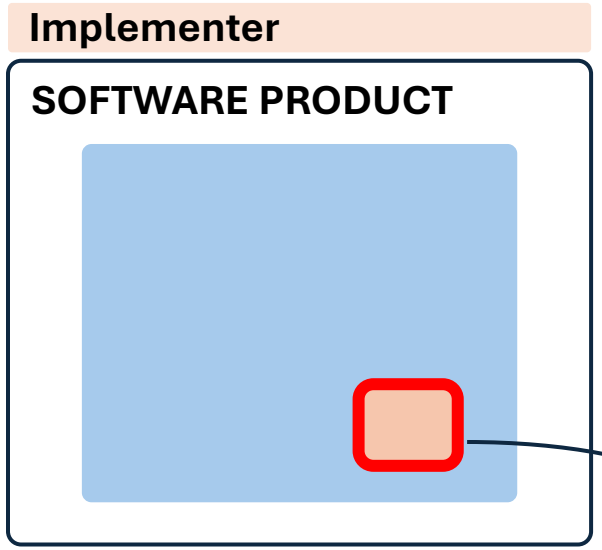
Changes to the Conformance Profile



Conformance requirements and evidence assessment as per standard pathway

Subset of conformance requirements that allow for alternative conformance assessment pathway

What it means for implementers



RED: Implementer-controlled configuration is disabled (Enterprise disabled)

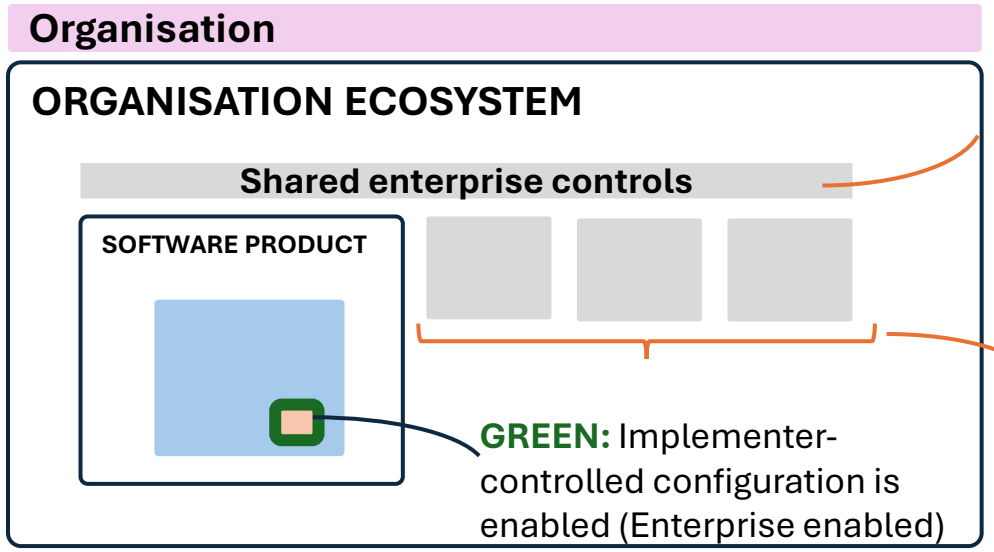
Implementer developing for (1) both non-enterprise and enterprise, or (2) enterprise-only.

Implementer would be required to:

- develop enterprise implementer-controlled configuration that defaults to disabled (Enterprise disabled).
- engage the Agency to undergo conformance assessment.
- provide additional evidence to demonstrate enterprise capabilities and how the underlying risk managed by the subset of conformance requirements are met.

Implementer conformance would be subject to the organisation underdoing additional conformance assessment with the Agency.

What it means for organisations



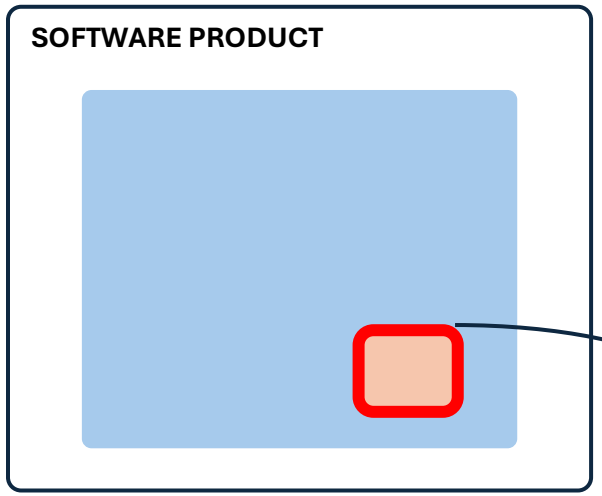
Organisation implementing conformant software product/s in their unique ecosystem.

Organisation would be required to:

- request the implementer to enable the enterprise implementer-controlled configuration (Enterprise enabled).
- engage the Agency to undergo additional conformance assessment for their unique ecosystem (including different software products and business systems that interact with national digital health infrastructure).
- provide additional evidence to demonstrate enterprise capabilities and how the underlying risk managed by the subset of conformance requirements are met.

What it means for implementers and organisations

Implementer



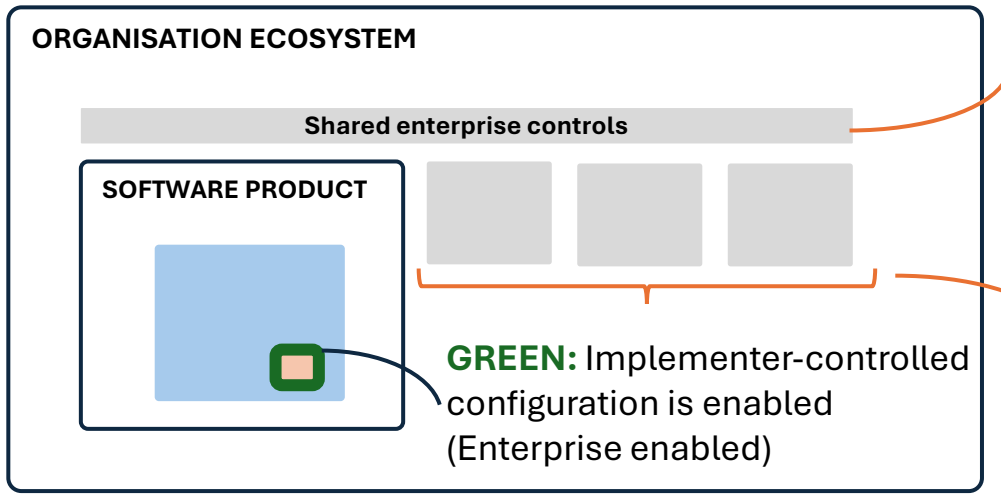
RED: Implementer-controlled configuration is disabled (Enterprise disabled)

Implementer developing for (1) both non-enterprise and enterprise, or (2) enterprise-only.

Implementer would be required to:

- develop enterprise implementer-controlled configuration that defaults to disabled (Enterprise disabled).
- engage the Agency to undergo conformance assessment.
- provide additional evidence to demonstrate enterprise capabilities and how the underlying risk managed by the subset of conformance requirements are met.

Organisation



For example, user authentication, user logging, inactivity timeouts, etc.

GREEN: Implementer-controlled configuration is enabled (Enterprise enabled)

Products and systems interacting with the national digital health infrastructure. For example, Entra, SIEM, EMR, RIS, LIS, Prescribing System, Dispensing System, etc.

Organisation implementing conformant software product/s in their unique ecosystem.

Organisation would be required to:

- requests the implementer to enable the enterprise implementer-controlled configuration (Enterprise enabled).
- Organisation (along with implementer) must engage the Agency to undergo additional conformance assessment for their unique ecosystem (including different software products and business systems that interact with national digital health infrastructure).

Continue the conversation

Join our community forum: Conformance Consultation

Scan the QR or use link to join

https://communities.digitalhealth.gov.au/communities

Sunsetting conformance profiles

Australian Government
Australian Digital Health Agency

Sunsetting

Risk-based sunsetting of legacy conformance profiles

Improves patient safety and interoperability	Greater clarity and consistency	Industry certainty and transparency	Faster and more efficient assessments	Supports modernisation efforts
Retiring outdated standards and ensuring digital health systems to meet evolving clinical safety, security, policy, interoperability, and privacy standards.	Clear and consistent set of requirements that can be understood, planned for, and addressed proactively.	Clear lifecycle management, enabling vendors and healthcare organisations to plan upgrades and transition activities effectively.	Consistent requirements streamline preparation and review activities, helping reduce assessment timelines and administrative overhead.	Enabling a structured transition from CDA-based implementations to contemporary FHIR-based standards.

Key Concepts

1 Evidence-led decision and data requirements

Effective sunsetting decisions must be underpinned by an evidence-led approach, supported by timely access to the right level of data.

- Critical to maintaining clinical safety and continuity if care.
- Ensures sunsetting decisions are proportionate and informed.
- Critical to support accurate risk identification, impact assessment and transition planning.

2 Risk-based transition timeframe

A risk-based transition timeframe is the period defined for transitioning from an existing conformance profile to a new or revised state, determined based on the level of risk associated with continued use of the profile, the impact of transition, and ecosystem readiness.

Transition timeframe may vary between conformance profiles depending on risk criticality, legacy adoption levels, implementer and user readiness, and broader ecosystem dependencies.

3 Target-date model

Adopt target-date model – a four-stage timeline for conformance profile sunsetting and uplift activities.

- Target 1: Cessation of conformance assessments for the to-be sunset conformance profile.
- Target 2: Implementers completion of their conformance uplift.
- Target 3: Full client base transition to the uplifted software product versions.
- Target 4: Sunset execution.

4 Continuous monitoring & industry engagement

Targeted communication and transition planning are undertaken with internal and external stakeholders, including the management of any disconnections arising from non-conformance.

Conformance status and transition progress are closely monitored through checkpoints at six, three, and one month before the sunset date, with ongoing assessment of any changes to the risk posture and implementer readiness.

Legislation

- Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016,
- My Health Records Act 2012 and My Health Record Rules and Regulations 2026
- National Health (Pharmaceutical Benefits) Regulations 2017 (Cth) and the Electronic Prescriptions Information Technology Requirements Instrument 2019
- Healthcare Identifiers Act 2010

Current sunsetting progress

Completed

- **HI Service** - CP v1-v1.3 sunset
- **My Health Record** - Adv Care Planning v1.0, AIR v1.0, Clinical Documents (v1.0-v1.3), Consumer Entered Information (v1.01-v1.3), eHealth Path Report (v2.0), MHR Connecting Systems (v1.6), Shared Health Summary (v1.4) all sunset

In progress

- **Electronic Prescribing -** Software transition off CP v2.3
- **Development of the CDA to FHIR transition plan**

Upcoming timelines

30 Sep 2026
Electronic Prescribing CP v2.3 sunset

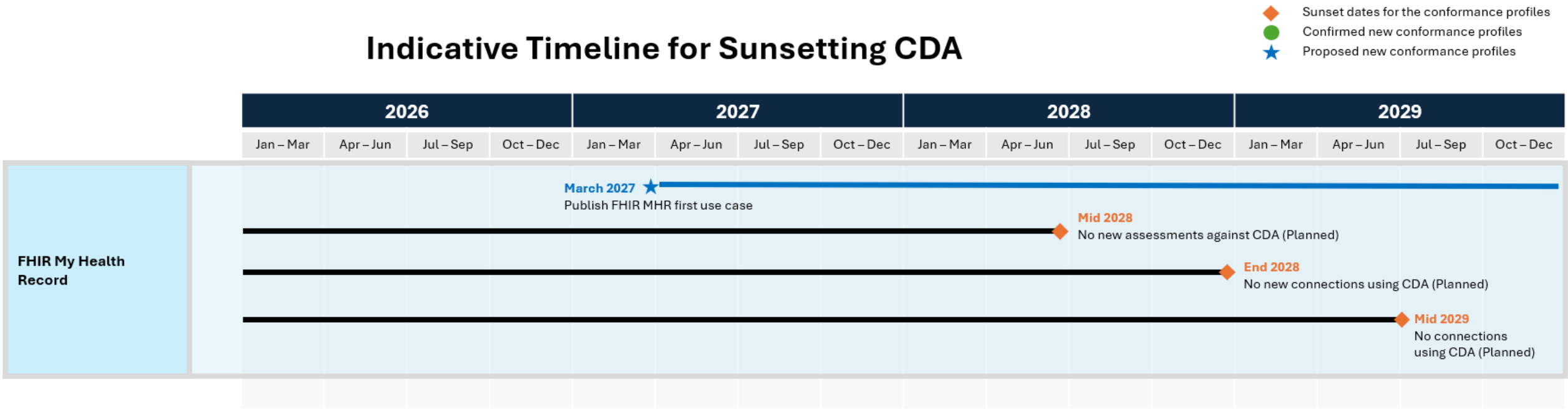
31 Mar 2027
Electronic Prescribing Client migration off v2.3 CP complete

30 June 2027
HI Service CP v1.4-v4.0 sunset

1 Dec 2027
HI Service CP v4.1-v5.0 sunset

Indicative Timelines for Sunsetting CDA

Will be subject of consultation as part of the FHIR Conformance Profiles Consultation



Note:

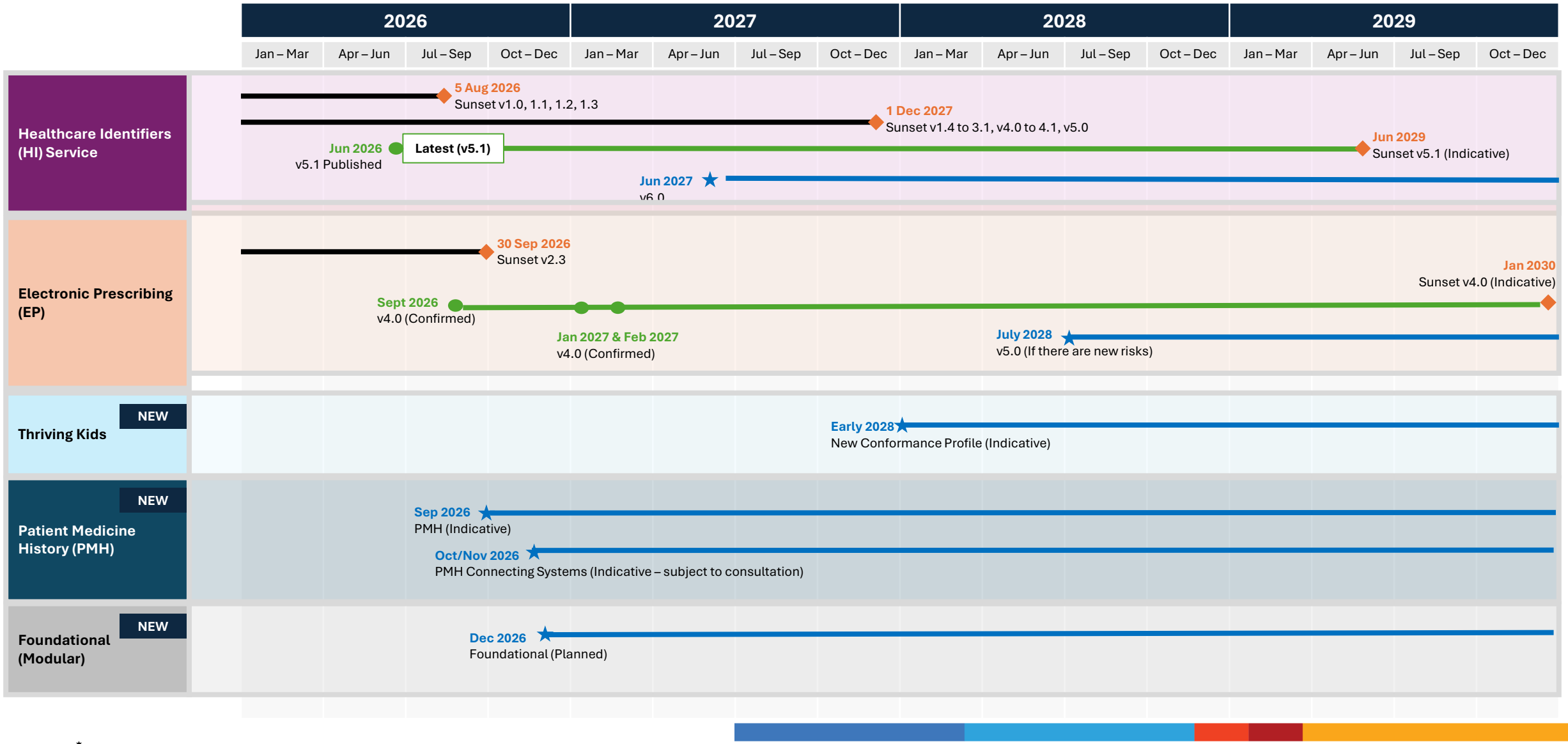
- Specific streams (e.g. Pathology) may be subject to earlier timelines
- New capability and requirements (e.g. Child Health Record) will only be made available in FHIR, not CDA

Conformance Profile Roadmap

Australian Government
Australian Digital Health Agency

Conformance Profiles

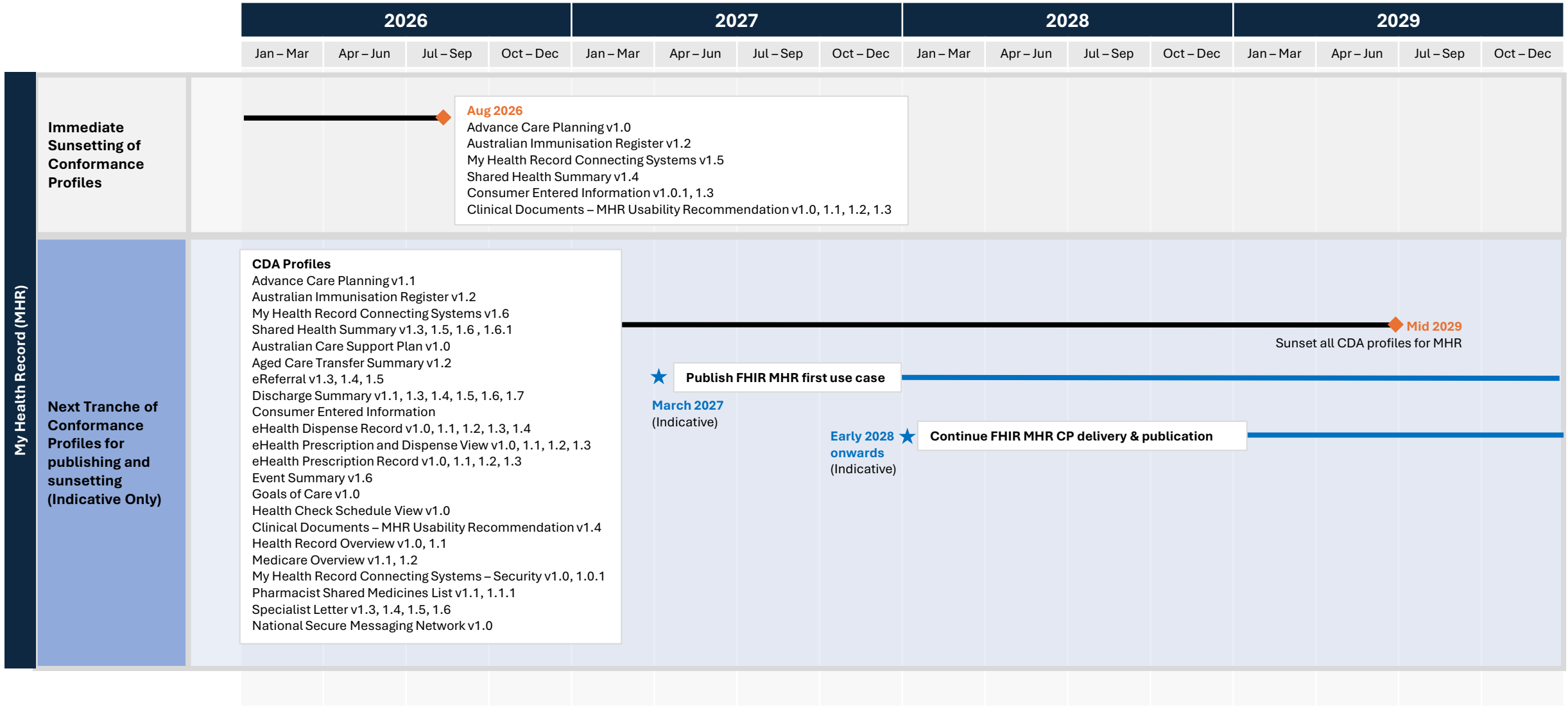
Publishing and Sunsetting Roadmap as of August 2026



Conformance Profiles

Publishing and Sunsetting Roadmap as of August 2026

- Sunset dates for the conformance profiles
- Confirmed new conformance profiles
- Proposed new conformance profiles

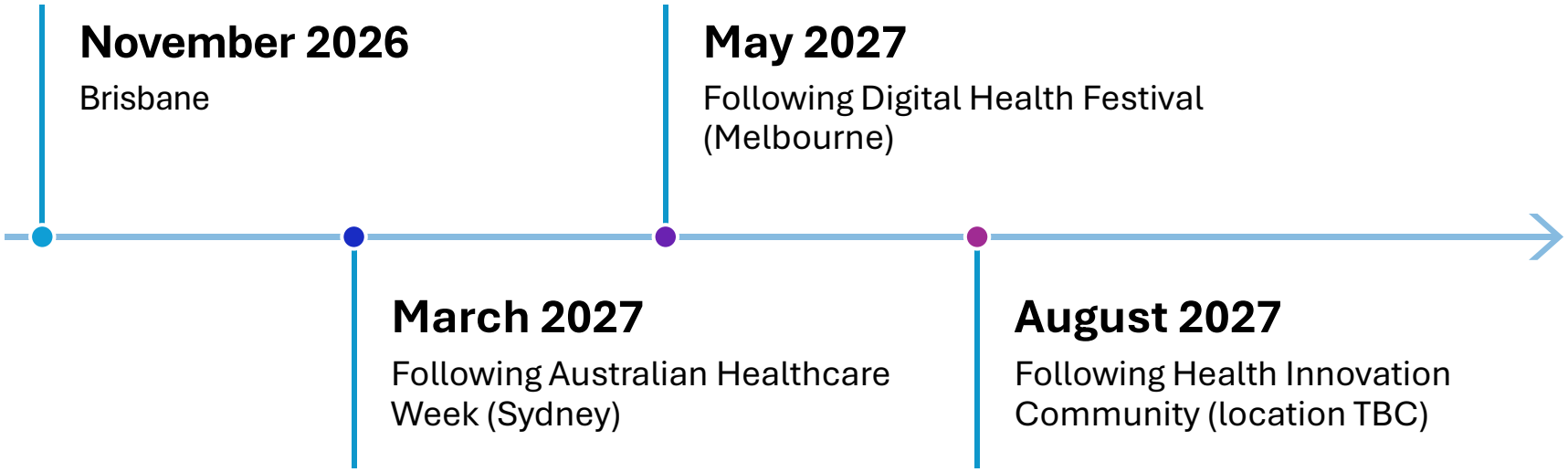


Australian Government
Australian Digital Health Agency

Quarterly Conformance and Assurance Advisory Forum

A collaborative forum between the Agency, industry, jurisdictions, providers, and organisations that meets quarterly to identify emerging conformance risks, inform requirements, and provide strategic advice on conformance and assurance outcomes.

Key dates



Conformance Assessment Automation

Australian Government
Australian Digital Health Agency

Current Challenges

As conformance testing scales, there is a growing need for greater consistency, better connected tools, and improved end-to-end visibility.

Clarity and interpretation

Requirements can be interpreted inconsistently, creating uncertainty during development and assessment.

Process and efficiency

Limited early self-testing means issues are often found late; observed sessions remain time-consuming.

Scale and complexity

Varying industry testing maturity and multiple concurrent programs increase workload pressure.

Fragmented lifecycle

No centralised platform to manage test development, execution, evidence, reporting & certification outcomes.

Inconsistent vendor pathways

Different vendor tools and processes create variability in execution, reporting and traceability.

Visibility and traceability gaps

Evidence, results, progress and compliance status are not held in a single source of truth.

Conformance Assessment Automation

A reusable, testable model for continuous validation

01 BEHAVIOUR-DRIVEN REQUIREMENTS

Write clear, testable Gherkin scenarios understood by business and technical teams.

02 EARLIER SELF-ASSESSMENT

Validate throughout development—manually or automatically—to improve readiness before formal assessment.

03 REUSABLE AUTOMATION

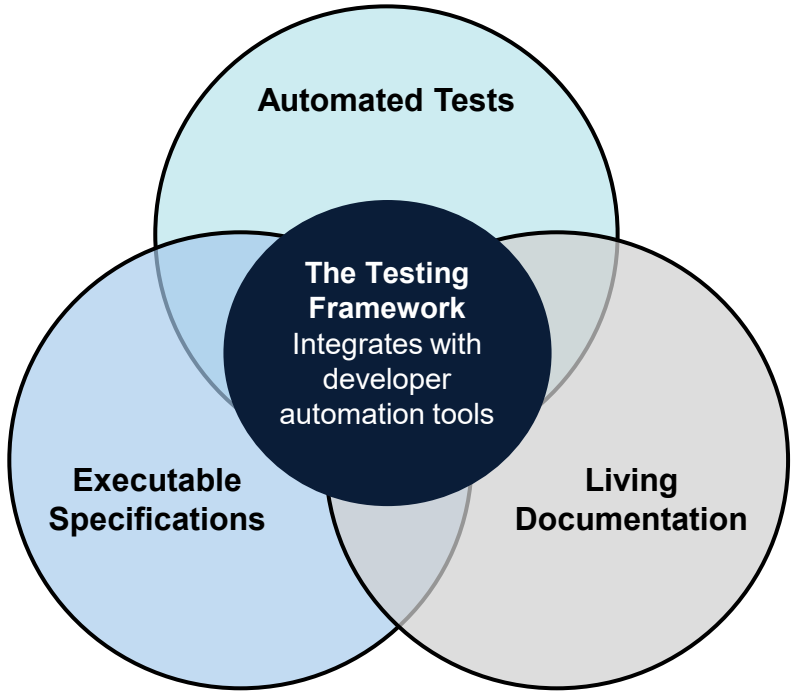
Share scenarios and test assets to improve consistency, reduce effort and scale across digital health programs.

Gherkin and Testing Framework

From readable behaviour to automated execution

Gherkin

- Business-readable plain-text language
- Uses Given/When/Then syntax and describes expected system behaviour clearly

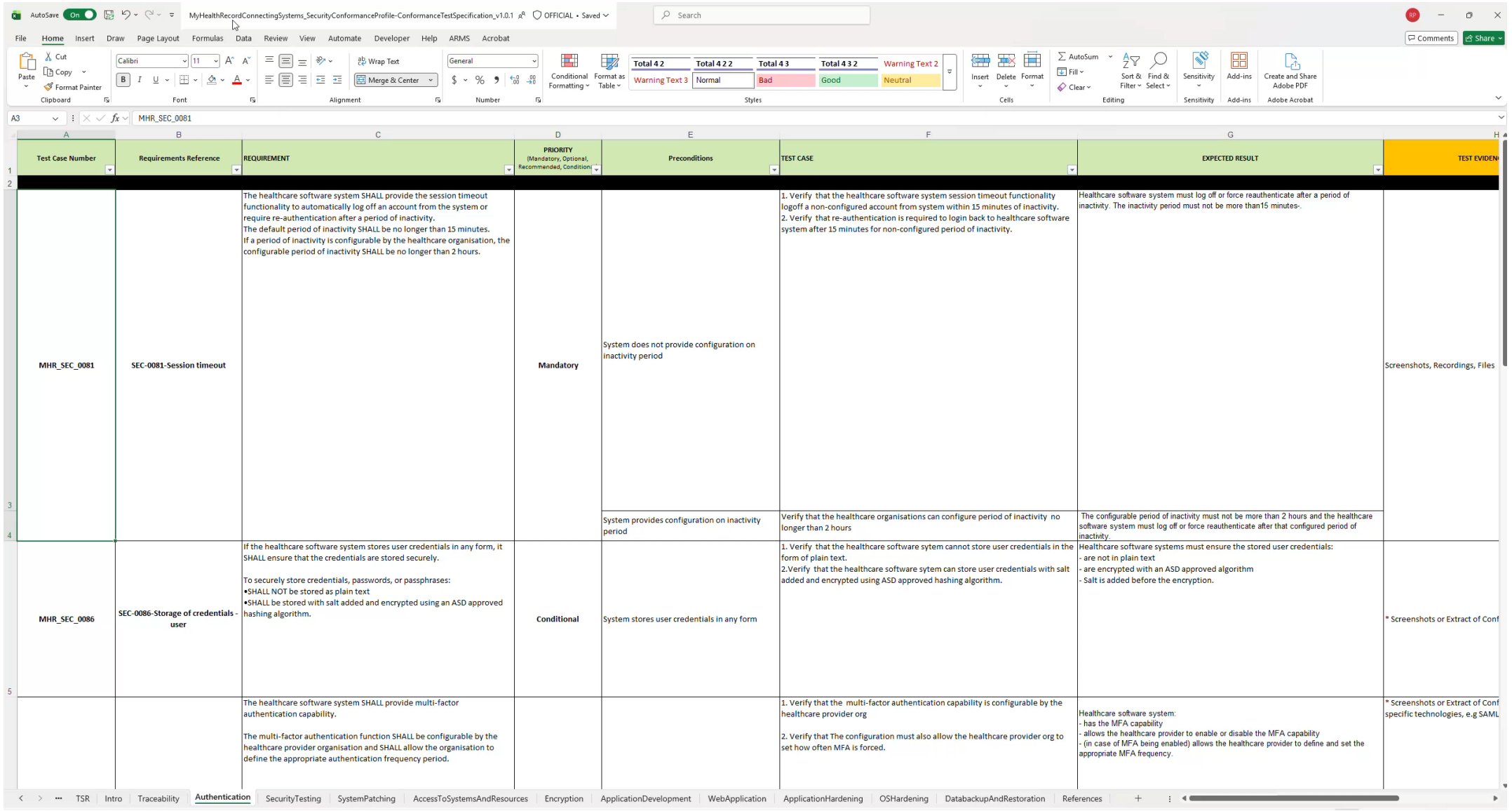


Testing Framework

- Executes Gherkin scenarios
- Connects feature files to test code
- Enables automated acceptance testing

Note: Gherkin scenarios can also be executed using frameworks such as Cucumber,SpecFlow, Behave, Jehave, Karate, providing flexibility across different technology platforms.

Current State CTS – Excel based



Test Case Number	Requirements Reference	REQUIREMENT	PRIORITY (Mandatory, Optional, Recommended, Condition	Preconditions	TEST CASE	EXPECTED RESULT	TEST EVIDEN
MHR_SEC_0081	SEC-0081-Session timeout	The healthcare software system SHALL provide the session timeout functionality to automatically log off an account from the system or require re-authentication after a period of inactivity. The default period of inactivity SHALL be no longer than 15 minutes. If a period of inactivity is configurable by the healthcare organisation, the configurable period of inactivity SHALL be no longer than 2 hours.	Mandatory	System does not provide configuration on inactivity period	1. Verify that the healthcare software system session timeout functionality logoff a non-configured account from system within 15 minutes of inactivity. 2. Verify that re-authentication is required to login back to healthcare software system after 15 minutes for non-configured period of inactivity.	Healthcare software system must log off or force reauthenticate after a period of inactivity. The inactivity period must not be more than15 minutes-.	Screenshots, Recordings, Files
				System provides configuration on inactivity period	Verify that the healthcare organisations can configure period of inactivity no longer than 2 hours	The configurable period of inactivity must not be more than 2 hours and the healthcare software system must log off or force reauthenticate after that configured period of inactivity.	
MHR_SEC_0086	SEC-0086-Storage of credentials - user	If the healthcare software system stores user credentials in any form, it SHALL ensure that the credentials are stored securely. To securely store credentials, passwords, or passphrases: •SHALL NOT be stored as plain text •SHALL be stored with salt added and encrypted using an ASD approved hashing algorithm.	Conditional	System stores user credentials in any form	1. Verify that the healthcare software sytem cannot store user credentials in the form of plain text. 2.Verify that the healthcare software sytem can store user credentials with salt added and encrypted using ASD approved hashing algorithm.	Healthcare software systems must ensure the stored user credentials: - are not in plain text - are encrypted with an ASD approved algorithm - Salt is added before the encryption.	* Screenshots or Extract of Conf
		The healthcare software system SHALL provide multi-factor authentication capability. The multi-factor authentication function SHALL be configurable by the healthcare provider organisation and SHALL allow the organisation to define the appropriate authentication frequency period.			1. Verify that the multi-factor authentication capability is configurable by the healthcare provider org 2. Verify that The configuration must also allow the healthcare provider org to set how often MFA is forced.	Healthcare software system: - has the MFA capability - allows the healthcare provider to enable or disable the MFA capability - (in case of MFA being enabled) allows the healthcare provider to define and set the appropriate MFA frequency.	* Screenshots or Extract of Conf specific technologies, e.g SAML

Future State CTS – Gherkin based

File Edit View H1

```
# Feature file for Security test case (Authentication)

# ConformanceProfileName: My Health Record Connecting Systems - Security Conformance Profile
# ConformanceProfileVersion: 1.0.1
# ProfileDate: 26/02/2026


# FeatureID: MHR_SEC_0086
# FeatureName: Secure Storage of User Credentials

# Priority: Conditional
# ConformanceRequirements: SEC-0086 Storage of credentials - user
# ConformanceRequirementReference: MHR Security Requirements

# TestCaseID: TC-SEC-0086

# Preconditions: System stores user credentials

# TestData: Username, password, stored credential values

# ExpectedResult: Credentials must not be plain text and must be salted and hashed using ASD approved algorithm

Feature: Secure storage of user credentials in healthcare system

  Background:

    Given the healthcare application is deployed in the test environment
    # Evidence: Application URL and deployment confirmation screenshot

    And the system stores user credentials in a persistent storage
    # Evidence: Database schema or storage configuration showing credential fields

    And a test user account is created in the system
    # Evidence: User creation logs or UI screenshot

    And audit logging is enabled
    # Evidence: Logging dashboard or configuration file


  Scenario: Verify credentials are not stored in plain text
    Given the tester has access to stored user credential data
    # Evidence: Database access screenshot or query tool access proof

    When the tester retrieves the stored credentials for a user
    # Evidence: SQL query result or API response showing stored credential value

    Then the stored credential should not be readable in plain text
    # Evidence: Retrieved value appears hashed/encrypted (unreadable string)

    And the stored value must differ from the original password entered
    # Evidence: Comparison showing original password ≠ stored value

    And an audit or access log should record the credential access activity
    # Evidence: Audit logs showing database access or credential inspection event


  Scenario: Verify credentials are salted and hashed using ASD approved algorithm
    Given the tester retrieves stored credential details including hash metadata
    # Evidence: Database fields showing hash, salt, and algorithm used

    When the tester inspects the stored credential mechanism
    # Evidence: Configuration files, code snippet, or system documentation

    Then the credential must be stored using a hashing algorithm approved by ASD
    # Evidence: Proof of algorithm (e.g., bcrypt, PBKDF2, or equivalent) in config/code

    And a unique salt must be added to the credential before hashing
```

Plain language format for easier business and technical review

Retain full traceability to requirements and test cases

Use Backgrounds and Scenarios to structure requirements

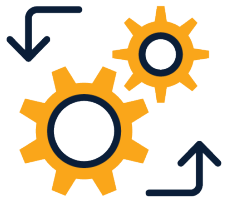
Given–When–Then syntax for consistent, easy-to-read tests

Supports quality reviews, vendor testing and future automation

How Gherkin feature files are used

One set of feature file supports both automated and manual testing

Automated testing



Industry-standard tools (e.g. Cucumber, Selenium, Console apps, CI/CD integration and others) execute behaviours consistently across web, mobile, desktop and backend systems

Manual testing

Gherkin feature files reduce manual translation from excel based CTS, enabling consistent and clear interpretation and faster creation of test scripts

Using Gherkin feature files appropriately

What Feature Files **ARE**

- Tools specifically for conformance assessment only
- A method to test explicit Australian digital health infrastructure behaviours
- A structured format for clear communication

What Feature Files **ARE NOT**

- Comprehensive business requirements
- Legal or Privacy requirements
- Professional practice and business process management requirements

Conformance Future State

A single testing support tool that transforms CTS into reusable Gherkin features, orchestrates manual and automated execution, captures evidence at each step and generates assessment-ready Test Summary Reports

1

CTS

CTS becomes a structured input: requirements, acceptance criteria and test cases are grouped so every scenario has a clear source and scope.

2

Feature files

Conformance requirements are translated into clear, reusable and executable test scenarios using BDD. These are reviewed and updated as standards or releases change.

3

Execution

Scenarios guide manual testers or trigger automated runs, recording pass/fail results and exceptions.

4

Evidence

Screenshots, logs and artefacts are attached, keeping evidence traceable from requirement through assessment outcome.

5

Reporting

Results are consolidated into TSRs that highlight status, gaps and evidence, giving teams a certification-ready view.

Single source of truth

CTS, feature files, evidence and reporting remain linked as one auditable thread.

Repeatable assessments

The same scenarios can be rerun across vendors, releases and regression cycles.

Better vendor experience

Vendors see clear expectations, evidence needs and certification-ready outputs.

Modular Conformance

Australian Government
Australian Digital Health Agency

Current Challenges

The current product-based conformance model has evolved over time, resulting in duplication, inconsistency, and increasing complexity.

Duplication

Conformance requirements, and supporting artefacts are developed separately across products, creating duplication and maintenance effort.

Inconsistency

Similar risks are addressed differently across products, leading to inconsistent controls, implementation and interpretation.

Limited Reuse

Vendors repeatedly demonstrate the same controls across products, increasing cost, effort, and assessment time.

Fragmented Traceability

Inconsistent links between risks, controls, tests, and evidence reduce transparency, assessment consistency.

Maintenance Overhead

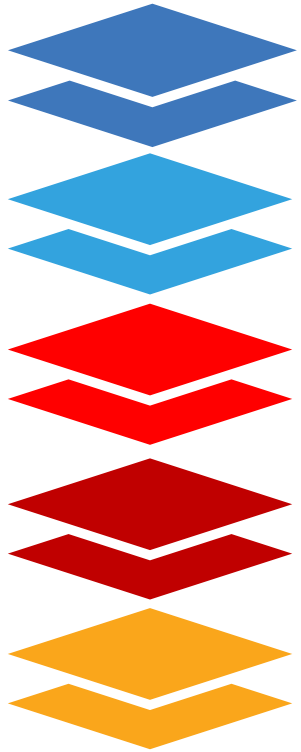
Changes require updates across multiple artefacts, products, slowing responses to new risks, policy changes, and modernisation initiatives

Scalability Constraints

Growing programs and conformance reforms are increasing pressure on a model that is difficult to scale and manage efficiently

Direction

Transition to a structured reuseable set of conformance building blocks



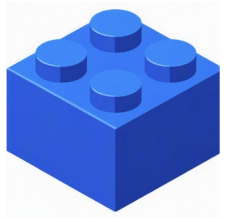
Modular Conformance introduces structured and reusable capability building blocks that define common conformance requirements once and enable their consistent application across multiple digital health products.

- Reduces duplicated requirements, assessments, and testing effort.
- Enables reuse of conformance evidence across products.
- Accelerates conformance, onboarding, and connection pathways.
- Improves consistency in the application of controls and risk mitigation.
- Supports a scalable approach to future digital health initiatives.

A scalable and sustainable modular conformance model delivering reusable conformance requirements, streamlining governance and reduced duplication across all digital health products

Building Blocks of Conformance

Define Once → Assess Once → Reuse Many Times

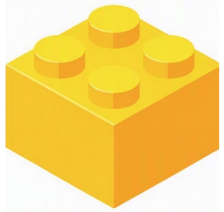


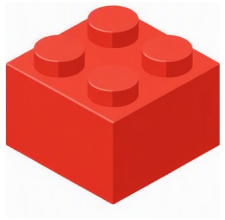
Foundational Profile

core cross-product requirements and shared controls

Shared Capability Building Blocks

• Security • HI





Product Specific Requirements

applied as needed by each product

- My Health Record
- Electronic Prescribing
- Healthcare Identifiers Service
- Health Connect Australia

The Foundational Profile establishes the core building blocks for future conformance requirements

Next steps

From concept to implementation

Foundation
Scope, governance and requirement gathering

→

Discovery
Current state, product, impact analysis, and feasibility study

→

Architecture
Define foundational, product modules, implementation approach

→

Rationalise
Map requirements, enable reuse and Traceability

→

Future State Artefacts
CP, CTS, CAS, declaration and others

→

Validate and Prepare
Consultation, approvals and rollout

Our Goal

Deliver a scalable Modular Conformance model with reusable building blocks that can be consistently applied across digital health products

Putting the pieces together

Peter O’Halloran

Australian Government
Australian Digital Health Agency

The opportunity for driving connected care

- The third edition of NSQHS Standards:
  - reinforce national efforts for connected systems to **enhance quality and safety.**
  - set clear, nationally consistent **interoperability requirements** for health services.
  - establish clear signals to software vendors, align health service investment with **national digital health infrastructure**, and complement the National Healthcare Interoperability Plan 2023-2028.
  - are a **strong national lever** for driving connected care and reducing fragmentation across health sectors.

Better Access

Sharing information to My Health Record by default

- ✓ **A powerful legislative lever**
  to substantially improve the completeness and utility of My Health Record
- ✓ **Initially applies to pathology and diagnostic imaging reports**
  legislation and rules outline which health information needs to be shared to My Health Record by default, and by whom.
- ✓ **Impacted providers must share to My Health Record by default**
  unless an **exception** applies or an **extension** of time to comply has been granted.

Future opportunities

Share by Default may expand to more types of health information over time.

Budget-funded focus areas:

- **Medicines information** — online prescribing first
- **Chronic Condition Management Plans**
- **GP letters** — to specialists and allied health providers

Subject to consultation and Government decisions.

Modernisation of National Solutions

Standards shaping our FHIR enabled future

Mandating standards

My Health Record Act Interoperability Standards defined by Agency

- SNOMED CT AU (incl. AMT) is already mandated
- AU Core and AU CDI will be mandated for all FHIR connections

The foundations for consistent connection of care

Australian Government
Australian Digital Health Agency

Current sunsetting progress

Completed

- **HI Service** - CP v1-v1.3 sunset
- **My Health Record** - Adv Care Planning v1.0, AIR v1.0, Clinical Documents (v1.0-v1.3), Consumer Entered Information (v1.01-v1.3), eHealth Path Report (v2.0), MHR Connecting Systems (v1.6), Shared Health Summary (v1.4) all sunset

In progress

- **Electronic Prescribing -** Software transition off CP v2.3
- **Development of the CDA to FHIR transition plan**

Upcoming timelines

30 Sep 2026
Electronic Prescribing CP v2.3 sunset

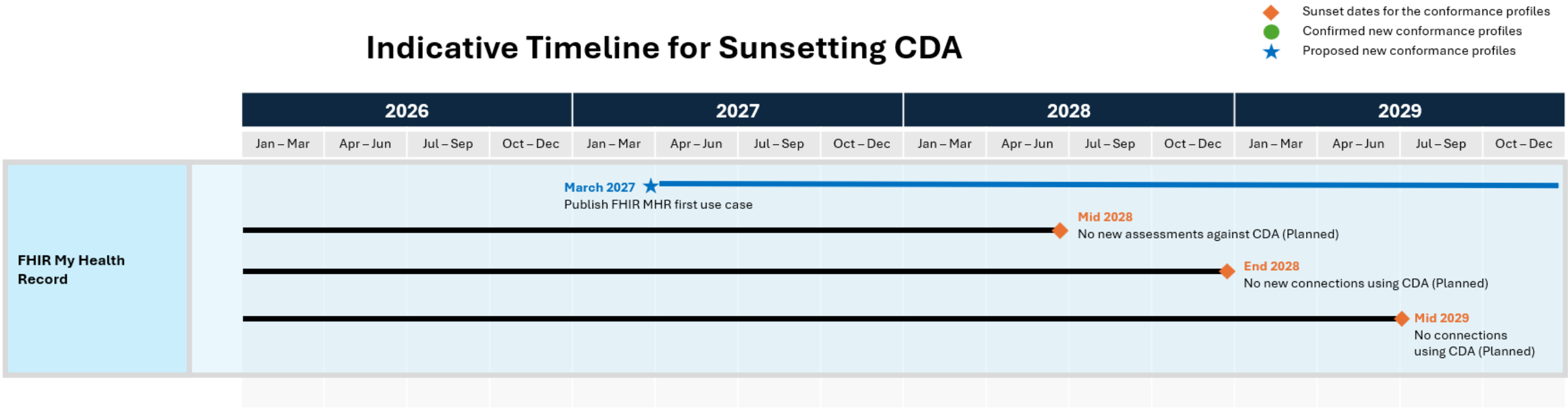
31 Mar 2027
Electronic Prescribing Client migration off v2.3 CP complete

30 June 2027
HI Service CP v1.4-v4.0 sunset

1 Dec 2027
HI Service CP v4.1-v5.0 sunset

Indicative Timelines for Sunsetting CDA

Will be subject of consultation as part of the FHIR Conformance Profiles Consultation



Note:

- Specific streams (e.g. Pathology) may be subject to earlier timelines
- New capability and requirements (e.g. Child Health Record) will only be made available in FHIR, not CDA

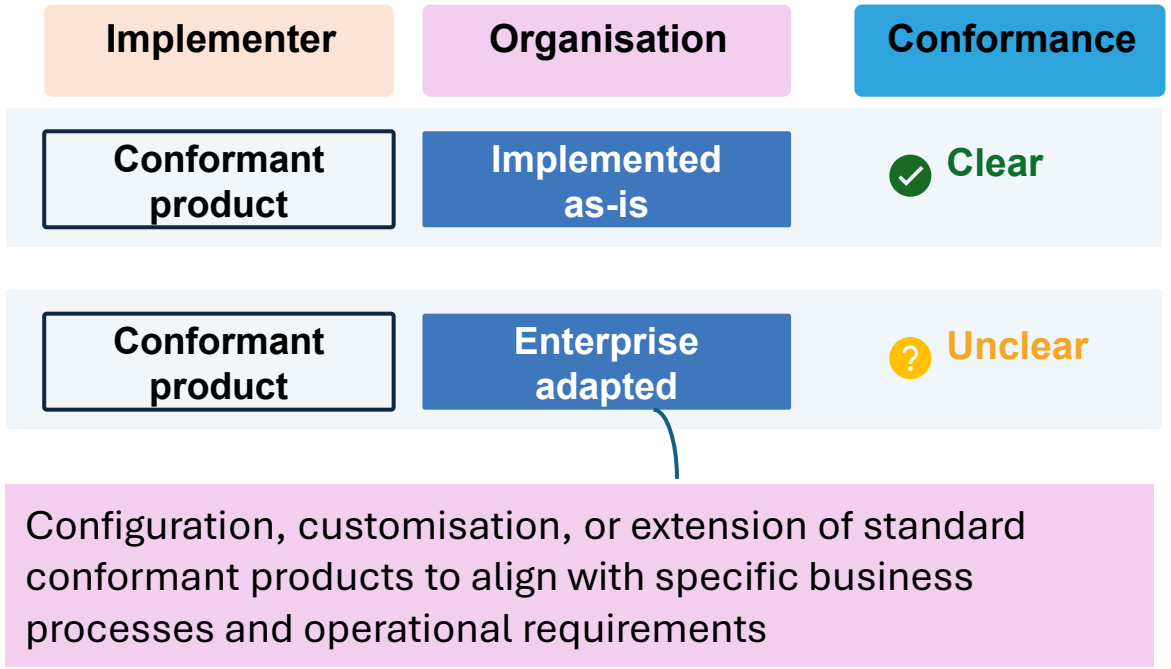
Enterprise Conformance

Challenge

Product-by-product assurance does not flex well for enterprise environments.

- Limited flexibility in conformance requirements can discourage adoption.
- Equivalent or stronger enterprise controls may not be recognised
- Support enterprise organisations with multiple products and business systems

Current state



Conformance Assessment Automation

A reusable, testable model for continuous validation

01 BEHAVIOUR-DRIVEN REQUIREMENTS

Write clear, testable Gherkin scenarios understood by business and technical teams.

02 EARLIER SELF-ASSESSMENT

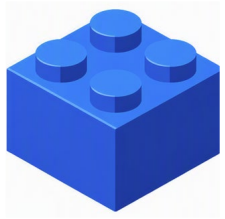
Validate throughout development—manually or automatically—to improve readiness before formal assessment.

03 REUSABLE AUTOMATION

Share scenarios and test assets to improve consistency, reduce effort and scale across digital health programs.

Building Blocks of Conformance

Define Once → Assess Once → Reuse Many Times

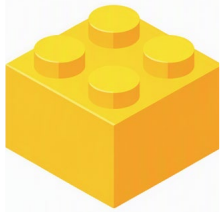


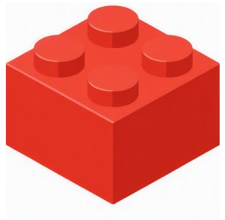
Foundational Profile

core cross-product requirements and shared controls

Shared Capability Building Blocks

• Security • HI





Product Specific Requirements

applied as needed by each product

- My Health Record
- Electronic Prescribing
- Healthcare Identifiers Service
- Health Connect Australia

The Foundational Profile establishes the core building blocks for future conformance requirements

Customer Experience and Product update

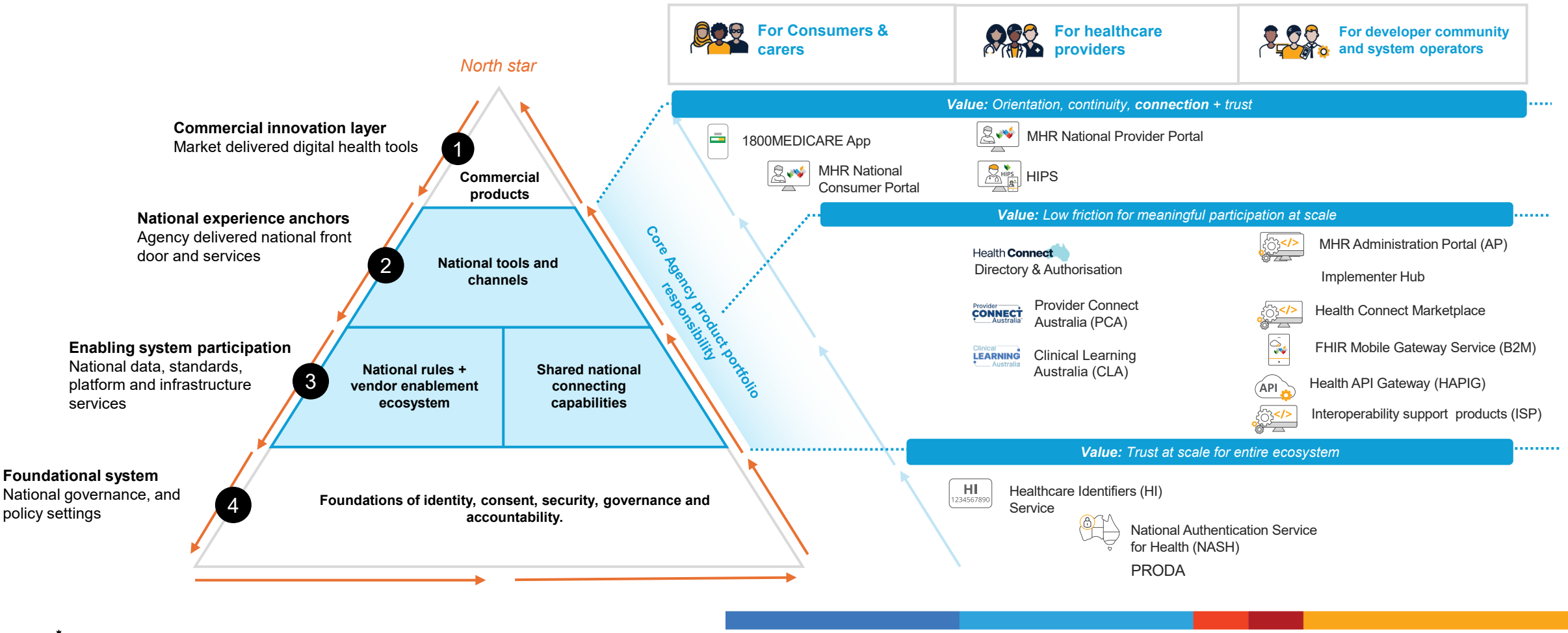
Ines Sostaric

Darian Eckersley

Australian Government
Australian Digital Health Agency

Product Value Pyramid

Orchestrating how products deliver value in each layer, aims to meet needs of the system holistically, supports addressing customer experiences and ensures our products work together for connected outcomes.

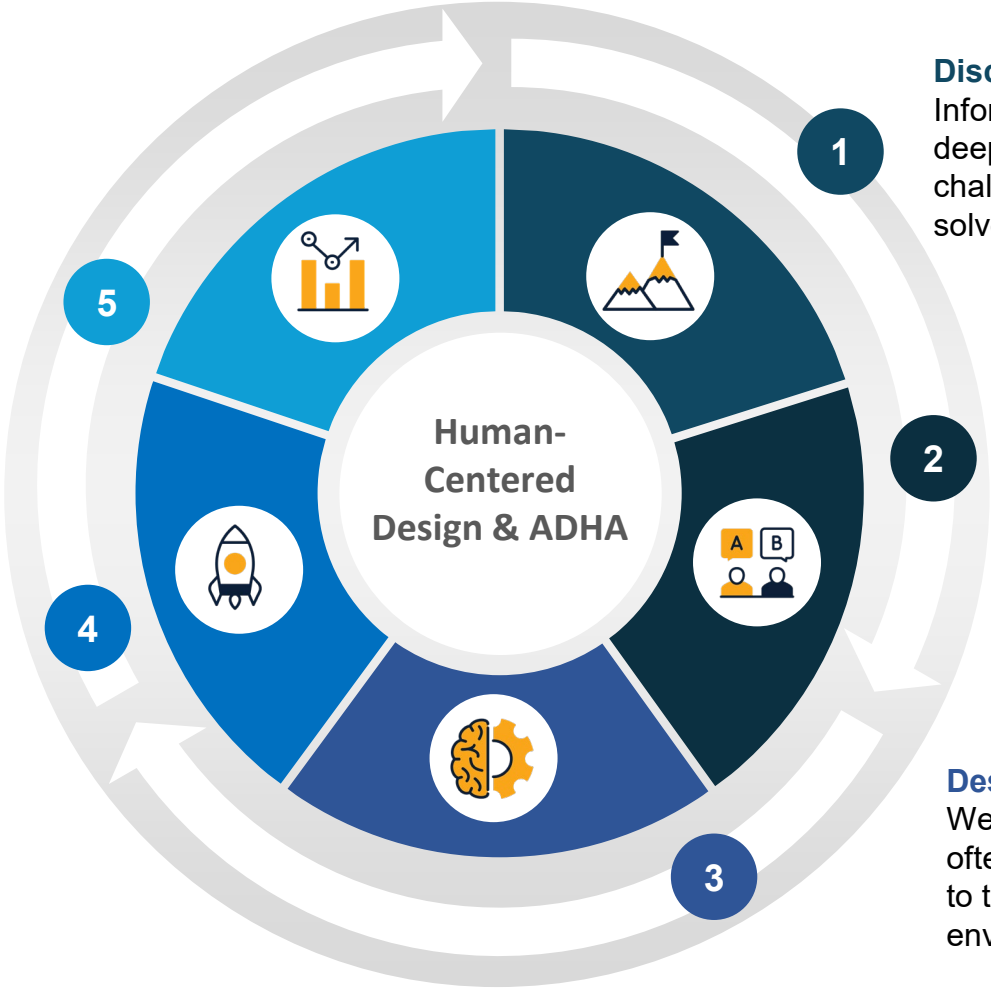


Experience Design Framework

Customers are at the center of product design and delivery at the Agency

Evaluate and Measure
Through ongoing feedback, user testing, data insights, and research, we learn, refine, and continuously improve outcomes over time.

Assurance and Release
We continuously test and assure solutions with real users throughout development and release, ensuring they are usable, effective, and fit for purpose.



Discovery and Definition
Informed by research and user needs, we build a deep understanding of people, their experiences, challenges, and the problems that matter most to solve.

Explore and Validate
We collaboratively explore, design, and validate potential solutions with users, stakeholders, and technical experts to ensure feasibility, desirability, and alignment.

Design and Refine
We design, build, and iterate solutions early and often, partnering with users throughout the process to test ideas and validate them in real-world environments.

Experience Design & Connected Care

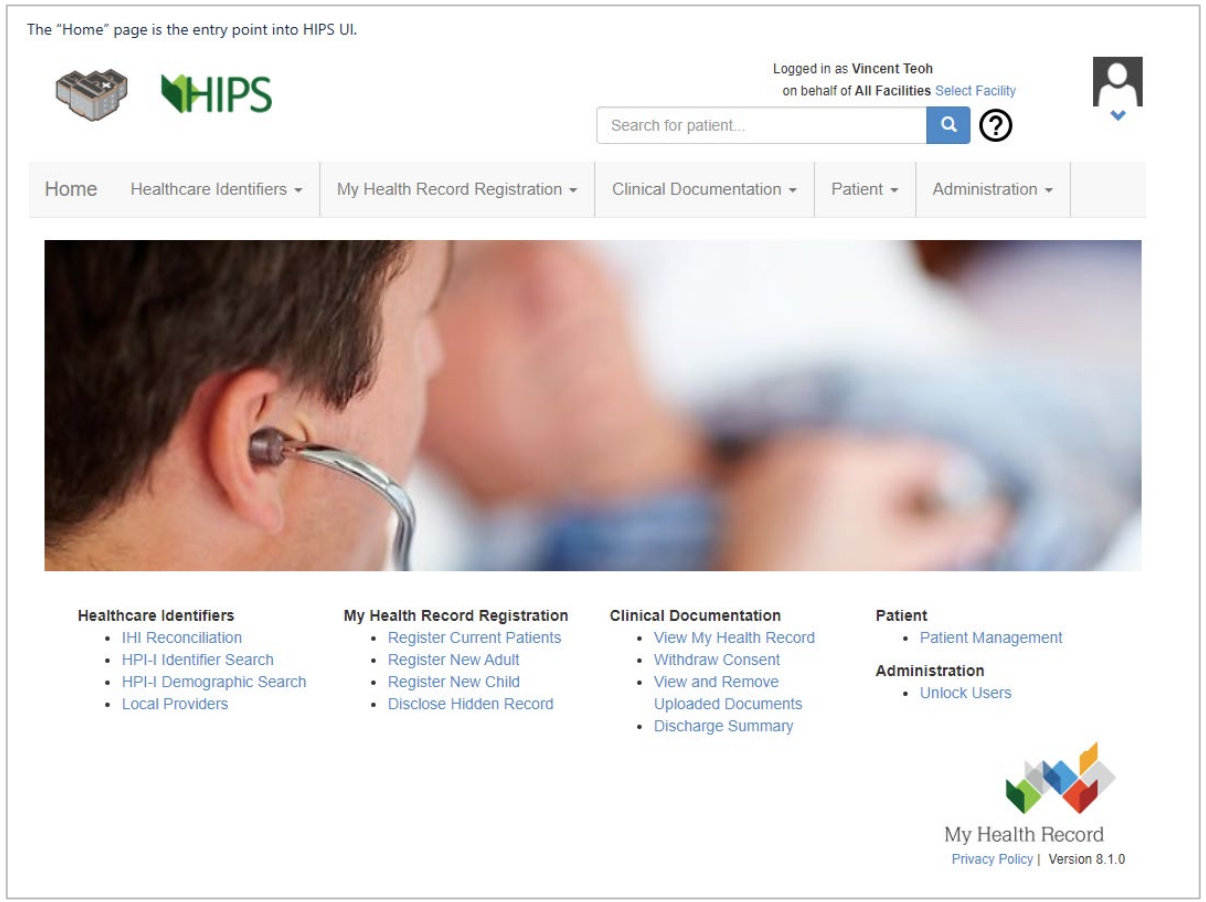
Evolving connected care enablers alter the landscape in which digital health services and products are designed.

Human-centred design (HCD) practices ensure the promise of technology enablers are met by solving the right problems.

In this new environment experience design must address:

- **End-to-end system thinking:** As systems become integrated, we can deliver more consistent, high-quality experiences across the ecosystem.
- **Greater automation and connectivity:** Better-designed ecosystem services enable automated pathways and reduce provider effort beyond the point of care.
- **Person-centred care:** Shifting from provider-centric to person-centred models gives consumers more meaningful features, choice, and utility.
- **Cognitive-aware design:** Context-rich data and dynamic displays require careful design to prevent overload, clinician burnout, and the exclusion of vulnerable consumers.
- **Better collaboration and information flow:** Notifications and alerts co-designed with users to add value and avoid data fatigue.
- **Data provenance and trust:** More data sources require transparent design that supports provenance, explainability, and trust for both providers and consumers.
- **Workflow-aligned, integrated data:** Data should fit naturally into user workflows, using standards to solve real problems, not a one-size-fits-all model.
- **Improved wayfinding and search:** As structured data grows, navigation and search must improve to support both providers and consumers, with context playing a crucial role in their journeys.

HIPS HealthViewer



The case for change

- Software currency
- Security
- Conformance
- Mobility
- Deep integration
- Responsiveness to change e.g. My Medicare
- Product signals;
- Feedback channels, user groups
- Experience and usage date

Rationale for HealthViewer

A modern viewer that is easier to upgrade, safer to operate, and simpler for clinicians to use

The Case for Change

Faster more effective clinical access & use

HealthViewer reduces friction for clinicians while improving the platform foundation behind My Health Record access.

Designed for real workflows: embedded in clinical software or browser-based, across desktop, tablet and mobile.

Value Drivers

01 Quick upgrades

Easy installs keep pace with My Health Record releases.

02 Security conformance

Meets the My Health Record connecting-system profile.

03 Platform quality

Improves security, performance, usability and accessibility.

04 Fewer clicks

Key patient information appears on the overview page.

05 Flexible adoption

Embeds in clinical software or runs in a browser.

06 Clinician-led design

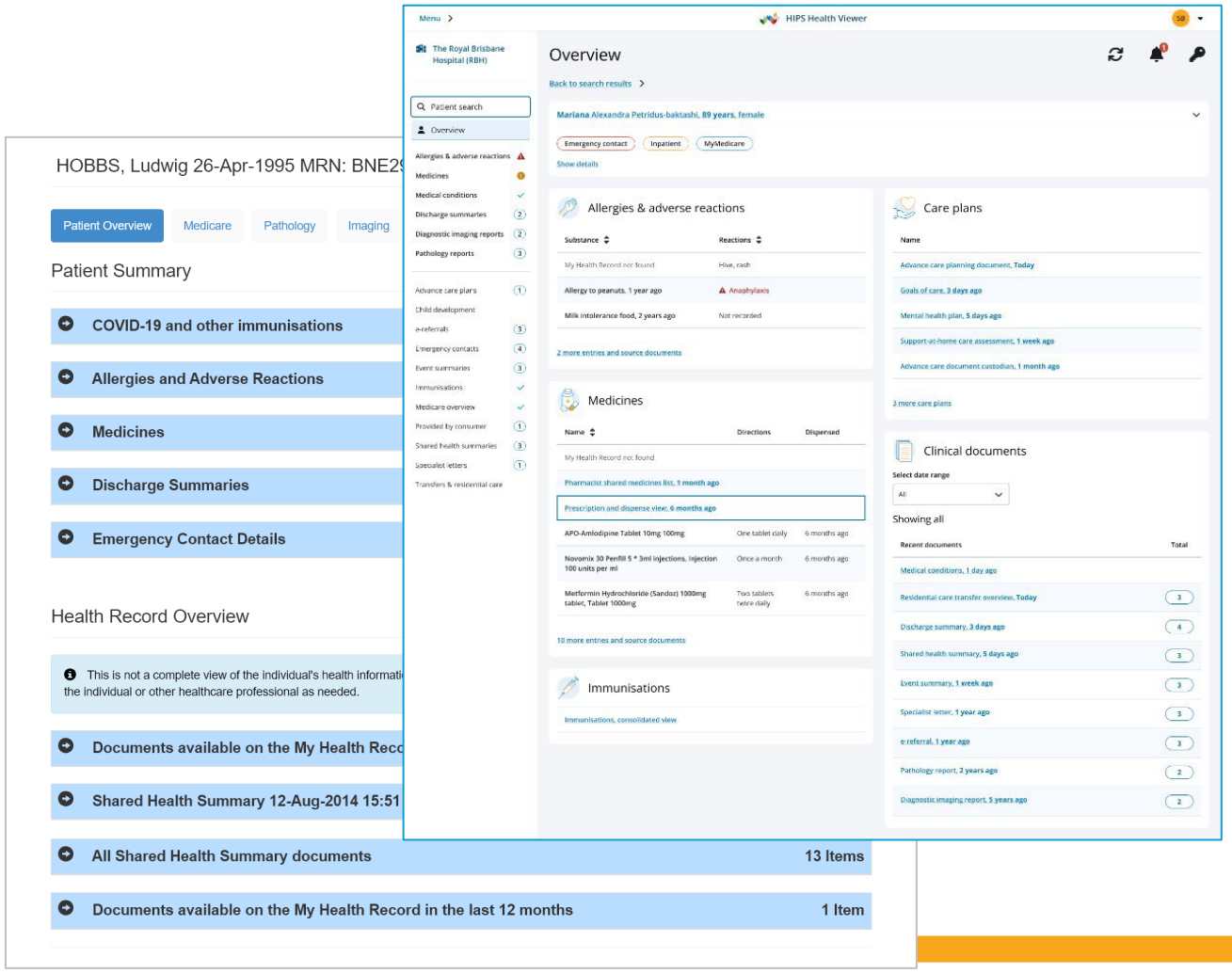
Co-designed information architecture supports workflows.

Experience Design in practice

HIPS Health Viewer, Agency's design approaches, expertise and rigour, from the outset to ensure an optimal experience for clinicians and a truly modernised channel.

Objectives:

- Ensure the Agency's **User-centred design** process was appropriated into the project.
- Build a **constructive/collaborative** thriving design process and environment with the established HIPS team.
- Provide a **user-experience quality baseline** to ensure the new design solved real problems and well understood needs.
- Ensure design activities such **Collaborative design** with clinicians, design **validation testing** and **Accessibility compliance** was embedded in design process and included in future cycles.
- **Capture user behaviours** across the platform to inform design decisions.



Experience Design in practice

HIPS Health Viewer, Collaboration and co-design throughout for better product outcomes

1 Evaluation and enhancement

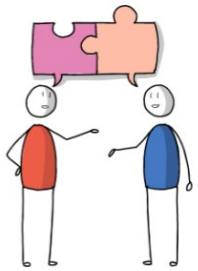
- 2023 Usability Heuristics baseline
- Evaluated the Information Architecture (taxonomy, content)
- Defined themes in terms of core scenarios we need to focus on

250+

Medium to critical usability & design insights through heuristic evaluation & usability test ran with 8 clinicians

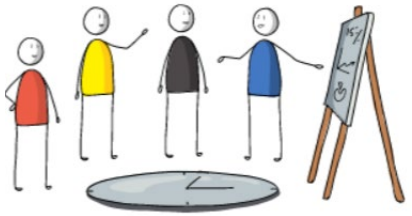
2 Engaged users throughout

- Embedded DHAs over 5 months, 8 clinicians each time
- Conducted multivariable testing, card sorting and user test sessions across 3 phases
- Incorporated new functionality based on user-needs and feasibility



3 Ways of working

- Bi-weekly design sprints
- Broke down overwhelming design changes into 17 UX design spec deliverables
- Defined UX metrics to monitor for continuous UX enhancement



4 On-going design rigour

- Iterative UX design delivery collaboration with product managers and developers
- Incorporated release assurance, accessibility & UX standards into design spec acceptance
- Created a new UI design system for future re-use, quality, efficiency and compliance

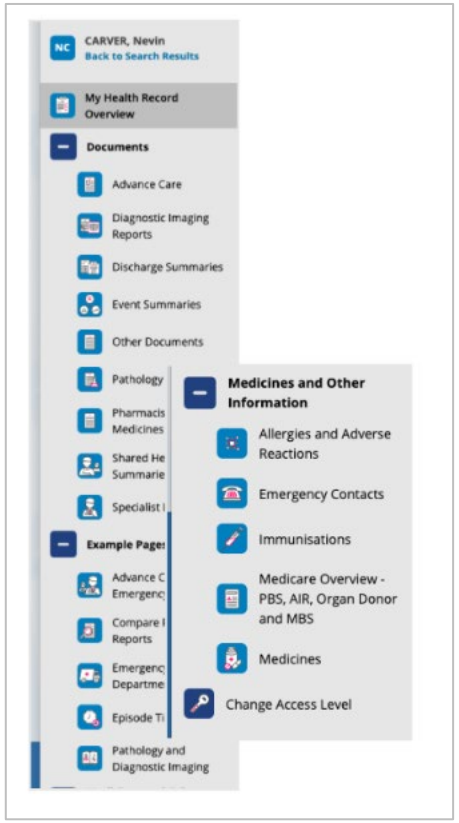
Experience Design in practice

Enhancement example and enduring impact

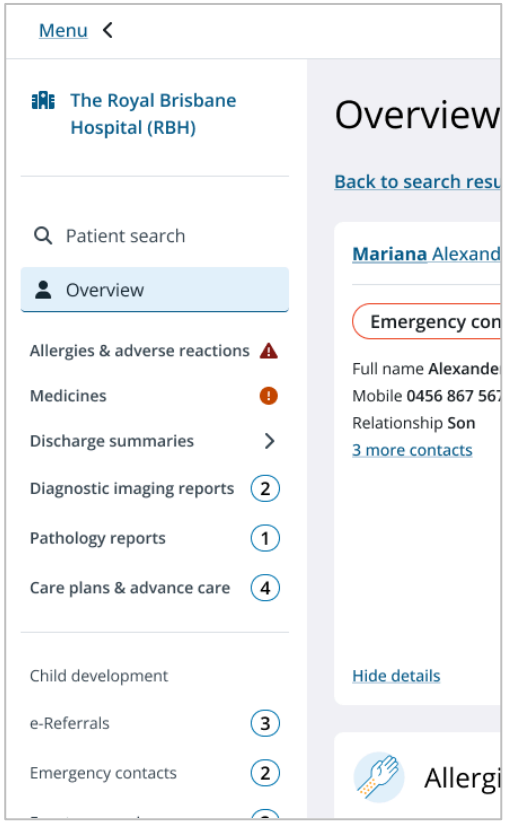
Navigation Outcomes:

- Information architecture redesigned and streamlined co-designed with clinicians and card sorting data
- Removal of customisation to ensure consistent quality
- Design which reduces cognitive load and promotes findability
- Consistent My Health Record labelling and terminology across channels
- Reduction of clicks to common pathways
- Increase visibility of system status with information counts and status inclusion
- UI design which provides better usability

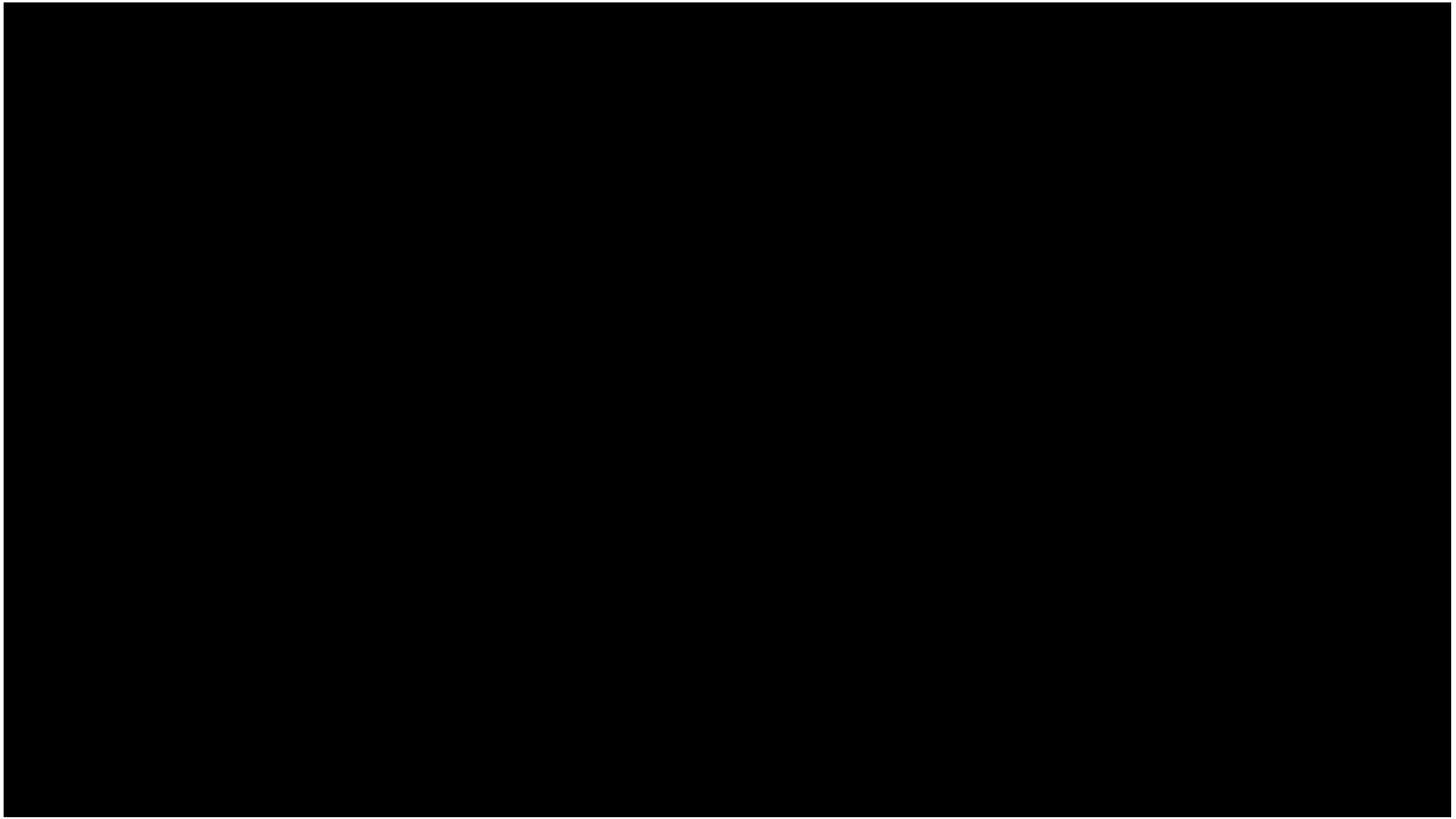
before



after

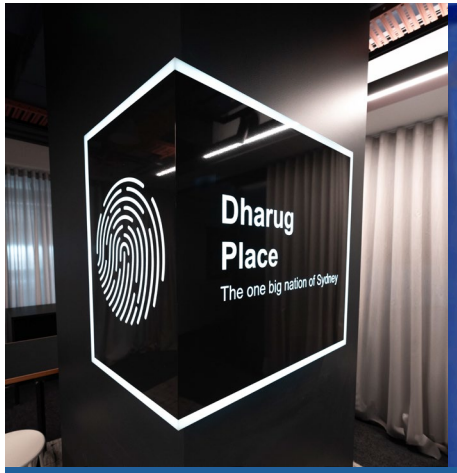


The HIPS HealthViewer



From design to impact, measuring design impact

Using evidence to improve clinical care, testing speed, consistency and usability.



Evaluating HIPS-UI vs HealthViewer:

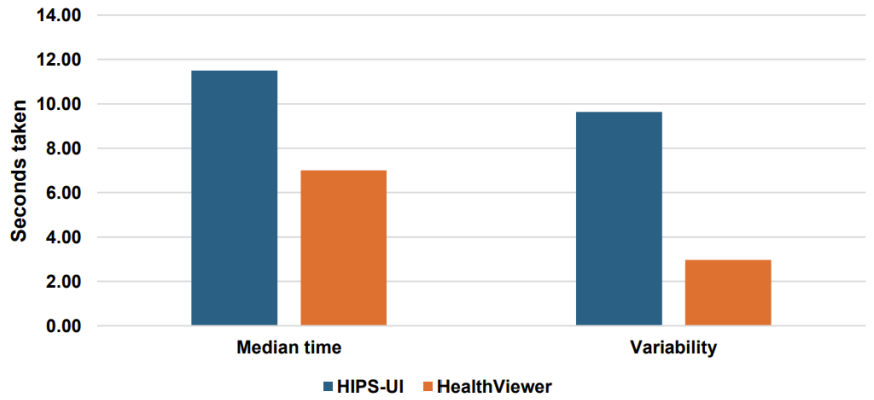
- Agency-led time-and-motion study using Dharug Place (the Agency's Experience Centre)
- Compared: HIPS-UI & HealthViewer
- Focus: real-world clinical tasks
- Objective: measure efficiency + usability

Simulated clinical tasks with healthcare professionals

1. **Participants**
   10 clinicians from mixed hospital roles
2. **Method**
   Structured retrieval tasks with moderated think-aloud sessions
3. **Measures**
   Completion time, user variability and perceived ease of use

Key findings and what they mean for clinicians

HealthViewer is faster, more consistent, and easier to use



- 1.6x faster task completion
- >3x less variability across users
- Higher ease-of-use scores (6.7 vs 5.8)
- Improvements seen across most document types

Strong preference for navigation, layout and clarity

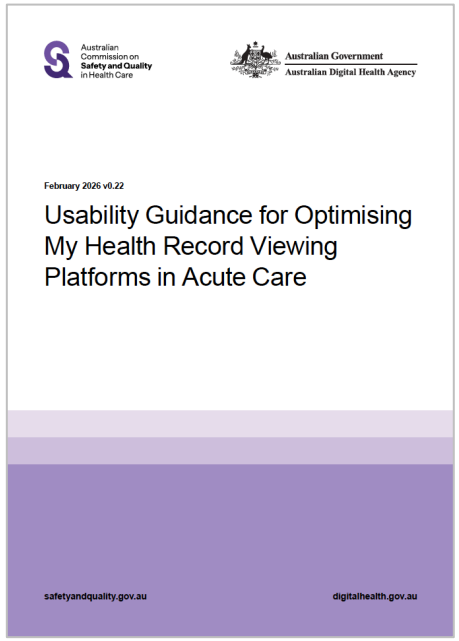
Design improvements translate into workflow efficiency

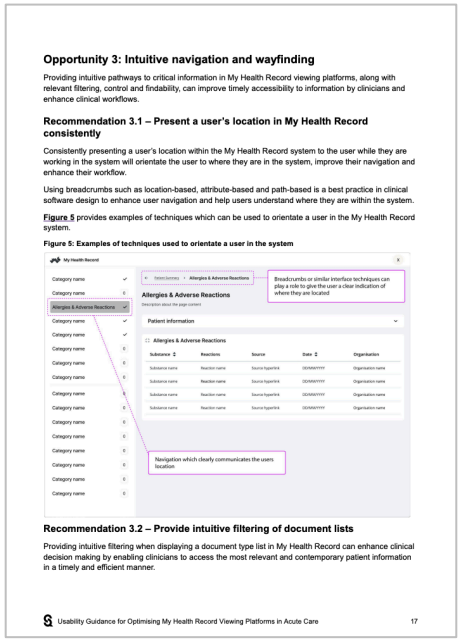
- Faster access to critical patient information
- Reduced cognitive effort – less searching
- More predictable workflows in time-critical settings
- Driven by:
  - Clear navigation
  - Better information grouping
- Fewer steps

Design directly supports faster clinical decision-making

Co-designing and guiding the future of My Health Record

The Usability Guidance for Optimising My Health Record Viewing Platforms in Acute Care offers practical recommendations for health services and software vendors to improve interface design and navigation.





The six areas of opportunity addressed:

- **Opportunity 1:** Best practice product design processes and standards
- **Opportunity 2:** Transparency and visibility of record status and content
- **Opportunity 3:** Intuitive navigation and wayfinding
- **Opportunity 4:** User Centered information flow and display
- **Opportunity 5:** Clear and consistent labelling and terminology
- **Opportunity 6:** Usable and understandable emergency and restricted access controls

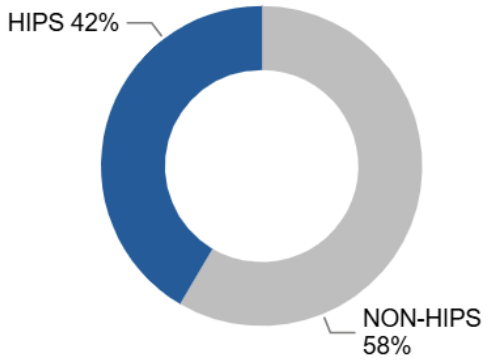
June : HIPS vs Non-HIPS Performance Metrics

Period covered: 01-30 June 2026

For June, HIPS clinical documents delivered **42% uploads (18M)** and **50% views (9M)** against Non-HIPS — demonstrating that while HIPS contributes a slightly smaller share of uploads, it achieves **parity in views consumption**, reflecting stronger utilisation of content delivered via HIPS.

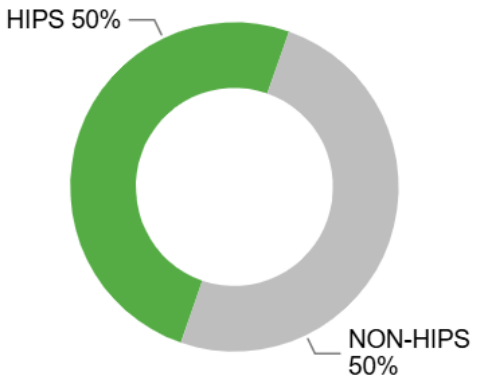
TOTAL UPLOADS

HIPS Uploads **18M**	Non-HIPS Uploads **25M**
Average Daily HIPS Uploads **632K**	Average Non-HIPS Uploads **889K**



TOTAL VIEWS

HIPS Views **9M**	Non-HIPS Views **9M**
Average Daily HIPS Views **339K**	Average Non-HIPS Views **333K**



HIPS vs Non-HIPS Historical Performance

Period covered: 01 July 2020- 30 June 2026

As of June 2026, **HIPS continues to demonstrate sustained growth**, accounting **35% (715M)** of **total uploads** and **45% (260M)** of **total views.**
Over the five-year period, HIPS uploads increased from over **20M in 2020** to nearly **185M in 2025** while HIPS **views** rose sharply from nearly **3M in 2020** to **83M in 2025**, reflecting accelerating clinician reliance on HIPS content. This trend is reinforced by **strong average annual growth rates** of **76% for uploads** and **113% for views**.

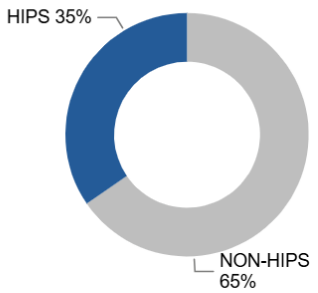
HIPS Uploads
715M

Average Daily HIPS Uploads
327K

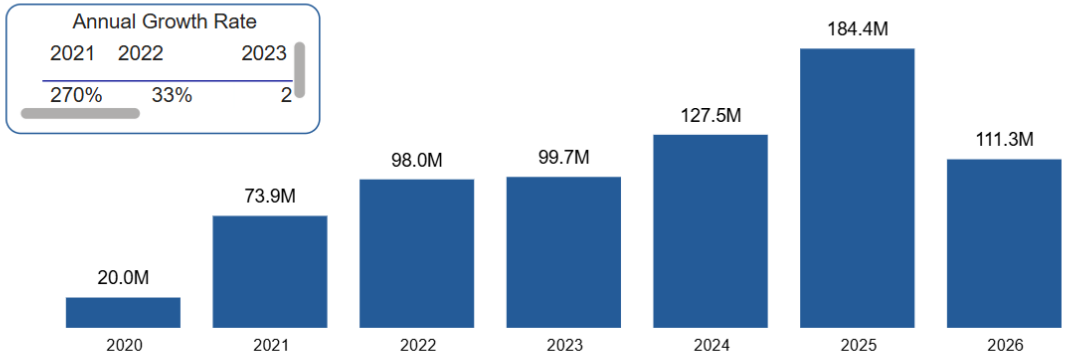
Non-HIPS Uploads
1bn

Average Daily Non-HIPS Uploads
618K

Total Uploads



HIPS Uploads - Yearly Performance



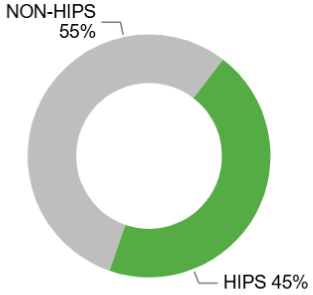
HIPS Views
260M

Average Daily HIPS Views
119K

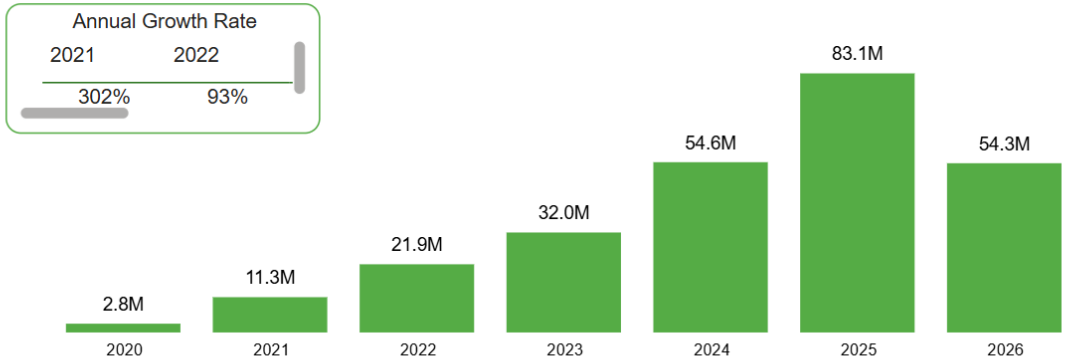
Non-HIPS Views
320M

Average Daily Non-HIPS Views
146K

Total Views (Document/Page)



HIPS Views (Document/Page) - Yearly Performance



Official Sensitive

Sunsetting legacy HIPS versions

HIPS 9.1 released in May 2026

- Supports HIPS HealthViewer
- Deprecation of previous HIPS User Interface

Older HIPS versions will be sunset over the following horizon;

- v6.x – 31 March 2027
- v7.x and up to v8.2.1 – 31 August 2027
- v8.3.0 and v8.3.1 – 30 November 2027

Recent successes and Next Steps

- Alayacare became our first implementation of HealthViewer this year!
- Work is underway to uplift jurisdictions and private hospitals viewers
- HealthViewer 1.2 Release (pending 2026 release)
  - Minor UX / UI enhancements
  - Smart Launch (part of SMART on FHIR specification)
    - Vendor agnostic
    - Launch in context
    - Secure (authorisation)
    - Partnering with EPIC & ACT Health (Digital Canberra)

Supporting HIPS HealthViewer Adoption

HL7 Australia FHIR Connectathon Brisbane 25 – 26 August 2026

Agency demonstration Proof of Concept

Test and prototype integration between clinical systems and HealthViewer

Access to HealthViewer and Smart App Launch resources and expertise

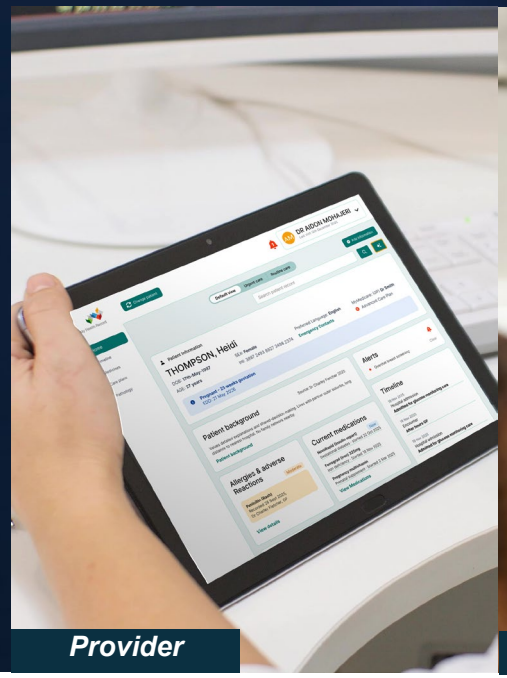
Further information;

Reach out to your Partnerships Manager, or

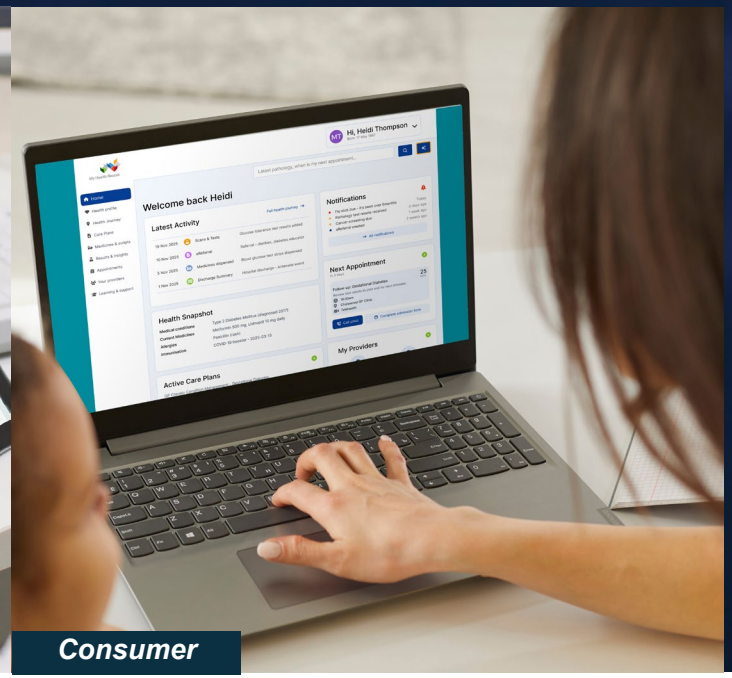
Raise a support ticket via HIPS engagement channel

My Health Record portal, vision for the future

A North Star for the My Health Record use, design exploration and concepting. Visualising opportunities which can be realised by future connected care transformation enablers.



Provider



Consumer

Scope what it is and what it isn't

- Not currently a formal, confirmed list of planned features, purely conceptual.
- Leveraging available evolving direction from programs and community initiatives.
- Focusing on ADHA operated My Health Record channels. *(NCP, NPP)*
- Constrained to the purpose of the My Health Record system
- Responsive web modernising existing channels, combining and streamlining the technical stack and design systems. Not a native mobile app.
- Not intended to replace existing CIS but to serve as My Health Record access in specific scenarios or for roles currently not strongly supported by My Health Record integration
- Excluding but influencing 1800MEDICARE, HIP Viewer and providing guidance of My Health Record future implementations.

Target customer experiences

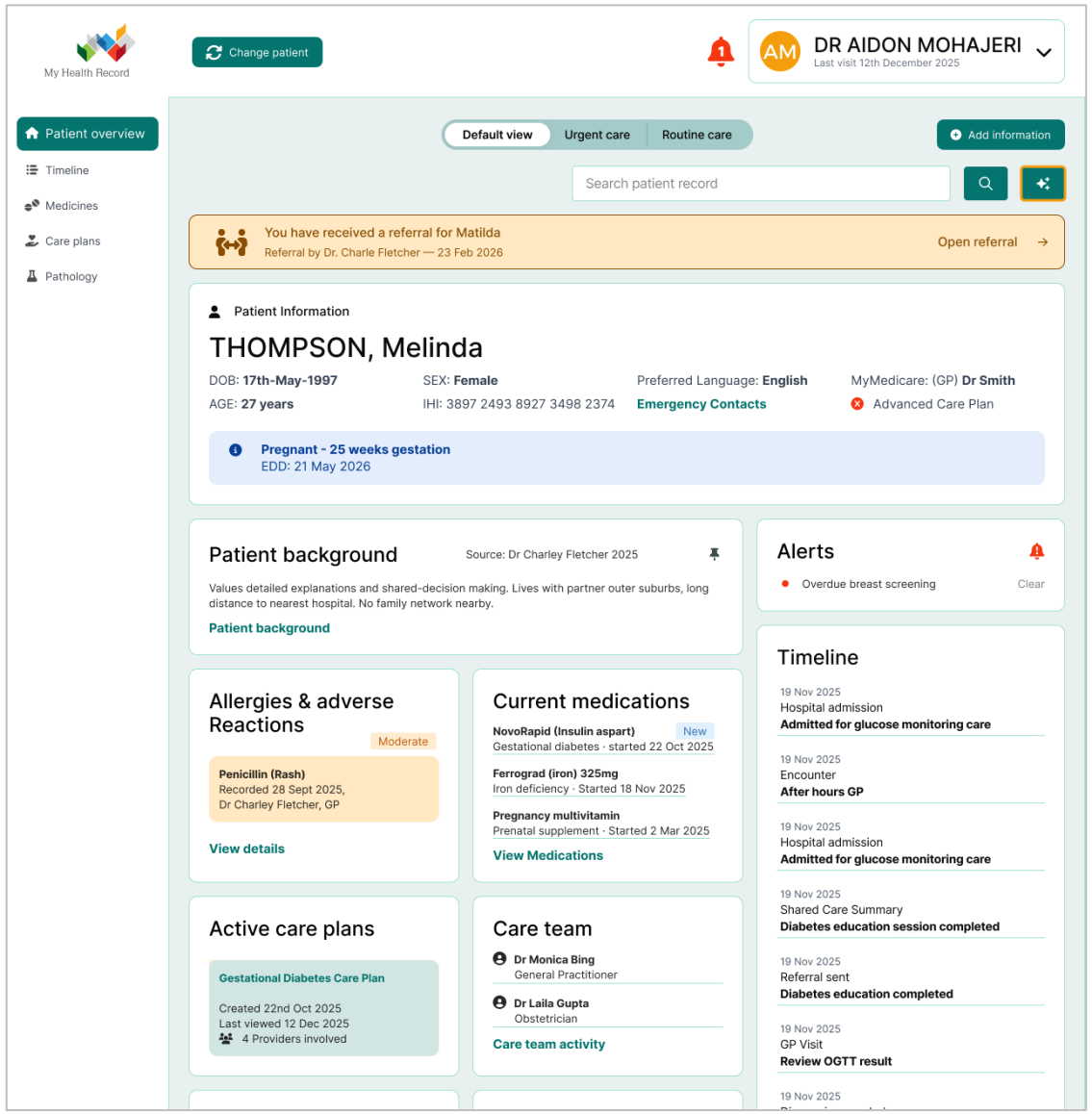
Consumer

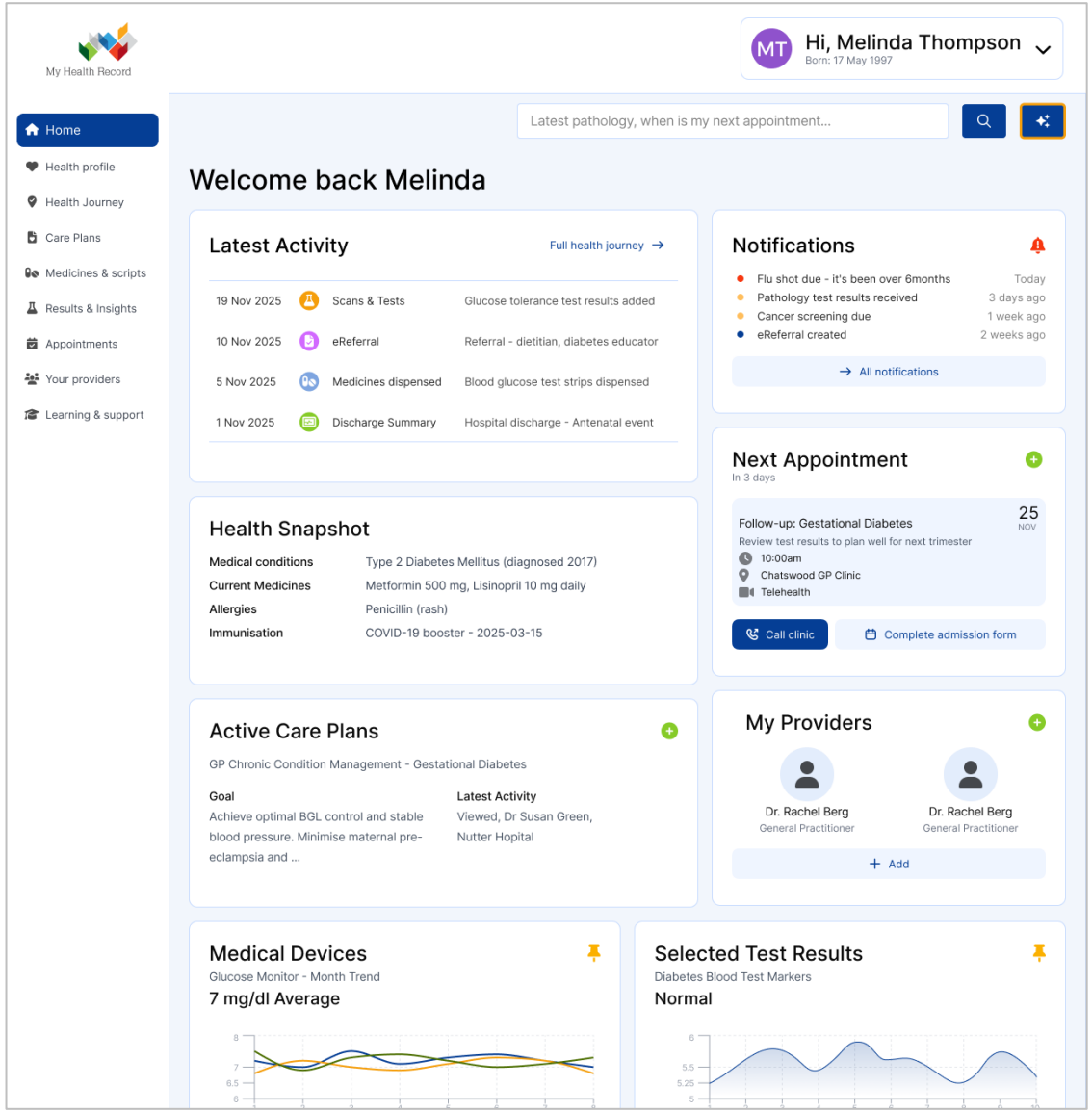
- **Help me understand my health journey**; the technology is just a means to an end
- **Clearly explain what happened and what I need to do next**, reducing cognitive and emotional load
- **Design for consumer-centric digital literacy**, comprehension, and understanding not just clinical expertise
- **Make important changes in my healthcare** easy to see and understand
- **Support me to act**, not just access information; help me contribute, manage, and make informed decisions.

Provider

- Provide faster, **low-friction clinical access** to My Health Record within the product's **unique care contexts**
- Support continuity of **care across** different roles, functions, and settings through clinical movement design
- Preserve clinical meaning, **data provenance, and trust** with task-oriented information design
- **Enhance wayfinding, searchability, and findability** to support efficient information retrieval
- Automate workflow contributions and **reduce the burden of content upload and maintenance**.

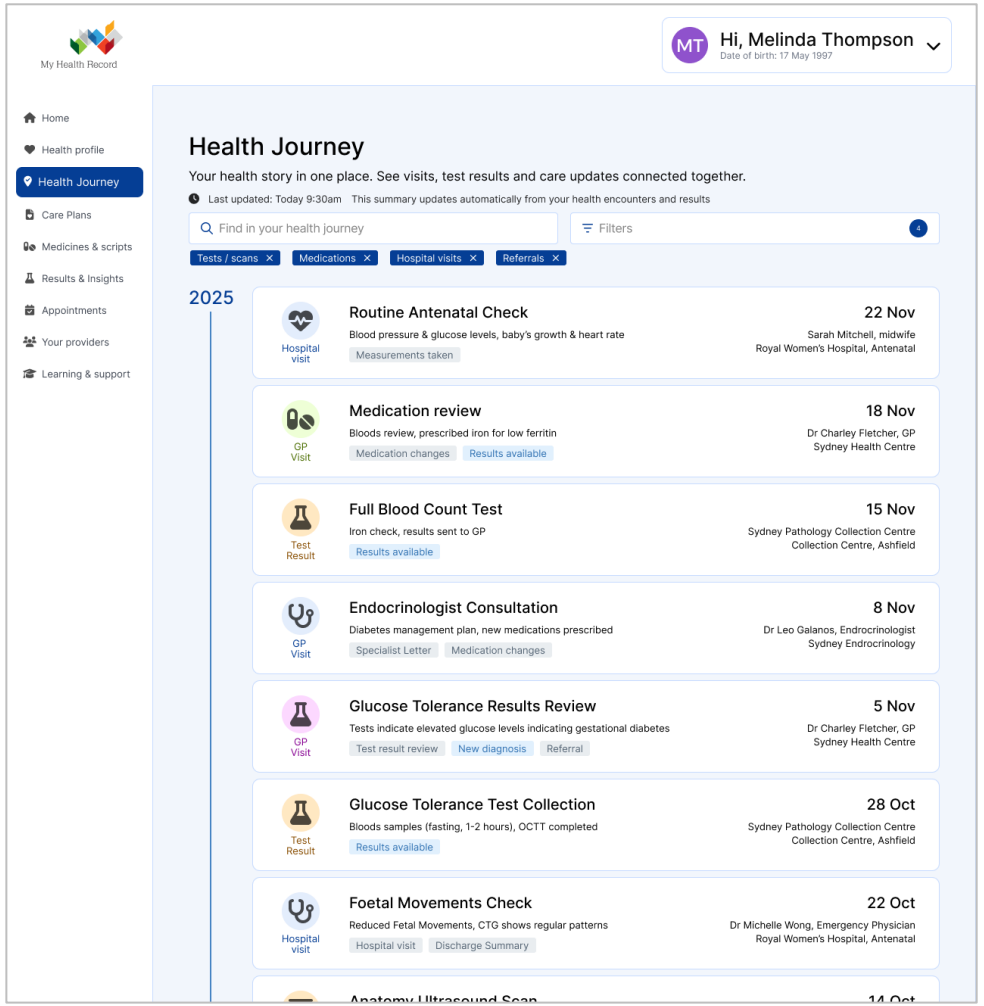
Consumer & Provider future portal

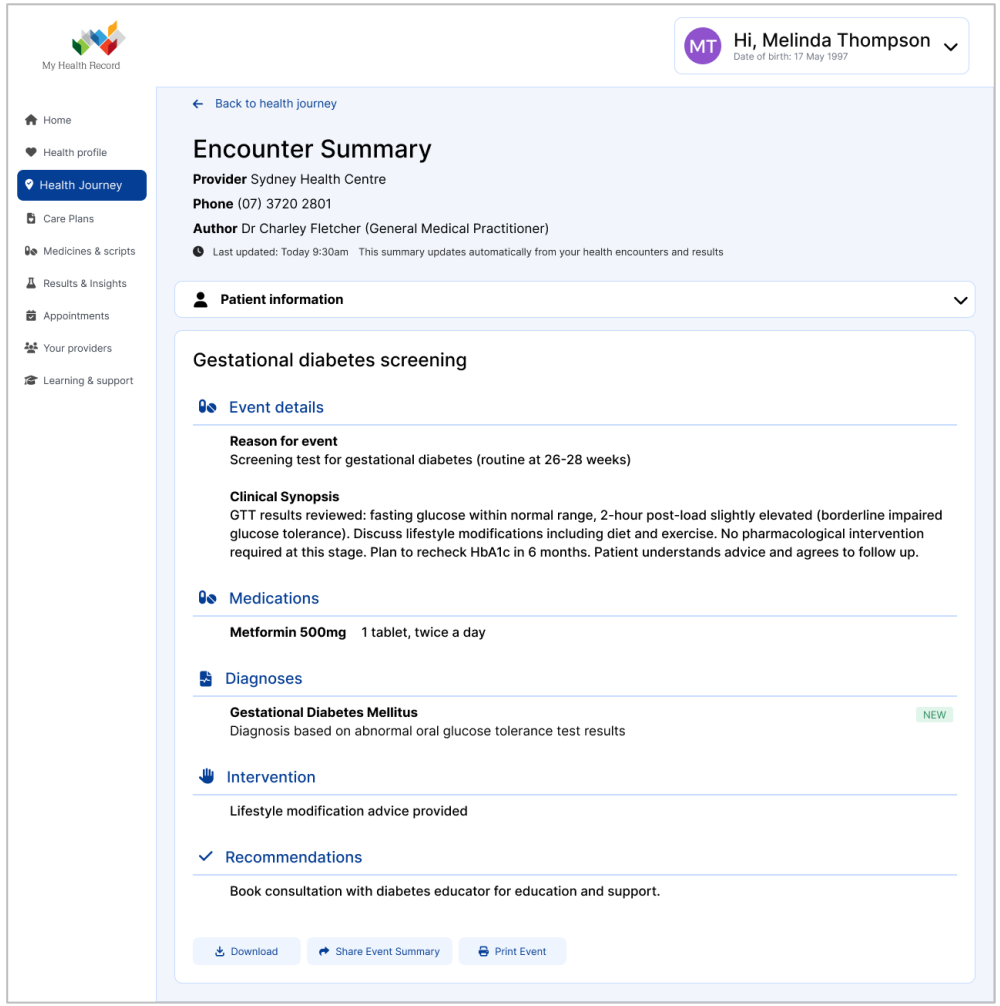




Timelines & encounters

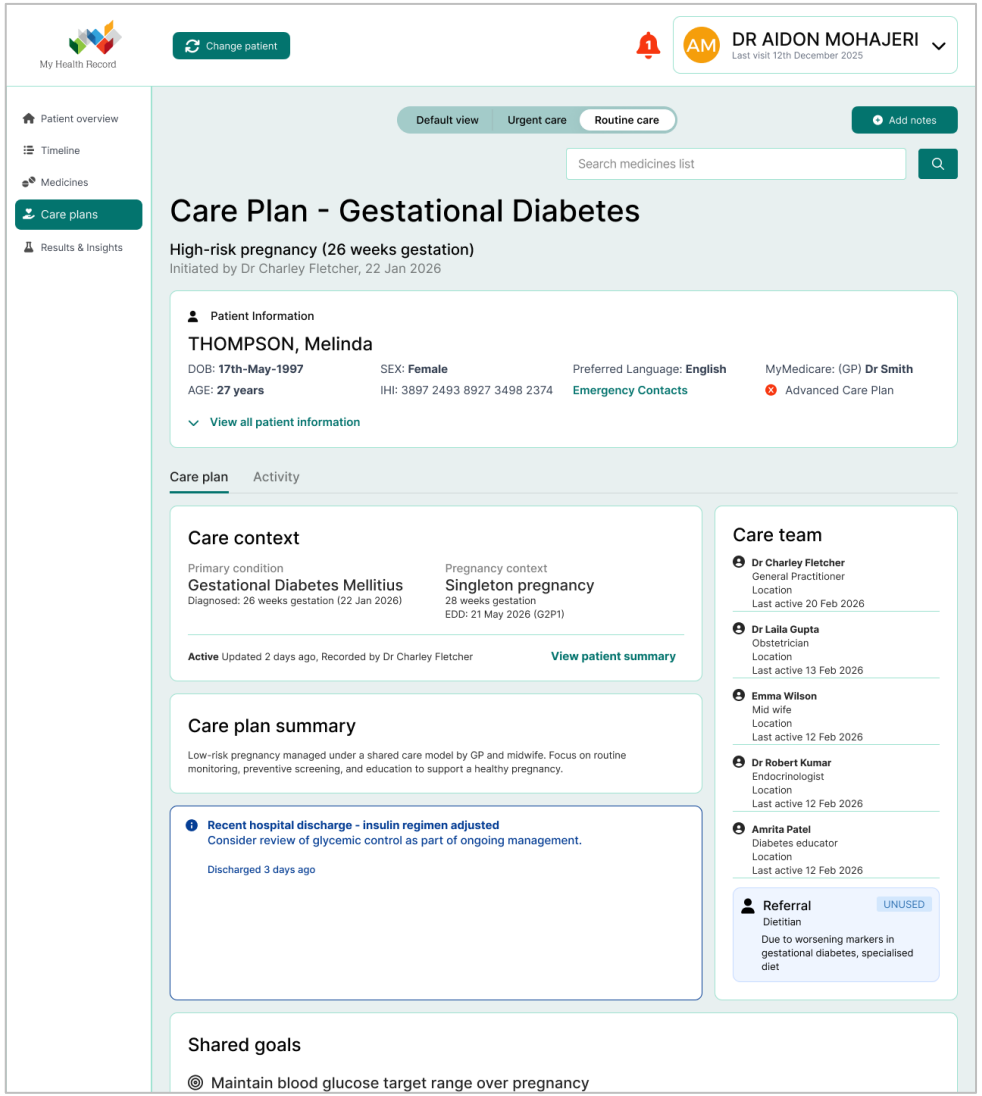
Contextual consumer timelines and enhanced provider patient navigation





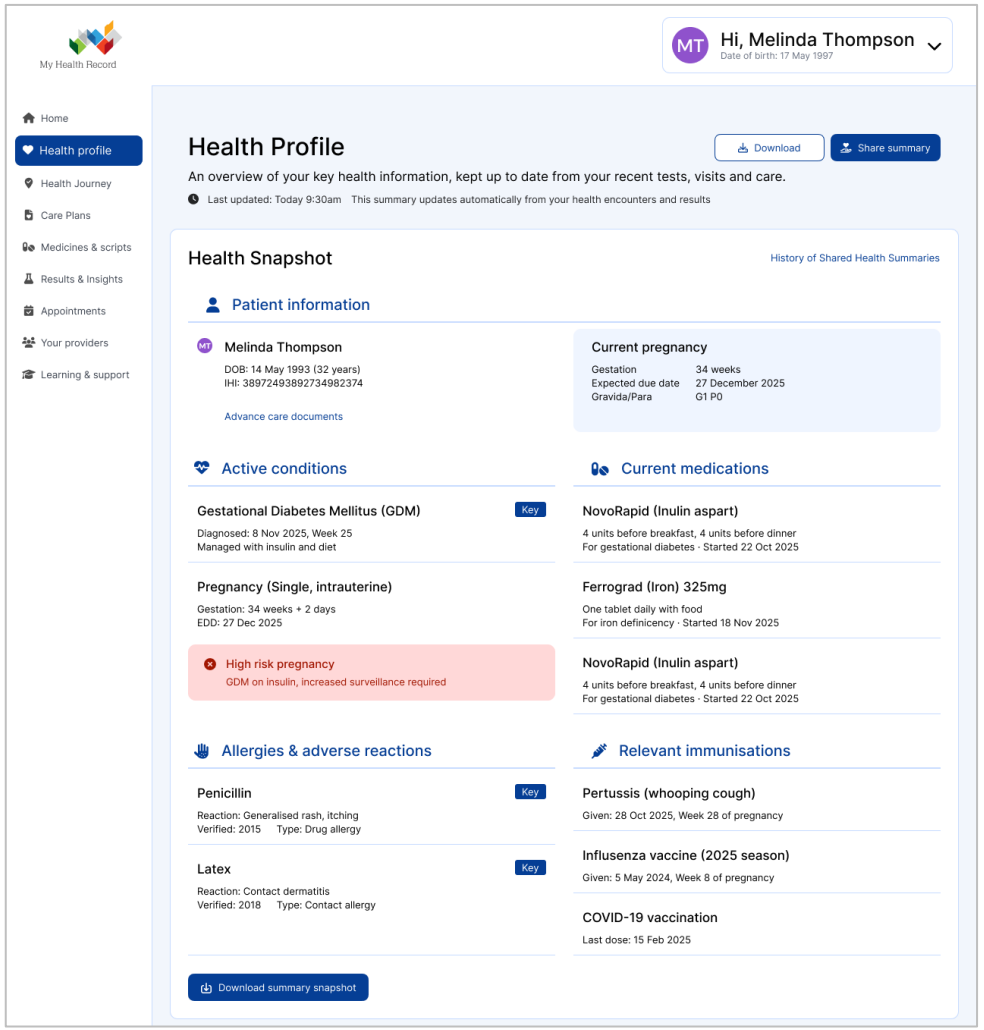
Shared care plans

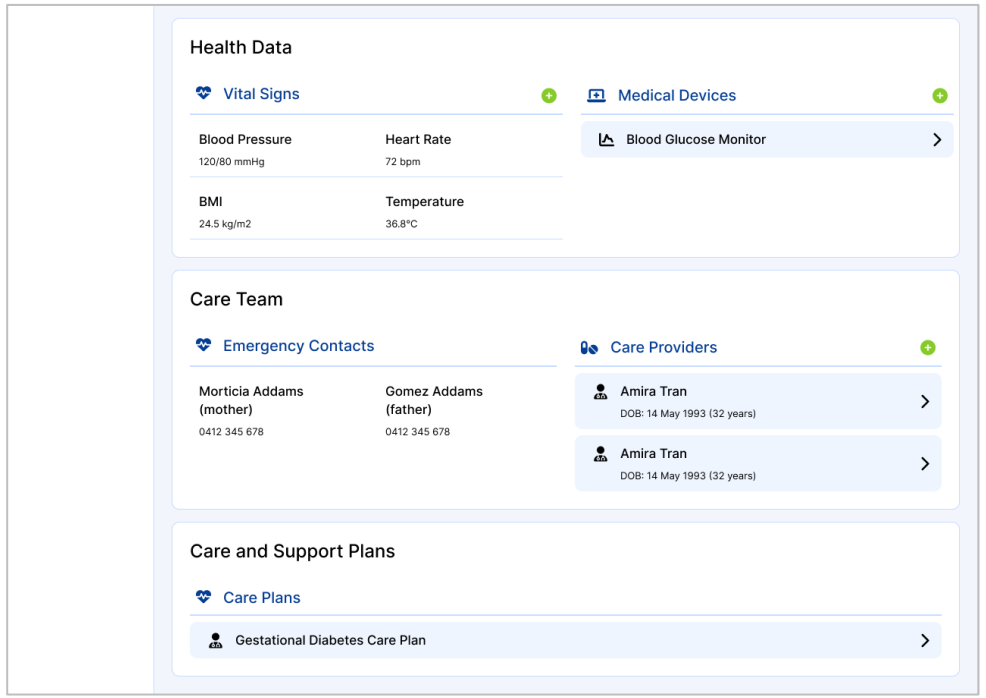
Multi-disciplinary care team enablement



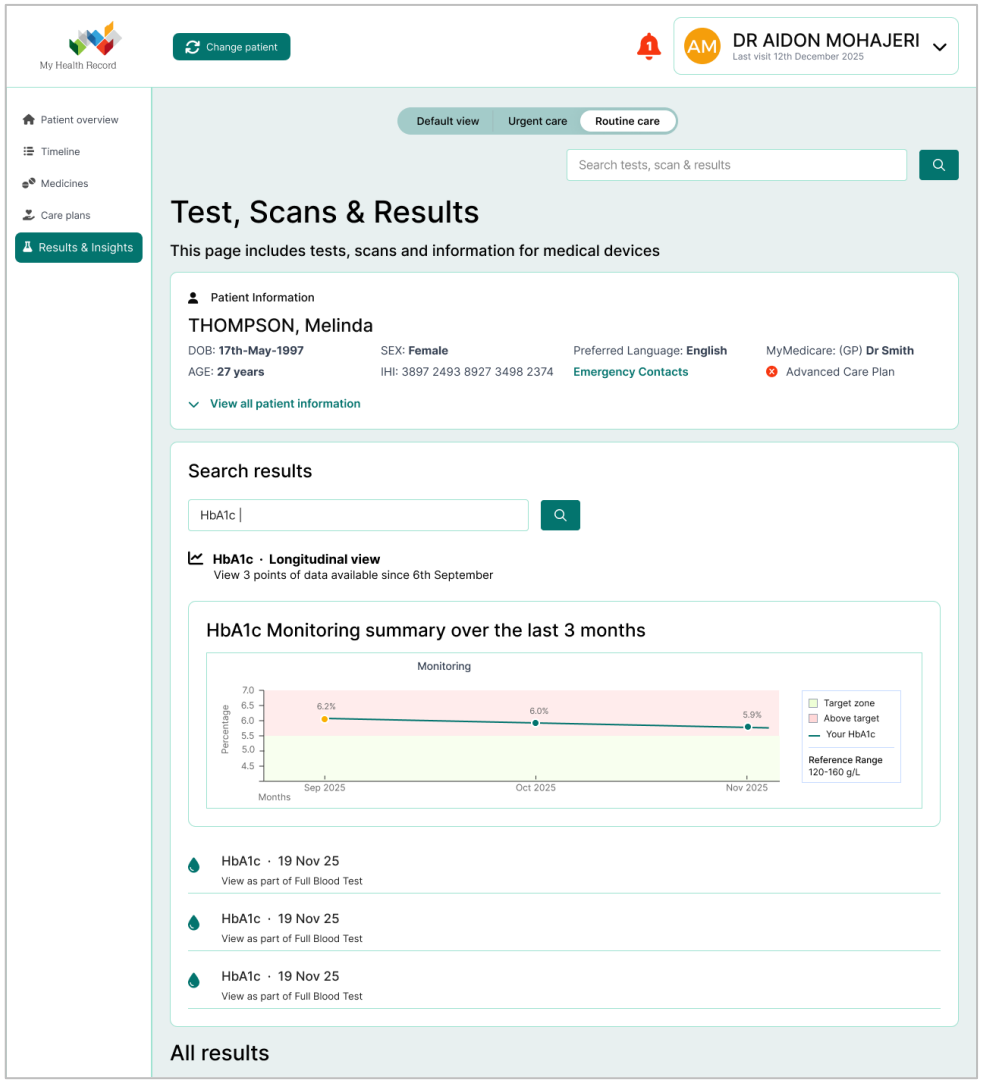
Consumer health profile and patient summary

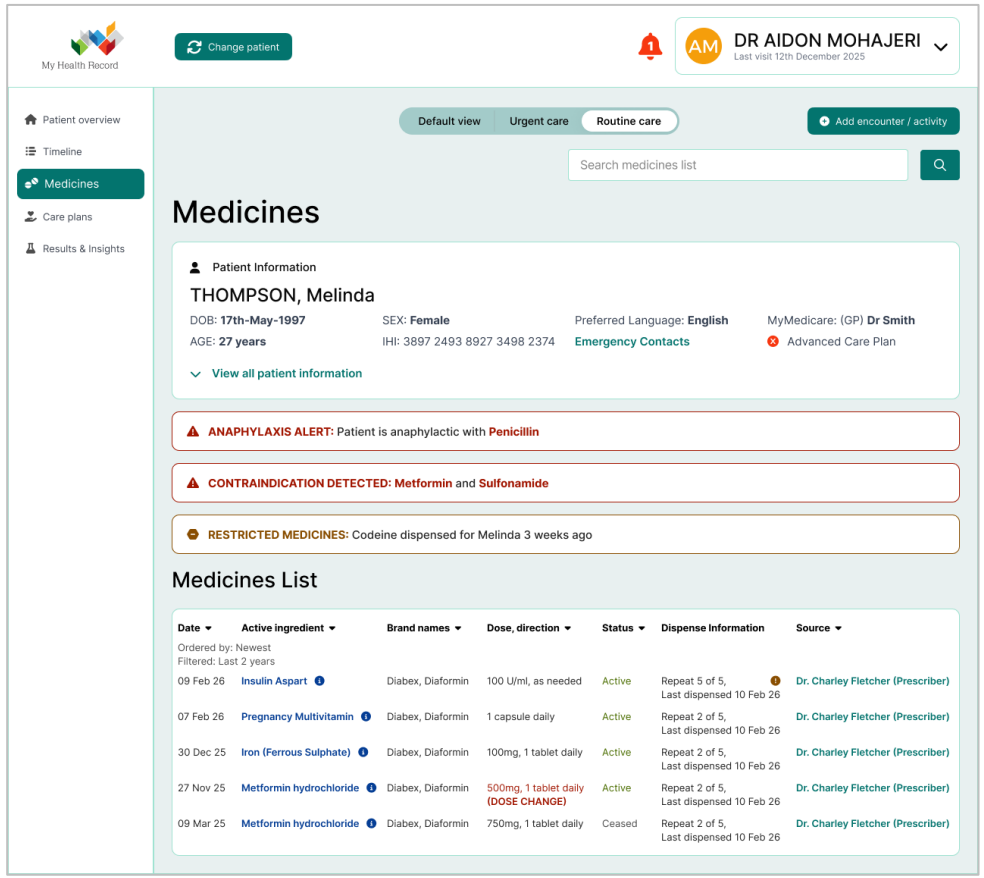
A current trusted view of health information to empower consumers





Results and medicines opportunities





Facilitator and Panel Q+A

Sandra Cook
Branch Manager
Connected Care

Ryan Mavin
Branch Manager
Informatics and Standards

Ines Sostaric
Branch Manager
Customer Experience and Products

Alex Powell
Branch Manager
Clinical Governance

Peter O'Halloran
Chief Digital Officer

Other Ways to Stay Connected

WEB: digitalhealth.gov.au

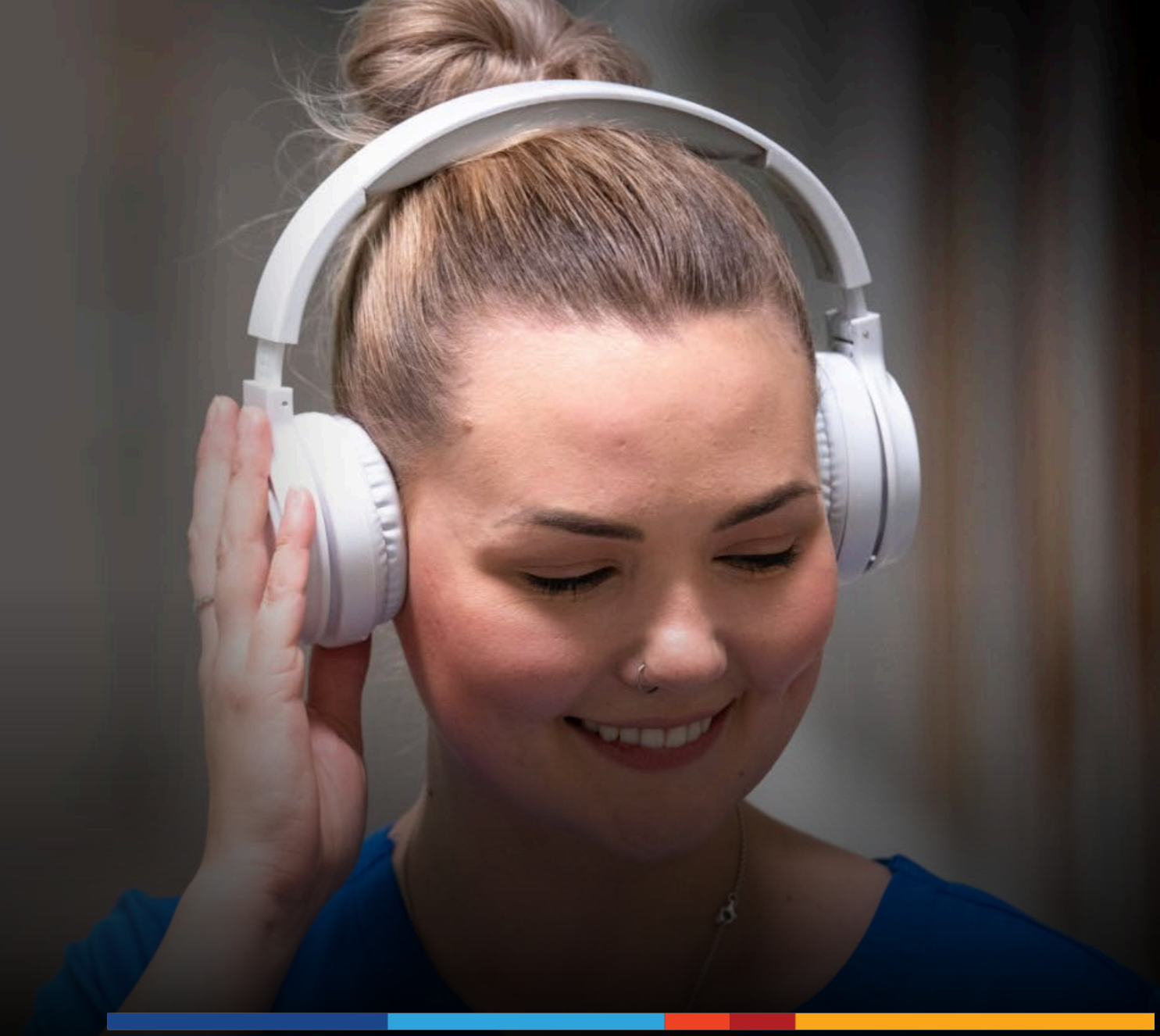
EMAIL: help@digitalhealth.gov.au

PHONE: General enquiries 1300 901 001

Australian Digital Health Agency

@AuDigitalHealth

@AuDigitalHealth



Australian Government
Australian Digital Health Agency